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**BIOGRAPHICAL DISRUPTION OR
REINFORCEMENT? MEN'S LIFE HISTORIES OF
EMOTIONAL DISTRESS**

by

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DECLARATION

I hereby declare that this thesis is entirely my own work and has not been submitted for a degree at another university.

ABSTRACT

The main focus of this thesis has been an investigation into the lives of men who have experienced some form of mental health problem. It has been suggested that mental illness may not be the most helpful way of conceptualising these experiences, as it presupposes the validity of the medical model of explanations and meanings. Instead it has been proposed that the term 'emotional distress' allows for the embodied nature of the experiences, and distances them from medical definitions. The key sociological concept used in the thesis is that of biographical disruption, a notion used by Bury (1982) in the context of chronic illness, and one of the aims of the research has been to establish the usefulness of this concept to research on experiences of emotional distress. The chosen methodology in achieving this aim is that of life-history narratives, which have been used in the study to illustrate the ways in which emotional distress emerges from and impacts upon the lives of individuals. Eight men provided life-history narratives, and these were supplemented by published (auto)biographical accounts, and by my own experiences as a mental health service user. As men were identified as the focus for the research, an investigation into the role of masculinity as a factor which mediates these experiences was also undertaken. Thus, the contribution that the study makes to sociological knowledge is to extend the concepts which have been applied to chronic illness, into the field of emotional health, with a particular focus on biography, on the role of masculinity, and on embodiment and emotions. It also contributes to an understanding of emotional distress, an experience which is often hidden from view. The thesis concludes that all of these sociological ideas are indeed valuable in the search for meaning in the experience of emotional distress.

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CHAPTER 1

INTRODUCTION

BACKGROUND TO THE STUDY

In November 1997 I was diagnosed with depression, and admitted to a psychiatric hospital, where I was to spend the next four months of my life. This was the culmination of a period of about two years, during which I was aware that things were not right with me, that I was not fulfilling social or professional obligations, and that during much of this period, I would have preferred to be dead than alive. The time that I spent in hospital was characterised by a mixture of fear, relief, anger and frustration, but ultimately by a recognition that many of the individuals with whom I was spending my time, were amongst the most caring and interesting people I had ever met. I was treated to fascinating insights into their lives, and felt at times somewhat ashamed that the stresses that had led me to become a psychiatric patient, seemed totally trivial in comparison with the events in the lives of those with whom I was spending my time. I must confess that this came as a surprise to me, because I had had no dealings with mental health services, nor with anyone who had been a service user, and so my preconceptions of both the services and the patients were based on stereotypical images portrayed by the media and transmitted through society, based around the 'insane', the 'mad' and all the negative messages invoked by the image of the 'loony bin'.

Medical staff included a mixture of the kind and understanding, and the rigid and more authoritarian types more in keeping with their stereotypical images, but I was

able to recognise that all were working within the constraints of a system which were built around the management of a varied group of individuals, with diverse and time consuming needs. More than anything, I found that support was always available from fellow patients, whether it was in the form of emotional support, or information about the system, medication or the likely trajectory of my recovery. Having entered the hospital in a state of dread about being there, and of the individuals I was going to encounter, after a short time my dread was of being released back into the life that had resulted in my depression. In the event, this was an unfounded dread, because as I had been self-employed for many years, the time spent not fulfilling my obligations, followed by the period in hospital, had resulted in my being made bankrupt within two weeks of admission to hospital. Thus, my working life and my home were not available to return to, social ties dissipated during my time in hospital, and my marriage had ended prior to my admission. Though at first fearful of the loss of all these familiar aspects of my life, as my recovery progressed I began to recognise that these losses represented an opportunity to rebuild a different sort of life for myself.

One of the steps I took in this rebuilding process, was to enrol on a sociology A level course at the local college, mainly to prove to myself that my brain could still function. This, in turn led to applying to do a degree in sociology, and then discovering that there was in fact, a branch of sociology named 'The Sociology of Health and Illness', to which, as a result of my recent experiences, I was drawn. Naturally, I sought out wherever possible, literature involved with 'mental illness', as I still felt a strong need to gain an understanding of my own experiences. Though much of this literature was illuminating and added to my ability to apply various perspectives to my experiences, most of it focused on the experiences of women, applying feminist theories in order to

explain the apparent higher incidence of some diagnostic categories of 'mental illness' in women. Despite my recognition of the importance of these perspectives, I did gradually find myself asking questions such as, 'How does this explain my experience of depression?' and 'Where are the stories of those men I spent time with in hospital?' It was not surprising then, that when the opportunity presented itself to extend my time in academia by carrying out a doctoral research project, that I chose to concentrate on the mental health experiences of men.

The methodology I chose to explore these experiences was the collection of life history narratives, and I present a detailed account of my reasons for this choice in Chapter 3. It should however be noted that although the data which is used in the thesis comes from interviews which have been audio recorded and transcribed, this is by no means my only source of understanding and interpreting men's mental health experiences. This understanding is informed by my time spent as a mental health service user, during which time I was privileged to hear the stories of many men (and women), and from the several years I have spent as a volunteer and committee member of a local MIND group. In addition, during the process of selecting men to participate in the research, several meetings were often required to ensure that the men whose interviews were to be recorded fully understood the nature and purpose of the research, and were comfortable about their participation. Thus, my immersion in the field of mental health service users extended far beyond the time taken to conduct the interviews.

Within the Sociology of Illness literature, a prominent theme in recent years has been the sociological analysis of chronic illness, and at the forefront in this analysis was

Bury's (1982) conception of chronic illness as 'biographical disruption', and the various critiques and extensions to this notion. When I compared the results of these analyses with my own experiences of depression and of becoming a mental health service user, and with the many life stories I had heard from other service users, it seemed clear that many of the same issues and theoretical concepts which had been raised in the studies of chronic illness experiences, were of at least equal relevance to the experiences of 'mental illness'. This leads directly on to the way in which these experiences should be analysed, in that if the notion of biography is the important one in understanding these experiences, then a life history narrative approach offers to produce the appropriate data in order to produce such an analysis.

Other sociological debates also offered themselves as relevant to mental health experiences, one of which was the move toward bringing 'the body' back into sociology, and the suggestion that emotions were a means of bridging the mind/body divide. Again my own experiences had brought about the realisation that those experiences categorised as mental illness, were far being solely phenomena which took place in the mind, but were thoroughly embodied experiences, which included physical and biological, psychological, and social elements, all inextricably intertwined. Thus, the sociology of emotions debates appeared to offer a way to include these various aspects. The preferred terminology of service user groups at this time was that of 'mental distress', with the intention of distancing the experiences of users from the medically based illness model, but in the light of the embodied, emotional nature of the experiences, I have preferred the term 'emotional distress'.

The final area of sociological theorising which has informed this study, is that of gender studies, but in particular the body of literature which has been labelled 'The New Men's Studies'. The recognition that men's experiences were not prevalent in the literature on the sociology of mental illness persuaded me that it should be these that my research should concentrate on. Once again, my own experiences informed this decision, as I had become aware that being a man was significant in the way that I experienced emotional distress, and in the way that others reacted to these experiences.

Thus, it can be seen that a mix of personal experiences and exposure to sociological theoretical perspectives and debates, has informed both the subject matter of this research, and the ways in which it is to be carried out. The sociological questions which are to be addressed in the study are:

- (i) What is the relevance of the chronic illness literature, and in particular, the notion of chronic illness as biographical disruption, to the study of emotional distress?
- (ii) In what ways are biographies an important factor in understanding the experiences of individuals who suffer emotional distress?
- (iii) What do the sociological debates about the importance of recognising the embodied nature of social phenomena contribute to the study of emotional distress?
- (iv) How may the issues raised by 'The New Men's Studies', and the social construction of masculinities, inform the understanding of men's experiences of emotional distress?

I will now move on to briefly outline how the thesis has been arranged in order to address these questions.

THE STRUCTURE OF THE THESIS

In chapter 2, I will give a summary of the sociological and other literature which has informed the study. This summary begins with an account of literature on chronic illness, with a particular focus on the debates around Bury's (1982) notion of chronic illness as biographical disruption, before moving on to highlight some of the published work which falls broadly under the heading of mental health literature. Included under this heading is literature from the sociology of mental illness, from psychiatric and psychological sources, and from autobiographical accounts of experiences of emotional distress. This chapter then goes on to examine some of the issues which have arisen on the subject of men's health and illness, and includes literature from within the New Men's Studies, and ends with a consideration of sociological debates about the importance of bringing the body and emotions back into sociology, and how these have contributed to the study. Chapter 3 will examine the methodological issues encountered in the research, beginning with a justification for the use of life history narratives as a suitable methodology for the research, before moving on to consider practical matters including sample selection, collecting the data, interpreting the data, and ending with a review of the ethical issues which were encountered.

Chapters 4-8 will be where the narratives are brought to the fore, and will address a range of themes and issues raised by the data. In chapter 4, I will examine the ways in which explanations for emotional distress are developed by the participants, and in chapter 5, the focus will move on to illustrate the ways in which emotional distress has been experienced by the contributors. There is some overlap in the subject matter of these two chapters, as the accounts of experiences of distress inevitably include attempts to give meaning to the experiences, and this can include explanatory elements. One of the most important aspects of these experiences for some of the participants is that of treatments, including hospital based treatments, prescription drugs or talking therapies, and it these experiences which will be examined in chapter 6.

As the previous section of this introductory indicated, the experiences generally categorised as 'mental illness' are far from solely psychic in their nature, and include many bodily elements. In chapter 7, the accounts given in the narratives of these embodied aspects of emotional distress will be examined, and the chapter will also include the theme of spiritual meanings, which some of the men who took part in the study included in their accounts. The chapter which is concerned with analysis of the data is chapter 8, and will examine the issue of masculinity in the narratives, including the role of adolescent experiences in the development of masculine identities, and will also focus on issues such as emotional expression, paid work, and intimate relationships, and how these interact with both masculine identity and the experience of emotional distress.

In chapter 9, the notion of biographical disruption is revisited, and the various themes and issues which emerged from the data chapters are re-examined in order to assess the nature of the relationship between emotional distress and biographical disruption. In the final chapter, I will return to the questions raised in the previous section, and outline the sociological issues and the policy implications which arise from the analysis of the narratives. At the end of this chapter, I will make some final comments and reflections on the experience of carrying out this research.

CHAPTER 2

A REVIEW OF THE LITERATURE

INTRODUCTION

The cluster of experiences which are categorised as ‘mental illness’, and which are diagnosed and treated by the medical profession within the specialism of psychiatry, are disparate in their nature, and the boundaries surrounding these experiences are somewhat ‘fuzzy’, having been subject to changes over time, and across different cultures. It seems clear though, that a large and increasing number of people are affected by such experiences. What also seems clear is that these experiences often have a significant impact on the lives of individuals, and that this impact results from the nature of the experiences, the nature of psychiatric intervention, and the stigma which society attaches to those labelled ‘mentally ill’. An indication of the impact on people’s lives is demonstrated by the statistic that approximately 87% of mental health service users/survivors are economically inactive in the UK, a figure which is much greater than for those with a physical disability (Sayce, 2000: 20). The effect of this is often social exclusion, in the form of a downward spiral into poverty, and a loss of autonomy and self-esteem, resulting in threats to the biographical trajectory of the individual.

Though little work has been carried out in examining the biographical impact of ‘mental illness’ there has been a significant amount of work within the sociology of health and illness on the relationship between chronic illness and biography. I will begin this chapter by reviewing this literature, beginning with Bury’s paper, ‘Chronic Illness as Biographical Disruption’ (1982). I will then move on to outline the debates

and critiques which followed this paper, in particular those which argue that chronic illness may, in some circumstances be biographically *reinforcing* or *reaffirming*, and the ways in which individuals seek ways to adapt to their altered circumstances, and the role that narrative plays in this process. I will then move on to examine the literature about 'mental health' and 'mental illness'. Despite the growth of health and illness as a discipline within sociology, relatively little sociological research has been carried out in the field of mental health, and this is especially so with regard to men's experiences in this area, but I will give an overview of those issues which have been addressed by sociologists, and also highlight some literature which has emanated from other disciplines, including of course, psychiatry, psychology and philosophy. I will end this section with a brief overview of the literature concerning suicide, and the links between this and emotional distress.

As my research focuses on the experiences of men, I will then go on to review the literature which explores the links between masculinity and men's health experiences, drawing on this literature to examine how the construction of various forms of masculinity might contribute to men's emotional distress, and how both the experience of distress and the resulting medical intervention might be seen as a threat to men's sense of their masculine selves, clearly an important element of their biographies. Finally, I will turn to philosophical and sociological debates about the mind/body split, and the sociological move toward the social aspects of emotions as a means of overcoming some of the problems of this duality. Having carried out this review of a wide range academic writings, I will move on to suggest that rather than the medical categories of mental illness, the experiences contained within these categories are better conceptualised as 'emotional distress', and that an exploration of

this concept in the context of the biographies of individuals who have gone through these experiences provides the potential to challenge dualities such as mind/body, emotionality/rationality and agency/structure. This analysis brings us to the heart of issues of self, subjectivity and social identity, and provides the tools to produce a 'phenomenologically informed exploration of emotions, which enables us to bring the lived body "back in" to our understanding of intersubjective, intercorporeal social life, including the circuits of selfhood upon which it rests, and the micro-macro linkages this provides' (Williams, 2001: 54).

CHRONIC ILLNESS AND BIOGRAPHIES

In 1982, Bury wrote what was to become a seminal paper in which he explored the concept of biographical disruption as a way of understanding the experiences of individuals with a chronic illness. The need for such a concept arose, in part, because the existing conceptual framework for theorising illness, Parsons' 'sick role', was regarded as inadequate in providing an understanding of the ways in which long term illnesses, which required long term management and adaptation rather than cure, were theorised. Bury described three aspects of biographical disruption which may arise as individuals experience chronic illness:-

- 1) 'the disruption of taken-for-granted assumptions and behaviours', leading to the question 'what is going on here?' (1982: 169)

- 2) 'disruptions in explanatory systems normally used by people, such that a fundamental re-thinking of the person's biography and self-concepts is involved' (1982: 169)
- 3) 'the way in which individuals respond, a process which involves 'the mobilisation of resources in facing an altered situation' (1982: 170).

Whilst Bury used this framework in the context of physical conditions such as diabetes and arthritis, it is my contention that it may be of equal relevance to those experiences which are diagnosed as mental illness, and which involve long term medical intervention, either through the use of prescribed drugs and/or periods of hospitalisation, and fundamental changes in the lives and expectations of individuals. Karp supports this contention, arguing that individuals experiencing depression become engaged in 'a life centred on a nearly continuous process of construction, destruction, and reconstruction of identities in the face of repeated problems' (1996: 75). Bury highlights how uncertainty is a major factor in chronic illness experiences, and Karp point out that 'chronic emotional illness poses especially difficult problems of sense- making because the source of the problem is unclear and its course uncertain' (ibid: 75). Even in circumstances in which there is less apparent chronicity in terms of the medicalisation of distress, because emotional distress has the potential to raise questions about 'self', and because of the high levels of uncertainty involved, such experiences are likely to result in a situation in which an individual becomes 'caught up with interpreting past selves, coping with present selves, and attempting to construct a future self that will "work better"' (ibid: 15)

Since the publication of Bury's paper, other writers have criticised the application of the concept of biographical disruption in chronic illness, on the grounds that for many individuals it may not represent an accurate reflection of their experience. This is particularly the case for those whose lives have been beset by difficulties, and for older members of the population, for whom the onset of chronic illness may be seen as just another setback to be faced (see Cornwell, 1984; Pound et.al. 1998). Indeed, it has been argued by some writers that entry into the world of illness, may for some be better represented as 'biographical reinforcement', by creating a stronger sense of identity (see Carricaburu and Pierret, 1995). In the context of mental illness, there are some individuals who enter the mental health community and find a niche for themselves, where their knowledge of the 'system' provides them with a more secure and stable sense of identity than they held in their previous social setting. Though these observations clearly highlight the importance of recognising the powerful influence of *timing* and *context* in any assessment of the degree to which an individual's biography may be disrupted by chronic illness, and therefore the caution which is necessary in making generalisations, they do not negate the usefulness of the concept. The fact that some people do seem to successfully adapt to their new state, or may in fact have a biography largely formed by the experience of chronic illness, it may be the case that their biography does not match that which society provides as the model one, or is not one they themselves would have chosen, which may in itself be a form of disruption.

The issue of adaptation by the chronically ill to their condition has been taken up by Bury and other writers in recent years. The degree to which adaptation is necessary, and the form that it takes, are largely related to the meanings which the illness has for

the individual, and Bury (1991) identifies two types of meaning in respect of chronic illness. The first of these relates to the *consequences* of the illness for the individual, particularly as regards the symptoms which accompany or form part of the illness, and the degree to which these impinge upon the life of that individual. The second type of meaning is the *significance* which is attached to particular forms of chronic illness, because

different conditions carry with them different connotations and imagery. These differences may have a profound influence on how individuals regard themselves, and how they think others see them. Chronic conditions vary markedly in terms of their symbolic significance within segments of the cultural order, and these are bound to affect adaptation (Bury, 1991: 453).

When applied to mental illness, it is not hard to see that both the ‘consequences’ and ‘significance’ of the experience of emotional distress are likely to have a profound affect on the way in which individuals are able to adapt to their experiences.

When analysing the ways in which individuals adapt to chronic illness, Bury emphasises the importance of distinguishing between *coping*, *strategy* and *style*, terms which, he suggests, have been used vaguely and interchangeably by medical sociologists. Thus, ‘coping involves maintaining a sense of value and meaning in life, in spite of symptoms and their effects’, whilst ‘strategy . . . directs attention to the actions people take, or what people do in the face of illness, rather than the attitudes people develop’, whereas ‘style . . . refers to the way in which people respond to and present important features of their illness or treatment regimens’ (Bury, 1991: 461-462). In examining these aspects of adaptation, Bury also stresses the importance of

recognising both ‘the positive actions people take’ (ibid: 464), and not just things they have done to them, as well as on the constraints imposed upon them by their social position and the resources they have available to them. Radley also develops this theme, suggesting that ‘whatever modalities are used by a person to resolve the dual demands of symptoms and society, we can speak of him or her having a particular *style of adjustment to illness*’ (1994: 154). This writer makes two other points which will be shown to have particular significance in the realm of mental illness; firstly he points out the importance of acknowledging that ‘living with illness in a world of health’ (ibid: 139) has its own consequences for adaptation, and that, following on from this, in many cases ‘the illness attains what has been called a *master status* in relation to other aspects of the person’s identity’ (ibid: 155). In order to be able to understand and interpret these aspects of adaptation, it is necessary to listen to the narrative accounts given by those experiencing chronic illness. Having outlined some of the debates within the chronic illness literature, and suggested where these might be applicable to the experience of emotional distress, I will now conduct a review of the mental health literature.

MENTAL HEALTH LITERATURE

Sociological interest in the range of experiences usually categorised as mental illness came to the fore in the 1960s, with critical accounts of various aspects of these experiences. Goffman’s interactional approach highlighted such issues as the asylums as examples of ‘total institutions’, and how as such, they affected the identity of patients (1961), and interpretation of psychosis as ‘social interaction rituals’ (1967),

and the ways in which 'spoiled identities' were created as a result of stigma (1968). Other writers who identified themselves as 'anti-psychiatry' in the 1960s and early 1970s, made their critiques from within the psychiatric profession, arguing against a purely medical interpretation of mental illness, in favour of a more existential understanding of these experiences (Laing, 1960). Other writers even argued against the very notion of a mental illness, suggesting that its use was confined to enforcing compulsion, and that it should be divided into diseases of the brain, which were in fact physical illnesses like any other, and were therefore a valid area for medical intervention, and those behaviours which were social problems of living, which were not (Szasz, 1971). Foucault, by examining a history of the ways in which 'madness' has been understood and treated in society, demonstrates the socially constructed nature of mental illness, and indeed, the way in which society has constructed the polarity between reason and madness (1967), whilst medical historians have provided us with a social history which illustrates the experiences of those incarcerated in lunatic asylums in different historical periods (see for example, Porter, 1996). In terms of sociological research, within the critical psychiatry framework, the study made by Rosenhan highlights the problematic nature of medical definitions of mental illness, using schizophrenia as an example, suggesting that 'normality and abnormality, sanity and insanity, and the diagnoses that flow from them may be less substantial than many believe them to be' (1973: 250-251).

Picking up on the notion of the socially constructed nature of categories of mental illness, and extending it to social causation models, feminist writers have demonstrated how women were negatively and disproportionately affected by diagnoses of hysteria, anxiety and depression, and how this arose as a result of

patriarchy and women's subordinate position in society (Busfield, 1996; Chesler, 1972). Apart from the early 'critical psychiatry' work, and the equally critical analysis provided by feminist writers, and despite the growing body of work emerging from within the sociology of health and illness, sociology has paid little attention to mental illness. Exceptions to this neglect include the work of Pilgrim and Rogers (1999) who, among other things, provide an accessible coverage of the debates surrounding different sociological and non-sociological explanations of the causes of mental illness, and how these models justify different treatments. One of the few sociologists to have produced empirical studies to develop a causal model of mental illness, in particular depression in women, is George Brown, who, along with colleagues, has produced a valuable body of work both on the causes, and later, on effective interventions based on his causal model (Brown and Harris, 1978; Harris et al., 1999; Brown, 2002). Though only focusing on women's experiences of one particular diagnostic category, and not challenging the validity of this category, this body of work does provide valuable insights into the links between the lives of individuals, their susceptibility to, and the onset of their depression. Philosophers have also explored the links between life histories and distress, with Jaspers in particular providing an interesting commentary on the connections between life history experiences understood as psychosis, arguing that these links are best understood as 'meaningful' connections, rather than causal ones (1974). Debates abound as to the nature of mental illness, from the biomedical, brain disease model, and increasingly the potentially even more reductionist genetic explanations, through to models drawing on social constructionist and social causation explanations. Some of the latter, as we have seen, do not seek to challenge the assumptions underpinning medical definitions, whereas others, such as

the individual growth model tend to view distress as part of a continuum (see Sayce, 2000 for an assessment of the strengths and weaknesses of these models).

In selecting the contributors to this study, I have elected not to focus on any diagnostic category on the basis that ‘diagnoses fail to meet criteria for “caseness”’ (Horwitz, 2002: 145). However, diagnosis is an important element in the experiences of some individuals who suffer distress, and whilst for many chronic illness sufferers, it may mark the end of a period of uncertainty, for those experiencing emotional distress it may serve to confirm and heighten their ‘perception of the difficulties they face in negotiating their illness and its treatment, as well as their active attempts to maintain and create an identity as a person rather than as a mental patient’ (Mulvaney, 2000: 588). The diagnosis which is applied to an individual will, of course, determine the type of treatment which is administered, whether that treatment be voluntary or compulsory, chemical, electrical or psychological, and whether or not the individual is hospitalised as part of the treatment. Thus, just as there is considerable debate about the causes and nature of distress, so forms of treatment are subject to challenge and debate from a range of academic disciplines. Just as the ‘critical psychiatry’ movement came mainly from within psychiatry, so some of the more recent critiques of psychiatric treatments also come from within the profession. Perhaps the fiercest of such critiques is that of Breggin (1993) who describes both the ineffectiveness and the potentially disabling side effects of both ECT and pharmacological interventions. Warner, who is also someone who has practised psychiatry, is also critical of the use of drug treatments for those diagnosed as having schizophrenia, arguing that

in part, the modern pessimistic view of the untreated course of schizophrenia may have developed because the introduction of antipsychotic drugs in the mid-1950s and

their subsequent, virtually universal employment in the treatment of psychosis has masked what was previously known of the natural history of the illness (1994: ii).

The disputed nature of emotional distress means that there are competing treatment professionals, and so it is not surprising that some of professionals defend their own treatments through a critique of others. In this category Johnstone (1989), a psychologist, has produced a particularly vehement critique of many aspects of psychiatric treatments, whilst Beck (1989) in writing in support of cognitive therapy, challenges other models of treatment. As a result of the relative ineffectiveness and the potentially devastating side-effects of physical treatments, many service users express preferences for the talking therapies, on the grounds that they are less damaging. But these treatments have themselves been subject to critique, notably by Masson (1993), himself a practising psychotherapist, on the grounds that they encourage users to change in order to better fit into the social world they inhabit. This effectively places the blame for their distress on themselves, and does not question the values of that social world, and potentially assumes that the views of the therapist are more valid and highly valued, further disempowering the user.

The other debate which has taken place within professional and academic circles, and within user groups, has been about the changed emphasis away from the hospitalisation and segregation of those experiencing distress, towards the approach usually described as 'care in the community'. The perceived benefits of such a move are generally thought to have been a reduction of the difficulties faced by individuals in returning to social life after an often lengthy stay in hospital, often resulting in the 'institutionalisation' of the individual (Goffman, 1961); a normalising of their experiences, thereby providing a challenge to the stigma which society has attached to

mental illness; and always in the social policy debates, a reduction of the costs to the NHS. Though welcomed by many commentators, including user groups, and seen to have provided benefits for many service users, this shift to community based care has not been regarded as an unmitigated success, with one writer arguing that 'the chronically mentally ill patient has had his locus of living and care transferred from a single lousy institution to multiple wretched ones' (Powell cited in Barham, 1997: xi; other contributors to this debate include Sayce, 2000 and Parr and Philo, 1995). Some writers have suggested that far from bringing down barriers between mental health service users and the wider population, community care has reinforced these barriers, and that fear, whether imagined or real, has become the driving force behind much policy decision making (Laurance, 2003). The experiences of some of the contributors to this study reflect some of the issues raised in these debates.

Though somewhat thin on the ground, especially within sociology, literature which is of particular interest is that which focuses on the experiences and gives the viewpoints of service users. Some of these come from popular culture or journalistic sources (Real, 2003; Milligan and Clare, 1993; Styron, 1991) and are often somewhat 'confessional' and/or heroic in nature, relating how individuals' lives have been affected by emotional distress and how they coped with it, presumably very well as they have had their work published. One particularly useful work in this genre is by Karp (1996), who as a professor of sociology in the USA has experienced periodic bouts of depression during his adult life. He is thus able to draw together his own experiences, his own research with other mental health service users, and his 'sociological imagination' (Wright Mills 1959) to produce a valuable insight into the

nature of distress and the meanings of illness. Within the context of depression, Karp has identified four potential 'identity turning points':

- a) 'a period of inchoate feelings',
- b) 'the sense that there is really something wrong with me',
- c) 'a crisis stage', and
- d) 'a period of coming to grips with illness identity' (1996: 57).

Through these stages, it is suggested that 'depression, like any serious chronic illness, forces decisions that shape the overall contours of one's life' (ibid: 107), often leading to lack of employment opportunities and difficulties in relationships. This results in an element of chronicity in the experience of depression, thus again raising the issue of the applicability of the concept of biographical disruption in relation to emotional distress because, as Karp suggests, 'depression has a chronicity that makes it like a kind of mental arthritis; something that you just have to live with.' (1996: 10).

Indeed, the very nature of emotional distress, particularly when it becomes medicalised as mental illness, may mean that biographical disruption has an even greater relevance than for physical illness conditions. Thus, for instance, 'because depression is often defined precisely as an illness of the self it constitutes, in effect, a case study for considering how individuals arrive at illness definitions and then reconstruct their identities accordingly' (Karp, 1996: 14). What makes Karp's study of particular interest for my study is how closely his framework maps on to that of Bury (1982).

The growth of service user movements over the past 20 years has resulted in the publication of books which give a voice to users, allowing them to provide their own explanations and understandings of their experiences, and of particular interest in this regard are those edited by Read and Reynolds (1996) and Spandler (1996). The lives of some of the narrators have benefited from involvement in user groups, and the role of such groups, both in improving lives of individuals, and in influencing policy making, is a subject which is addressed by some writers. Issues such as the empowerment of service users (Barnes and Bowl, 2001), and the growth of user groups as an example of the increasing importance of 'new social movements' (Kelleher, 2001) are among those explored in this body of literature.

The World Health Organisation has identified suicide as a major health concern worldwide, and it has been estimated that during the year 2000, approximately 1 million people will have taken their own lives, representing a global mortality rate of 16 per 100,000 (www.befrienders.org). Add to this the injuries and disability resulting from 'failed' suicides, and the effect on those close to those who have chosen this action, it can be seen to be a phenomenon which impacts on the lives of many people. Suicide is closely linked with emotional distress, whether it seen as a result of distress, or as is often the case, suicide is seen as evidence of mental illness in itself. It has been estimated that 'mental disorders (particularly depression and substance abuse) are associated with more than 90% of all cases of suicide (ibid: 1). Sociological interest famously dates back to Durkheim's work on the subject, though little attention has been given to the subject in recent years, and little in the way of empirical work has been carried out. Such academic work which has been produced has mainly come from within psychology and focuses on policies which are aimed at

reducing the incidence of suicide (Lester, 2001; Rutz, 2001), and on the prevalence of suicide in adolescents (Diekstra, 1995; Sabo et al., 2005). These studies provide little or no empirical or phenomenological evidence, rather relying on epidemiological data in support of psychological theories. Suicide is predominantly a male response to distress, although attempted suicide and self-harm have been generally associated with women's experiences. In the UK, around 75% of suicides are by men and 'since the 1980s suicide has been the most common cause of death for men aged between 15-44' (www.mind.org). Several of the men's narratives touch upon the subject of suicide, and this strong association between men and suicide leads me into the following section, in which I will briefly outline some of the literature which links men's health experiences with constructions of masculinity.

MASCULINITY AND HEALTH

As has already been suggested, much of the sociological work on mental illness has concentrated on women's experiences, and has generally used feminist perspectives to explore how gender constructions have impacted on these experiences (Busfield, 1996). The same has largely been true of work generally within the sociology of health and illness, where discussions about the effects of gender on the health experiences of individuals has largely done so from the perspective of women's experiences. However, the emergence of the New Men's Studies since the 1980s has sought to redress this imbalance in gender studies, and has examined how the construction of various forms of masculinity, particularly hegemonic forms (Connell, 1987) have impacted on men's lives. Although this emerging body of literature has

not produced a great deal of work in the field of health and illness, there have been some valuable contributions in this area. The main issues which have been addressed here have included ways in which the compulsion in young men to achieve hegemonic forms of masculinity may lead to risk taking behaviours, leading to poor health outcomes, and the societal restrictions on men in their ability to express emotions which has also been shown to potentially have negative effects on health, as ways of explaining men's reduced life expectancy as compared to that of women (Moynihan, 1998; Lee and Owens, 2002; Sabo and Gordon, 1995). Another area addressed by writers in this field has been the apparent reluctance of men to make use of health services, or to follow health promotion messages (Lee and Owens, 2002), thereby negatively affecting the prognosis of their illnesses. Some writers have gone so far as to issue a warning that 'masculinity may be dangerous to your health' (Harrison et al., 1992). A connected issue here, and one that has particular relevance to the biographical implications of ill health, is how illness or disability might impact on men's ability to successfully perform their masculinity (Charmaz, 1995; Gerschick and Miller, 1995), and the ways in which men deal with these threats to their masculine selves (Smith and Sparkes, 2002). This has been highlighted in the context of chronic illness by Charmaz, who suggests that,

illness can threaten masculine identities and lead to identity dilemmas and . . . these dilemmas, like the illnesses themselves, can be recurrent and chronic. Identity dilemmas for men revolve around the following oppositions: active versus passive, independent versus dependent, autonomy versus loss of control, public persona versus private self, and domination versus subordination. (1995: 267)

Though much of the literature referred to above addresses the relationship between masculinities and conditions which are generally treated as physical illnesses or disabilities, many of the issues raised are at least as relevant, and perhaps more so, to the experiences of emotional ill health. Thus, it has been noted that,

once we realise that the elusive 'masculine identity' does not exist inside the boy's psyche, but rather it is a social construct to which the boy must bend and comply, we can understand why it is impossible for most boys to feel secure about it . . . Masculinity, unlike femininity, is conferred. (Real, 2003: 172).

It is this insecurity relating to masculine identity which may be reflected in the behaviours of adolescent boys, whether in the form of risk taking behaviour, drug and alcohol abuse, or expressed as anxiety, depression or some other form of emotional distress. There has been some work produced specifically in this area, though generally from outside sociology (see especially Clare, 2000; Real, 2003).

MIND, BODY AND EMOTIONS

Ever since the development by Descartes of the concept of human beings as having both a body and a mind, philosophers have debated the relationship between body and mind, often attempting to repair this separation (see for instance Ryle, 2000; Lowe, 2000). Physiologically speaking, of course, what links these two aspects of the person is the brain, and some writers have taken a scientific perspective on the matter and suggested that 'all mental phenomena whether conscious or unconscious, visual or auditory, pains, tickles, itches, thoughts, indeed all of our mental life, are caused by

processes going on in the brain' (Searle, 1991: 18), thus leading to the crude assertion that 'brains cause minds' (ibid: 39). Whilst at one level this is undoubtedly true, it is also clear that the processes which occur in the brain to produce these mental phenomena are produced in response to external stimuli, and the ways in which we experience and interpret these phenomena are also culturally and socially mediated. The debates surrounding the nature of mind and body are clearly relevant in understanding the nature of those experiences usually regarded as mental illness, literally meaning an illness of the mind. Though psychiatry utilises the term mental illness as the description of such experiences, much of it is based around explanations which concentrate on brain malfunctions, which its treatment aims to redress, thereby confirming the scientific position taken by Searle (1991), that the brain is the cause of the mind. Psychologists and psychotherapists on the other hand, conceptualise distress as resulting from social or developmental stimuli, with an implicit assumption as to whether these reactions are regarded as appropriate or not.

It can be seen then that many of the debates as to the nature of mental illness/emotional distress to a significant degree reflect the philosophical debates surrounding the nature of mind and body. In recent years within sociology, and particularly within sociology of health and illness, moves have been made to utilise the concept of emotions as a way out of some of the epistemological problems resulting from the mind/body issue. Thus, whilst the emotions which we experience within our bodies are undeniably caused by processes which can be explained physiologically, it is also true that 'individuals are connected to society through the emotions they experience. Herein lies the importance of mood and emotion for the study of society and social organisation' (Denzin, 1984: 24; see also Williams, 2001;

Lupton, 1998). It is also evident that our sense of self is moulded by our emotional responses to the social world in which we live, and so the concept of emotions allows us to incorporate the biological (including genetic) as well as the social and cultural, in our understanding of our experiences in the social world and within ourselves. Based on these ideas, it would seem that rather than conceptualising those experiences usually described as mental illness, emotional distress allows for a more valid interpretation of the nature of these experiences. It would appear that this can incorporate biological processes, social circumstances and societal norms and expectations to be incorporated into an explanatory framework for the causes and therefore, the validity of different therapeutic interventions, into an understanding of emotional distress. Emotions are of course always experienced internally, but the degree to which they are expressed or repressed, as we have already seen, can contribute to health outcomes in a variety of ways, further supporting their usefulness in this field (See Kennedy-Moore and Watson, 1999; and Lyon, 1996 for a discussion of the importance of 'social emotion' to the sociology of health and illness).

CONCLUSIONS

The sociological literature on the subject of chronic illness, particularly the work of Bury and the ways in which chronic illness is the cause of biographical disruption (1982), would appear to have some relevance to the experiences of mental health service users. The debates which followed this paper have been outlined, and in particular those that seek to problematise the straightforward causal relationship

between chronic illness and biographies, and those which go on to explore how individuals respond to threats to their biographies at various stages of the onset of illness. The next section of the chapter gave a brief overview literature on mental health emanating from a range of academic disciplines. The main focus has been to explore the different explanations and understandings of the nature and causes of 'mental illness' and how these in turn are used to validate different therapeutic interventions, including discussions about the use of hospitalisation as part of these interventions. The literature about, and resulting from the growth of user movements, is relevant to this study, as several of the participants have had some involvement with these movements.

As my research focuses on the experiences of men, the recent literature which has linked men's health experiences to social constructions of masculinity, is an important resource, allowing an examination of the associations between such constructions and men's experiences of emotional distress. Finally, the debates about the nature of, and relationships between mind and body, and the ways in which a focus on emotions may resolve some of the problems arising from mind/body duality, leads me to argue that the concept of emotional distress may be a more appropriate concept than the highly medicalised notion of mental illness, in exploring the participants' experiences. Drawing together the various strands of the literature allow me to apply the various perspectives outlined in interpreting the narratives of the contributors to the study, as I examine the links between biographies and distress, the ways in which individuals understand and explain their experiences in relation to the various models of which been put forward. In addition to these aspects I also analyse how constructions of masculinity might have contributed to experiences of distress, and how the individuals

respond to threats to their masculine selves, and also looking at some of the descriptions of the way they bodily experienced distress in the light of the mind/body debates discussed in this chapter. In short, I use the debates and perspectives outlined in this chapter in order to interpret and understand the experiences described in the narratives, both in terms of the nature of those experiences, and the ways in which they are told. Having set out in this chapter how the various strands of literature have been used in developing a theoretical framework for the study, I now move on to set out the methodological issues involved.

CHAPTER 3

LIFE HISTORY NARRATIVES

INTRODUCTION

When setting out to research any aspect of social life, the sociologist is confronted with a wide array of methodologies from which to choose. Clearly, the choice made will be influenced by the nature of the issue to be studied, the individuals who will provide the data for the study, and also the personal preferences, beliefs and theoretical standpoint of the researcher. In my own case, the choice I have made is narrative collection, and in particular, autobiographical or life history narratives. One only needs to look along the shelves of the methodology section of a sociology library to see that this form of research method has become increasingly popular (see for instance Lieblich and Josselson [1997] and Chamberlayne et al. [2000]). However, it is not merely because of its present popularity that I have chosen this method, and in this chapter I will provide a rationale for my choice.

Feminist researchers in particular have favoured narrative as a methodology, as it is seen to be less exploitative than many other interview based methods, and provides a voice for those in society whose voices are often not heard. In a similar vein, providing a way of giving a voice to those whose lives have been affected by emotional distress seems equally valid, given that their voices may have been ignored because of the stigma attached to emotional ill-health, and may have been drowned by the power of medical discourses. As a result, it is important that in analysing the data collected in this form, the researcher seeks 'to find ways of

working with texts so the original narrator is not effaced, so she does not lose control over her words' (Riessman, 1993: 33-4). In addition, the method can provide a rich source of data, and it is suggested that 'personal narratives of non-dominant social groups . . . are often particularly effective sources of counterhegemonic insight because they expose the viewpoint embedded in dominant ideology as particularist rather than universal, and because they reveal the reality of a life that defies or contradicts the rules' (Personal Narrative Group, 1989: 7). As my study focuses on the experiences of men, an important element of my analysis will focus on gender issues. Riessman has argued that narrative based research has highlighted the fact 'that women and men have distinctive vocabularies of emotion that have not been sufficiently acknowledged in mainstream mental health research' (1993: 43). As important as these issues are, it is equally important to recognise that the research should look beyond the personal to the social context of both the experiences themselves, and of the narration of those experiences. In respect of this it has been pointed out that there may be a tendency for some researchers to be 'attracted to unusual people with unique life stories, but they do not manage to go beyond the presentation of a good story toward some kind of wider, theoretical meanings or implications' (Josselson and Lieblich, 1999: x), a tendency I have tried to avoid.

In the next section of this chapter, I will examine in more detail the reasons for choosing life history narratives as my preferred methodology, and demonstrate how the method is linked to my conceptual framework. I will then move on to discuss issues of sample selection, and the details of data collection. I will devote some time in examining the issues involved in the analysis of the data collected, in

particular the ways in which this analysis can be used to relate the personal to the social, whilst not losing sight of the need to allow the voice of narrators to be heard. Clearly this stage of the process is where interpretation comes to the fore, although as Riessman (1993) reminds us, the whole process from conception to writing up includes some level of interpretation or representation. This highlights the need for myself as researcher to remain reflexive throughout the process, and to acknowledge the extent to which my own experiences and preconceptions may influence these representations. This will form a major focal point of the section on the ethical issues which are involved in carrying out this type of study. Firstly though, I will examine the use of biographical narratives in the context of my research, and the reasons why I consider it as the most appropriate method for my purposes.

WHY LIFE HISTORY NARRATIVES?

In order to justify the use of a particular methodology for a research project, it is clearly necessary to show how it is both appropriate to the theoretical concepts which are to be explored and tested, and also to show that it is compatible with ethical and human considerations with regard to the individuals who will provide data for the study. But before examining the relevance of the method to those individuals whose lives have been affected by their experiences of emotional distress, I will first examine in more detail some of the more general theoretical considerations.

The increasing use of biographical narratives in sociological research has been explained at least in part because of their effectiveness in linking macro and micro levels of analysis, as 'biographies, which are rooted in an analysis of both social history and the wellsprings of individual personality, reach forwards and backwards in time, documenting processes and experiences of social change' (Chamberlayne et al., 2000: 1-2). This is in fact the very essence of biographical sociology, the way in which the study of individual life stories can be used to produce original knowledge of social processes and structures (Rustin, 2000). Implicit in this is the recognition 'that individuals have agency, that biographies make society and are not simply made by it (ibid, 46). Thus, in the case of my study, examining the ways in which emotional distress emerges from, and impacts upon the lives of individuals may be achieved by the analysis of oral biographies, highlighting the changes before, during and after the onset of emotional distress. In addition, these individuals may be regarded as, to some degree, 'marginal people', and therefore, because they have experienced

contrasting expectations as to how he or she should live, the subject becomes aware of the essentially artificial and socially constructed nature of social life – how potentially fragile are the realities that people make for themselves. In this awareness the subject throws a much broader light on the cultural order, the "OK world" that is routinely taken for granted by most. (Plummer, 2001: 134)

In the field of mental health, it has been suggested that studies which relate emotional wellbeing to social context have been 'too reliant on existing census or aggregate statistics as a source of specifying contextual variations' (Wheaton, 2001: 231). The biographical narrative provides a means to examine 'the essential

subtleties and variations of meanings of social context' (ibid: 231). In addition, life history narratives allow the researcher to give a voice to those in society who may be disempowered, as is evidenced by the views of Norman K. Denzin, as described by Plummer:

Researchers should take sides; should study experiences that are biographically meaningful for the researcher; should attend to pivotal turning point experiences; should uncover and display models of truth, accuracy and authenticity; should privilege languages of feelings and emotions over those of rationality and science; should examine multiple discourses and should write multivoiced polyphonic texts, which include the researchers' own experience. (2001: 13)

On the face of it, personal life-history accounts may be seen to provide rich data concerning the meanings of experiences for a particular individual, and these may be extended to provide valid data relevant to groups of individuals with similar experiences. These insights in themselves are worthwhile, especially if the data collected is used to improve the life experiences of other groups of individuals in similar situations. However, it is important for the sociologist to be able to use these insights to provide a view of, and an explanation for societal structures. This link between agency and structure has been one of the most debated within sociology for many years, and the sociologist C. Wright Mills was arguing nearly fifty years ago that 'personal troubles cannot be solved merely as troubles, but must be understood in terms of public issues' (1959: 226). One of the ways in which this can be explored, is through the life history narrative, because 'the concept of biography forestalls the individual-society split. It is a structure operating in both spheres. Its manifestations of life history, life story and

institutional biographical patterns bridge the gap between the theoretically induced “inner” and “outer” spheres’ (Fischer-Rosenthal, 2000: 118). Thus, the collection of individual life histories may be used as a means of providing an insight into the usually unseen nature of societal structures and their effects on social lives, a process which has been described as culture speaking itself through the stories of individuals ((Riessman, 1993). This carries particular relevance where the relationship between the individual and the society in which they live becomes problematic in some way, and it has been suggested that ‘respondents narratize particular experiences in their lives , often where there has been a break between ideal and real, self and society’ (Riessman, 1993: 3). Thus, the concept of ‘biographical disruption’ has clear relevance here. This also links to issues of identity, and particularly to situations where a sense of identity comes under threat, and in need of reconstruction, and it is to these issues that I will now turn.

ILLNESS NARRATIVES AND MENTAL HEALTH

There is a clear compatibility between one of my starting premises, ‘biographical disruption’, and mental health experiences and the collection of life histories. In this context it has been noted that ‘life stories are most fruitful when studying mentalities, basic views about life, social relationships, and expressions of emotions. They reveal how different historical events have affected people’s lives and what kinds of social and cultural developments there have been’ (Haavio-Mannila and Ross, 1999: 243). Thus, the biography of the individual, and how it connects with historical, cultural and social contexts might be revealed, in addition

to the personal experience of emotional expression, and therefore, emotional distress. The empowering nature of the narrative is also important, particularly when researching the lives of those who may have been disempowered by their experiences, so that 'when we tell stories about our lives, the point is to make our lives not only more intelligible, but also more bearable. We can make ourselves heroes of our own story – we cannot, however, actually become the authors of our own lives' (Neilsen, 1999: 50).

It is within the context of chronic illness that sociologists have paid particular attention to the role of narrative in repairing and restoring meanings which may be under threat (Bury, 2001) as a result of 'biographical disruption' (Bury, 1982), which may result from experiencing chronic illness (see also Williams, 1984). Bury highlights 'the importance (and to some extent, the limitations) of studying narratives in circumstances where the "unfolding" of illness, particularly chronic illness, come to dominate people's experience of everyday life' (2001: 264). The limitations referred to here concern the often mundane nature of narratives, and the ways in which they do not necessarily 'speak for themselves', an issue to which I will return in the section on the analysis of narratives. As the study of narratives, in this case 'illness narratives', can work at both the individual and societal levels, 'the exploration of chronic illness narratives may throw light on the nature of disrupted experience, its meanings and actions taken to deal with it', and in addition, may have 'the potential to reveal a wider set of important issues to do with the links between identity, experience and "late modern" cultures' (Bury, 2001: 264). The point is taken further by Hyden, who argues that

the advantage of studying illness narratives is that they make it possible to study the experience of illness from a number of vantage points: as a social and cultural construct, as a transformation and expression of bodily suffering, and most of all as the suffering person's attempt to construct his or her world, to find his or her own life-work and life context. (1997: 64-65)

This is seen to be of particular importance when there is a danger that professional medicine, under the impact of 'the technology-assisted physical and chemical probes of our century' (Risse cited in Bury, 2001: 266) silences the patients' suffering. Simultaneously, the growth of lay knowledge through expanding sources of information about illness, 'expands the range of culturally available narratives that can be articulated' (ibid: 268). These latter two points, I would argue, have particular relevance to medical psychology/ psychiatry. Looking from the viewpoint of the narrator, it has been suggested that illness narratives may be used in five ways:- '1. to transform illness events and construct a world of illness; 2. to reconstruct one's life history in the event of chronic illness; 3. to explain and understand the illness; 4. as form of strategic interaction in order to assert or project one's identity; and lastly, 5. to transform illness from an individual into a collective phenomenon' (Hyden, 1997: 55). Awareness of these issues has informed my interpretation of the life histories.

Many of the issues raised above in respect of chronic illness, may also be applied to experiences of emotional distress, particularly where such experiences contain an element of chronicity. In fact, life histories in some respects may have more relevance, when it is borne in mind that there are proven links between life events and depressive disorders (Brown, 2002). This is important when one considers that

there may often be a significant time delay between the negative life events and the onset of emotional distress, whereby ‘childhood adversity serves to increase the chance of having one or more current psychosocial risk factors . . . and the link with depression appears to take place largely via this route’ (Brown, 2002: 265). Thus, a lifecourse perspective is an important element in gaining an understanding of these experiences from the viewpoint of the individual themselves, and may shed light on the ‘difficult but interesting question . . . [concerning] how, and what types of social changes may be influencing the overall prevalence of mental health problems’ (Wheaton, 2001: 231). Lifecourse perspectives may also give an insight into the relationship between emotional distress and physical disorders, suggesting possible connections between these events (Brown, 2002), and I examine these issues in Chapter 7. Similarly, the effects of emotional distress and of any subsequent treatments on the life history of the individual may be revealed. In addition to these elements, links between life history collection and the empowerment of mental health patients has long been recognised, and in the early 1980s, oral historians ‘adopted life-history methods as an emancipatory tool, and launched the concept of “empowerment” as a lay concept in welfare practice’ (Chamberlayne et al., 2000: 2). This development also contributed significantly to the principle of user involvement in the field of mental health (ibid). Recent times have seen a burgeoning of interest in the ways in which lay health knowledge is important as a means of contestation of expert or professional knowledge, an issue which can be seen to have relevance in the field of mental health (Williams and Popay, 2001), and life history narratives may provide an ideal means of examining such lay knowledge. Whilst the concept of lay knowledge is an important one, it must be acknowledged that many of the men who participated in this study may be

regarded as possessing considerable medical expertise, through their long involvement with psychiatric services.

In the experience of emotional distress, an important issue is the threat to one's sense of self and identity. This threat results from both the nature of the experience and its relation to rationality, and the stigma which has been and continues to be attached to it. In these circumstances, the narration of a life story becomes 'a version of a life made ready for public consumption in a situation where identity is at risk from the negative stereotypes of frailty and the processes and procedures of caring' (Chamberlayne et al., 2000: 10). In other words, the very act of narrating one's life story becomes an element of maintaining or rebuilding one's sense of identity which has been threatened by both experiences which surround and are attached to emotional distress, and by the regimens of care which may follow such experiences. The importance of this is increased if we consider our sense of self as being not just an object in the physical world, but a 'part of social reality', a construction by which we live (Alasuutari, 1997: 16). If we accept, then, our identity as such a construction, we allow the possibility that it can be rebuilt and adapted to changed conditions:

To recognise that selves are, after all, constructions we live by enables us, when that is needed, to renew ourselves. It allows us to adopt a view of life and self that better adapts to changed conditions or which, because the conception of oneself is changed, changes the conditions by viewing them in a new light (Alasuutari, 1997: 16).

Indeed, it has been argued that biography is a more useful concept 'than the somewhat static and even normative identity concept. The concept of biography makes the concept of identity redundant' (Rosenthal, 1997: 23). The same point is made by Hyden, who suggests that 'today the narrative concept enjoys the pivotal position once assigned to concepts like identity – it could even be argued that the identity concept has become subordinate to the narrative concept' (1997: 52). From this exploration of the ruptures in biography and the ways in which we may use narratives to repair these ruptures, it can be seen that issues may be raised which are of great interest to the researcher, and in the context of emotional distress, this is certainly the case.

SAMPLE SELECTION

Having devoted a considerable amount of time in justifying the use of narrative life-history in the study of emotional distress, let me now turn to examine some of the more practical details of how the data was collected, beginning with the issue of how I selected my sample. Perhaps the first thing to say in this regard, is that I avoided selecting any individuals who were 'acutely distressed', and so did not collect data from anyone in hospital, or who displayed signs of acute distress. Clearly, this decision was based on ethical grounds, the possible risks to the individual outweighing any potential benefits from the information collected. This did not though, exclude people who are currently receiving some sort of treatment, because for many, particularly those with a diagnosis of bi-polar depression or schizophrenia, medical treatment is a life-long reality. In view of my focus on

biography, such life-long treatment informed my analysis, and related to this was another criterion of selection, that of chronicity. Within medical definitions, chronicity in respect of depression is regarded as that which lasts at least one year, and using this definition, chronic depression 'at any one point in time typically accounts for about half the depression in an urban population' (Brown, 2002: 267). This fact, taken together with the chronic nature of diagnoses of schizophrenia and bi-polar depression, suggests that those who have experienced some form of chronic emotional distress make up a large section of the population. However, as I have attempted to avoid the constraints imposed by medical definitions, and instead to focus on how distress is experienced by individuals, I have relied on chronicity as a concept defined by the individuals themselves. Whilst in many cases this may coincide or overlap with medically defined chronicity, it allows for other experiences to be included and compared. Thus, for instance, in my own case, whilst a medical definition of depression was applied to me for slightly less than one year, the experience of that distress has continued have an impact on my life for considerably longer than this period. Indeed, for myself and many others, decisions I make in my life are still influenced and constrained by the knowledge of my potential vulnerability as revealed by my experience of severe distress several years ago. Thus, chronicity in terms of long term effects, as self defined, was one of my criteria for sample selection.

The other major factor in the selection of my sample is that I concentrated only on men's experiences of emotional distress. The main reasons for this are first, that as my own experiences have influenced both my choice of research topic, and my theoretical concepts, and are undoubtedly reflected in my analysis of the data, it

seemed reasonable to select from a group whose gendered experiences may fruitfully be compared and contrasted with my own. Thus, an important element of my study was an examination of the relationship between the construction of various forms of masculinity, and the expression and experience of emotional distress (see Chapter 8). As gender constructions and reconstructions occur across the whole lifecourse, this element of the research is also compatible with a life history approach. Secondly, much of the writing on gender and emotional health has focussed on the experiences of women (see for example Chesler, 1972; Showalter, 1987; and Ussher, 1991; although as Busfield, [1996] points out, none of these writers are sociologists), and so an examination of men's experiences would seem to be long overdue.

Another set of issues which arise as a result of the small number to be included in the sample concerns the validity and representativeness of the data, issues which have long been regarded as important in social research. Riessman suggests that 'traditional notions of reliability simply do not apply to narrative studies, and validity must be reconceptualised' (1993: 65). It is suggested that this may be achieved in four possible ways: the persuasiveness of the account given; the correspondence of the accounts to the experiences of the individuals, which may be assisted by allowing those who take part in the study to see and comment upon the recorded narratives; the coherence of the narratives; and finally the pragmatic use which is ultimately made of them (Riessman, 1993). It seems clear that the way in which the accounts are interpreted by myself as researcher, is fundamental to all of these factors. Within feminist research, it has been suggested that 'truth' is an

important aspect of validity, although it is a particular conception of truth that is being utilised, and so

unlike the reassuring truth of the scientific ideal, the truths of personal narratives are neither open to proof nor self-evident. We come to understand them only through interpretation, paying careful attention to the contexts that shape their creation and to the world views that inform them. (Personal Narrative Group, 1989: 261)

This again would appear to place the responsibility for the validity of the accounts in the hands of the researcher, through the act of interpretation. However, if the researcher is successful in this process,

the truths of personal narratives are the truths revealed from real positions in the world, through lived experience in social relationships, in the context of passionate beliefs and partisan stands. They recount efforts to grapple with the world in all of its confusion and complexity and with the normal lack of omniscience that characterizes the human condition. It is precisely because of their rootedness in time, place and personal experience, and their perspective-ridden character – that we value them (ibid: 263-4)

The potential rewards are, then, high. In addition to this, Riessman reminds us that although ‘sample sizes in narrative studies are small, and cases are often drawn from unrepresentative pools . . . there is a long tradition in science of building inferences from cases’ (1993: 70).

In selecting men to take part in the study, I began by speaking informally to men I had met while I was a service user myself, and to men who I had met through my

involvement with a local MIND group. During these informal discussions I gave details of the study I was undertaking and made assessments as to whether it was appropriate to collect the life history narratives from each individual, and of course, the willingness of the men to participate in the study. This became an ongoing process, as several men initially selected as suitable participants withdrew for various reasons, including one man who withdrew less than half an hour before we were due to meet for the interview. Other men became acutely distressed and hospitalised in the time between them being identified as suitable to participate, and an interview being arranged, and therefore, it became inappropriate or impossible to include them in the study. Further reflections will be made on this process in the section in this chapter on ethical issues, and the effects of these issues on the data will be considered in Chapter 9. Ultimately, one-off interviews were carried out with eight men, lasting between 50 minutes and one and a half hours, and details of each of the men are shown in Appendix D. Of the eight men who were interviewed, I had met two during the time that I was a service user; one I got to know because we were both MIND committee members; one I met at a social event organised by MIND; one was a university student who approached me after hearing about my research; one I met at a meeting of a Men's Health Forum group; and two were introduced to me by other participants. The sample included a range of age groups, so that the life-course related elements of the narratives might be explored, and to allow for the influence of changing social conditions and contexts. Having established some of the issues regarding the sample, I will now outline the way in which the actual collection of the life-history narratives was carried out.

COLLECTING DATA

In this section, I will be examining the practical issues involved in obtaining a life history from men whose experiences were collected. The main points to be explored in this regard are the questions, prompts and information which were necessary for me to use, and how the data was recorded and managed. First however, the issue of where the meeting between the researcher and the narrators should take place will be addressed.

In view of the nature of the data collected - a biographical narrative rather than answers to set questions - it was necessary to use audio tape to record the narrative. This in itself imposed some restrictions on where the interview took place, in terms of background noise and privacy. In addition, because I hoped that a relatively continuous flow of narrative was to be obtained, it was important that the interview could take place without interruptions. Thus, whereas it may be quite possible, and even desirable, to complete questionnaires in public places, for the purposes of recording a life-history narrative somewhere quiet and private was deemed necessary. It is also important that both the narrator and the researcher feel comfortable in the surroundings in order that a rapport may develop, and so it is desirable that the place for the interview is discussed with each individual in advance to ensure that these conditions are met. This discussion also considered practical issues such as transport and access. Of the eight interviews carried out, three took place in my home, four in the participants' own homes, and one on campus.

Some of the details about the project, including the practical issues mentioned above, were considered best dealt with by way of informal discussions, as this was thought to provide the individuals with the best opportunity to ask questions, raise issues which may be of concern to them, and to make an informed choice whether or not to participate in the research. This discussion was then supplemented by leaflets which outlined the nature of the research, how the data was to be used and what the potential benefits of the project are, the rights of the individuals who took part, and a consent form that they read and considered in advance, signing it at the time the interview took place. A copy of these leaflets is enclosed in Appendix A and B. I also handed the participants a leaflet which gave details of myself, and this is included in Appendix C. In none of the interviews, were any problems raised by the contributors, and so I was able to proceed.

Riessman suggests that in collecting narrative data she uses the following guidelines: 'My preference is for less structure in interview instruments, in the interest of giving greater control to respondents. I advise my students to develop an interview guide . . . 5 to 7 broad questions about the topic of inquiry, supplemented by probe questions in case the respondent has trouble getting started' (1993: 55). However, even '5 to 7 broad questions' might be regarded as too many in view of the fact that I was asking respondents to recount their own life history, including those aspects that they perceived to be most relevant, or significant to their experiences of emotional distress. I would suggest therefore, that a more appropriate procedure is one in which 'the process of inquiry flows from the question – which is a question about a person's inner, subjective reality and, in particular, how a person makes meaning of some aspect of his or her experience'

(Josselson and Lieblich, 1999: ix), including of course, the social context of those experiences. The two main points here are 'the question' and 'some aspect of his or her experience'. The former required the design of a question which achieves the aim of the project, whilst allowing free expression by the narrator, and the wording which I used is included in Appendix B. It is a debatable point whether this should have been made available in advance of the interview, allowing the narrator time to consider their response, or should have been asked immediately prior to the interview, so that the narrative is, in a sense, more spontaneous. On balance I favoured the latter course, as I felt this might be less intimidating for the narrators, especially in view of the complexity of the question. This point, and the fact that at various times during the course of the interview it proved necessary to provide prompts, raises the question of how I, as the researcher, could avoid imposing my own agenda on to the narrative. In reality, this is perhaps unavoidable, and so placed a responsibility on me to remain conscious of this during the interview, and perhaps more importantly, during the later analysis stage. This is a point which has been addressed by other researchers using this form of data collection, who have asked whether by identifying our topics at the outset, we are in danger of shaping the accounts, or predetermining 'the selective principles guiding the narrator's choice of stories to be related in the interview (Bornat et al., 2000: 246). These writers argue the 'key concept is agency. People bring their own agendas and interests to the interview, consequently interviewer topics may well be reinterpreted, managed or straightforwardly resisted by the interviewee' (ibid: 247). This, combined with reflection and awareness by the interviewer should enable the narrator to retain control of their stories. This conclusion is supported by Plummer, who argues for conducting 'open and in-depth interviews in a highly active and

interactive fashion using only the most general of guides in order to help the subject construct a sense of their cultural world' (2001: 140). It is important though, to keep in mind that the context in which the narrative is collected 'influences the narrative's form, presentation and interpretation' (Hyden, 1997: 62). I have attempted to remain aware of, and address these issues throughout the research process, and the subsequent writing up of the thesis.

At this stage, the narrative was, of course, only in audio form, and so it was then necessary to transcribe it into written form in order for the analysis of the data to take place. Although, on the face of it, apart from being somewhat long-winded and possibly boring (Plummer, 2001), this would appear to be a relatively unproblematic task. However, as Plummer points out, it is necessary to:

consider the extent to which *literal* translation is required - for example, whether all the faltering, mumbling and confusions of everyday talk should be included, whether the text should be smoothed and rounded out in the transcription, and whether issues of mood and feeling should be commented upon. (2001: 150)

This depends on how the data is to be used, and so in the case of my research, it seemed important *not* to smooth and round the text, for the emotional expression will be an integral part of the analysis. Even silences may be significant!

The life history data collected by way of the interviews has been supplemented by accounts of experiences of emotional distress contained in published material, and in particular the work of Styron (1991), Milligan and Clare, (1993) and Real (2003) have been especially useful, although many other accounts have contributed to my

understanding of the issues. Secondly, my own experiences of emotional distress, and of being a mental health service user, and the effects these experiences have had on my life provides me with resources to interpret the stories collected. These resources include not only my own experiences, in terms of how they felt and what happened to me, but also meant that for a period of about a year I spent a lot of my time hearing the stories of individuals in the mental health settings in which I was a patient. In addition, over a period of several years I have spent time in the company of individuals involved with the local MIND group, and their stories have also contributed to my knowledge and understanding of the issues. I have also been able to see at close quarters how the lives of many individuals have been affected by their experiences of emotional distress, providing me with an ethnographic source of information. All of these other sources of data have also provided me with an important resource in my interpretation of the narratives, and it is to this aspect that I will now turn.

INTERPRETATION OF DATA

Having selected individuals to participate in the project, and then having audio-taped and transcribed their narratives, we come to perhaps the most difficult and important element of the project, the analysis or interpretation of their accounts. I will return later to the issue of whether it is analysis or interpretation which is more appropriate to describe the process, before going on to explore in some detail what frameworks or concepts may be applied in order to reveal meanings in personal

narratives, but first it is necessary to briefly consider what it is we hope to achieve by the process. Riessman argues that

‘the purpose is to see how respondents in interviews impose order on the flow of experience to make sense of events and notions in their lives. The methodological approach examines the informant’s story and analyzes how it is put together, the linguistic and cultural resources it draws on, and how it persuades the listener of authenticity’ (1993: 2).

In this way, Riessman claims, ‘individuals become the autobiographical narratives by which they tell about their lives’ (ibid: 2), but, of course, in addition to this they may reveal elements of the historical and cultural contexts that lay behind their accounts, and it is both aspects of these meanings which must be explored, for as we have seen earlier, ‘the text is not autonomous of its context’ (ibid: 21; see also Hyden, 1997). Though in my interpretive chapters I have concentrated on life story elements of the narratives, the historical and cultural contexts of the stories are considered, though this may not always be explicit. This is the stage of the research where the skills of the researcher must really come to the fore, where not only intellectual considerations are important, but perhaps even more so, skills of creativity and sensitivity to the material. In purely practical terms too, this stage involves a lot of hard work, entailing as it does ‘brooding and reflecting upon mounds of data for long periods of time until it “makes sense” and “feels right” and key ideas and themes flow from it’ (Plummer, 2001: 152). This is achieved by a process which involves reading the transcript and taking notes, leaving and pondering, returning and rereading and comparing notes until it is felt valid interpretations may be made (ibid). Thus the process of interpretation began whilst

I was transcribing the narratives, during which time certain themes and issues suggested themselves. I made notes of these, and during the writing up process re-read all of the transcriptions with these themes and issues in mind, and according to the outcome of this re-reading certain themes were included, while others were rejected.

Perhaps the reason that analysis/interpretation of narrative life histories is so complex is because such accounts contain so many elements, all of which may contain meanings which are relevant to the development of theoretical concepts. Among these elements Plummer (2001) lists the story, the plot, the characters, and themes and story lines, and from these various constituent parts, one of the aspects I sought to identify for my theoretical development was the emergence of 'critical life events' and the ways in which these may be linked to lifecourse crises (Plummer, 2001: 129). A tried and trusted method of linking empirical data with theoretical concepts is that of 'grounded theory' developed by Glaser and Strauss in the 1960s. This involves moving 'around a chosen empirical field sampling items that emerge as theoretically relevant until a "dense" analysis is completed. The goal is to produce theories out of data rather than from some *ad hoc* prior conceptualisation' (Plummer, 2001: 164). An alternative approach is the 'progressive-regressive' method introduced by Jean-Paul Sartre, which is 'a way of reading a life through moving both backwards (to sources and conditions in class, race, gender, emotion etc.) and forwards (to pragmatics and consequences) from a key event in a person's life – linking all this to wider issues of history and culture throughout' (Plummer, 2001: 165). This method allows for theorising from within the narratives, between different narratives, and between narratives and wider social

contexts, and was used successfully by Connell (1995) in his study of masculinities, in which he tried to show the 'use of life histories placed within a broader historical and theoretical frame of gender relations being enacted and worked through at a major point of crisis. Here life story, social structure, narrative and theory are all at work' (Plummer, 2001: 166), and I have tried to incorporate these aspects into my interpretations.

One of the ways in which theoretical concepts may be developed from life histories is by looking for the emergence of certain themes from the narratives (Jones and Rupp, 2000), and another is the identification of the different forms or 'genres' the narrator employs in telling his story. Bury (2001) argues that genres provide a particularly useful framework for analysing illness narratives, and he identifies three broad forms: 'contingent narratives' which address beliefs about the origins, causes and immediate effects of the illness; 'moral narratives' which may be employed to describe the change in relationship between individual, illness and society, and help to '(re)establish the moral status of the individual'; and 'core narratives' which provide insight into the connections between lay experiences and 'deeper cultural levels of meaning attached to suffering and illness' (Bury, 2001: 263). The importance of genres is that they are chosen by the individual to persuade us to understand their viewpoint, and 'different genres persuade differently' (Riessman, 1993: 18). Some researchers have developed this point further, and argued that the importance of narrative genres lies in the fact that they bring to the fore 'specific structures of language', and so enable the researcher to 'examine narrative language and its effects on subjectivity' (Squire, 2000: 205). However, it is important to recognise that the relevance of genres goes beyond the

level of individual subjectivity and its relationship with language. When making the links between the two, we are implicitly making assumptions about the way in which subjectivity is formed, and so draw on conceptual notions that go beyond the text. Thus, knowledge of the cultural and historical context is presumed and used to interpret the significance of the text (Wengraf, 2000), and it is important that this is recognised and incorporated into the analysis. Other writers have warned against the dangers of using a typology 'that is based on a limited set of narrative genres . . . and on a meta-narrative on illness' (Hyden, 1997: 53-4). Hyden suggests instead, a typology based on 'the relationship between narrator, narrative and illness', such relationship 'resulting in three *types* of illness narratives: illness *as* narrative, narrative *about* illness and narrative *as* illness' (ibid: 54). The latter type of narrative may have particular relevance in the field of mental health.

All of this suggests that whilst life history narratives may indeed contain rich sources of sociological data, it is certainly not the case that this data will 'jump out' at the researcher, and clearly, 'the stories do not necessarily "speak for themselves" nor do they provide direct access to other times, places or cultures' (Personal Narratives Group, 1989: 264; see also Bury, 2001). It is for this reason that I believe it is more accurate to describe the process of extracting meanings from these accounts as interpretation, rather than analysis. Interpretation would appear to allow for a greater recognition of the pre-conceptions and prior experiences of the interpreter in developing meanings from the narratives, and for an acceptance of the fact that multiple realities may exist simultaneously, just as multiple interpretations are possible. The concept of analysis conveys a notion of scientific preciseness and lack of alternatives that does not seem to match the nature of lives

or life history narratives. Thus, it may be argued that ‘only by attending to the conditions which create these narratives, the forms that guide them, and the relationships that produce them are we able to understand what is communicated in a personal narrative. These angles of interpretation not only provide different perspectives but reveal multiple truths of a life’ (Personal Narratives Group, 1989: 262). The notion of interpretation also allows for acknowledgement of the role of the researcher in the process, and highlights ‘the need to recognize both the agenda of the narrator and that of the interpreter as distinct and not always compatible’ (ibid: 264). It can be seen from the foregoing that any interpretation of narrative must include the experiences of the individual, the ways in which the individual relate these experiences to the cultural, historical and societal structures which inform both the actual experiences and the ways of telling them, and the theoretical and conceptual preconceptions, as well as the lived experiences of the interpreter! Though it has been argued that omission of any aspect of this list ‘invites the risk of misunderstanding and misinterpretation’ (Personal Narratives Group, 1989: 19), it sets the researcher a formidable task, and whilst I have attempted to remain aware of all these issues throughout the process, I cannot claim to have explicitly included everything on this list in my interpretations.

I was still left at this stage with the problem of what processes were necessary to achieve a valid set of interpretations, and the method which seemed most relevant when I was in the planning stage was the ‘biographic-interpretive method’ (BIM) (Wengraf, 2000). The main premise of this method rests on being able to separate from within the narrative two distinct types of data. The first of these is the parts of the account which reveal the *lived life* of the narrator, this being

composed of the uncontroversial hard biographical data that can be abstracted from the interview material and any other helpful source. This is seen as a long chronological sequence of the 'objective' historical facts about the person's life, the life-events as they happened, independently of whether or how they are referred to in the interview.

The second aspect is the *told story*, which

is the way that the person presents him or herself – both in their initial narrative and in their answers to specific questions – by selecting certain events in their life (and omitting others) and by handling them in a certain way (and not in another). (Wengraf, 2000: 145)

Though this was the framework within which I began the process of interpretation, I quickly realised that this approach presented me with some practical difficulties. I had approached the men who participated in the study and told them that I was interested in their life histories in the context of their experiences of emotional distress, and part of my motivation for choosing biographical narratives as the source of data was that it gave a voice to those whose voices are often not heard or marginalised, and whose lives were often hidden from view. Thus, it became clear that the first aspect of Wengraf's method, the 'lived lives' of the narrators was where I should concentrate the interpretive process. I felt that to focus on the ways in which individuals told their stories risked diluting the impact of their stories within the constraints of this study. I have been privileged to have had several opportunities to relate my own experiences to various audiences, and realise the importance to me that it was my story that people heard and not the style I told it in.

Accordingly, I made the decision to concentrate on the 'lived lives' of the individuals, and only to make reference to the way in which they told their story when it informed or explained aspects of their lives. Thus, although I have no doubt that the data I have collected may be regarded as life-history narratives, the ways in which I have interpreted these data are not strictly in conformity to the canons of narrative analysis, but more akin to the ways in which unstructured interviews may be analysed. This is not to ignore the fact that there are tensions contained within the narratives between their status as witness statements to actual events, and as attempts by the individuals to make sense of their experiences in looking back at their lives, and I have attempted to recognise and highlight these tensions within the analysis.

The decisions taken about the analysis open up the possibility that the study may be criticised for containing insufficient data, in that if I was conducting unstructured interviews then far more than the eight which I collected were necessary. However, I would counter this by referring to the additional resources at my disposal, outlined in the previous section. Thus, published (auto)biographical sources, and my own participant observation as, first of all a mental health service user, and then during my years of involvement with MIND, have provided me with valuable insights into the lives of individuals who have experienced emotional distress. Though neither the published material, nor the knowledge provided by my own experiences may be regarded as data in the same way as the recorded life histories, they certainly provide a prism through which this data can be compared, contrasted and interpreted.

What these other sources of data provide me with is, what has been described as ‘interpathy’, which ‘involves genuinely entering into the experience of the other and viewing their worldview *as if* it was the only way in which the world could be understood’ (Swinton, 2001: 143). Thus, the approach I have taken to interpretation of data may be regarded as a phenomenological approach, which ‘views a person’s *lived experience* of and within the world as the foundation of meaning . . . [and] is concerned with the strange tensions between the personal and social nature of experience’ (ibid: 100). Clearly many of the issues raised in this chapter so far, and in particular the journey I have described myself taking to reach my chosen method of interpretation, contain ethical issues, and it is to these that I will now turn.

ETHICAL ISSUES

When carrying out research, researchers often find themselves delving into the most private experiences of individuals, and in the area of emotional health in particular, these experiences may be associated with high levels of vulnerability in those individuals. It is clearly important, therefore, that ‘the ethical principal governing research is that respondents should not be harmed as a result of participating in the research, and they should give their informed consent to participate’ (Bowling, 1997: 138). Set against this, however, must be the potential benefits which may accrue to others as a result of research findings, either in terms of policy changes which may occur, through a greater understanding in society of the experiences of emotional distress, or merely through the process of having one’s voice heard.

Thus, it is important 'that risk be calculated in proportion to the importance of the research for humanitarian purposes' (Nuremberg Code cited in Homan, 1991: 10).

In the use of life history narratives, there is a further paradox, whereby:

a world of life stories that can surely aid human emancipation and help understand their lives may also be a world which, if we are not careful, leads to a packaging of stories where they may easily become forms of control, consumption and self-absorption, robbing lives of the very authenticity they thought they were claiming. (Plummer, 2001: 79)

In order for the researcher to be able to balance the contradictions which arise from these points, it has been argued that three guiding principles should inform the design, execution and dissemination of results of research, namely *beneficence*, *respect* and *justice* (Sieber, 1992: 18). The main ways in which these principles can be adhered to, is by the researcher remaining reflexive about the project, through obtaining informed voluntary consent, and by making every effort to ensure the privacy, anonymity and confidentiality of subjects.

The three guiding principles are clearly interconnected, and their importance may arise as a result of the researcher's attempts to penetrate the 'layers of fronts disguising various levels of private and less-than public information that insiders would prefer to conceal from the prying eyes of outsiders . . . and thereby discover the truth about science and society' (Adler and Adler, 1993: 249). In return for being allowed access to these private areas in the lives of individuals, the researcher has a duty to guarantee confidentiality and anonymity to their collaborators. However, several contradictions potentially arise in respect of these aims.

Confidentiality ‘refers to data and how data are handled’ (Sieber, 1992: 44), yet clearly, the information obtained in the course of the researcher’s investigations was in my case used in this thesis, and may be reproduced in published papers and disseminated through academic and non-academic audiences by way of presentations. Thus, although confidentiality will certainly mean not passing on information obtained during interviews, to those involved in the narrators’ lives, it also relies heavily on being able to guarantee anonymity, by ensuring that ‘the names and other unique identifiers of subjects are never attached to the data’ (ibid: 45). Thus all the names used in this thesis have been changed, and as far as possible, all identifying features such as place names and the names of institutional settings have been changed. This may have presented problems if ‘gatekeepers’ had been used to gain access, as details of the lives of the participants may have been recognisable to them, but that was not the case in this project. Apart from occasionally asking for confirmation that names referred to during the narratives would be changed, none of the participants showed particular concern over the issue of anonymity or confidentiality. Connected to this issue is the situation in which the research discloses harmful practices, which may have adverse affects on either the respondent or others, and so some commentators have suggested that ‘while researchers must try to prevent harm coming to their subjects, if they observe a miscarriage of justice, they have the obligation to report it’ (Gans cited in Adler and Adler, 1993: 263). Clearly, this should not be done without careful consideration and reflection by the researcher, and preferably with the agreement of the respondent. Though some issues arose in the narratives which might fit into this category, they had generally occurred a considerable time ago, and there were

no specific issues which I felt ought to be acted on, although clearly changes in practice or policy may be relevant with regard to some of the issues raised.

Other connected issues may arise when carrying out research in a mental health setting, for instance in having to decide whether or not to disclose the fact that an individual may be displaying suicidal tendencies or self-harming, so that they may be diverted from their intentions by the intervention of mental health professionals (a situation encountered by Richie and reported in Dale et al., 1988: 57). As I had chosen not to interview any individual who was showing signs of acute distress, no such dilemmas presented themselves during the course of this project. Had such a situation arisen, my close involvement with MIND, and with the carers employed by them, meant that I could have arranged support for the individual concerned. The only ways in which a researcher can satisfactorily deal with dilemmas such as these, is to involve the respondents in the decision making wherever possible, and by so doing, to *respect* their rights of self-determination. In this context, it has been argued 'that to *respect* a person as an autonomous being . . . is to take account in one's conduct that he/she has an autonomous nature, that he/she is self-determining and self-governing, or that he/she has desires, feelings and reason' (Downie and Calnan, 1994: 54). The need to operate with this model of respect should form a vital part of the relationship between researcher and narrator, a relationship which is potentially fraught with difficulties. One clearly needs to build a relationship based on trust, whilst remaining aware that friendship with research subjects 'can lead amongst other things to false intimacies, fraudulent friendships, and a masking of power' (Kirsch cited in Plummer, 2001: 212). I had to remain particularly aware of this issue as a result of already knowing and being known by some of the

participants. It is also necessary at all stages of the project to remain reflexive about the effects of the power relationships between researcher and narrator, because 'if we wish to understand a life story, then, we need to know where both the researcher and the teller of that life are coming from, what kind of relationship they are having together, and how this fits into the wider social order' (Plummer, 2001: 208). An important part of regulating the relationship between researcher and respondent is through the notion of informed consent, and it is this aspect that I will now address.

The Statement of Ethical Practice issued by the British Sociological Association in 2002 makes the recommendation that '*as far as possible* sociological research should be based on the freely given informed consent of those studied' (www.sociology.org.uk: 3). This consent should be in writing, and should be given on the basis that 'the subject is competent to make a rational and mature judgement', and that it should be given voluntarily and 'free from coercion and undue influence' (Homan, 1991: 71). In addition, for such consent to be *informed*, 'all potential aspects of what is to occur and what might occur are disclosed to the subject' and they should be in a position to understand this information (ibid: 71). (Samples of my information sheet and form of consent are included in Appendix A.) In order for informed consent to be achieved, clearly in these terms not an easy task, it has been suggested that it is necessary for the researcher to establish a rapport with their collaborators through 'the congruence of verbal and body language' and by establishing a relationship based on trust (Sieber, 1992: 28). In addition, it should not be assumed that acquiring informed consent is a process which is negotiated at the commencement of data collection and then filed away and forgotten! The principle must remain in the forefront of the researcher's

thinking throughout the project, and the narrator must remain free to withdraw from the project at any time. This was especially pertinent in this project, as narrators may have needed to withdraw to avoid further emotional distress, though clearly the consequences of withdrawal could be seriously detrimental to the project, and as has already been discussed, this did in fact occur on several occasions. Thus, making sure of the participants' willingness to contribute at the outset is vitally important. The researcher must also remain aware that in obtaining consent 'the decision on whether or not to proceed is effectively passed from the researcher to the participant' (Homan, 1991: 93), though the researcher must bear in mind his/her duty not to harm the participants. But, in attempting to reconcile these potential dilemmas, there is a danger that in making judgements as to what might or might not be in the best interests of the participants, the researcher may be guilty of paternalism (ibid: 72). Thus, in the continued negotiation of informed consent, once again the respective power of trained researcher *vis-à-vis* the 'untrained' subject needs to be acknowledged and reflected upon. Connected to this issue is the care I needed to take to ensure that the participants to the study, whilst often acknowledging the therapeutic benefits of telling their story, did not mistake the interview for a counselling session. Though the potential for this was there, it did not become a significant issue during the project.

Two other ethical issues arose during the course of the project, both of which I had considered in the planning stage, but neither of which I anticipated having the impact they did. First was the realisation that however I tried to justify my motivation for doing the research, as I talked to men to assess their suitability to participate in the project, and listened to their stories about their lives, I could not

get away from the fact that I was using the distress that these men had experienced in order to obtain a PhD. The way that I began to feel about the project is summed up by Plummer's observation that

The potential harm and damage, the sheer intrusiveness into someone else's life, the bare-faced cheek to believe that one can simply tell another's story, the uncritical self-satisfaction of telling another's story, the frequent arrogance of "colonizing" their world view – all this needs to be considered. (2001: 225)

The more I did consider these points, the less justified I felt in continuing with the project, and it was only the support and encouragement from the participants and potential participants which convinced me to do so. It did though, make the collection of the narratives a painful and extended process.

The second issue which arose, strongly linked to the above observations, was that as I heard the stories the men told me, I was unsurprisingly reminded of my own experiences of emotional distress. Though this was expected, and though I had become accustomed to talking about my own experiences, I was surprised about the intensity of the emotional impact this had on me. Again there were times when withdrawal from the project seemed necessary, and made the collection of the narratives extend over a far longer time period than I had planned. Whilst the sociological literature on research methodologies quite rightly highlights the need to avoid causing harm to contributors, little is said about the potential harm to researchers. The motivation for carrying out the research, the access to participants and the justification for being able to empathetically interpret the narratives were all based on my having been a mental health service user, but this very same fact

caused almost as many difficulties as it solved. Though the transcription of narratives and the process of interpretation were less painful than the collection of the data, I remained sensitive to these issues.

On completion of the research project, and the development of any conclusions, as a researcher I believe I have a further responsibility to those taking part in the research, and that is to find ways of disseminating these findings back to the participants (Bowling, 1997). It is important that this is done in a form that is accessible to them, which, it has been suggested, means that long and academically worded theses 'should include a shorter summary, understandable to the lay person, and this should be available separately' (ibid: 140). Some writers (e.g. Oakley) have gone so far as to producing two versions of their books, one for the academic world, and one for the 'lay' population. Whatever the chosen way of achieving dissemination, it is especially important when carrying out research with 'relatively powerless groups', a description which is perhaps relevant to members of the mental health community, that it is done so 'in a way which is as clear as possible to those individuals' (Roberts, 1981: 26). I have chosen to do this through presentations at MIND, and by inviting participants to meet with me for one to one discussions about my findings. In addition, on completing each interview, I offered to send a copy of the transcript of their narrative to the narrator, but none accepted this offer.

CONCLUDING COMMENTS

Clearly the reasons for selecting any particular methodology are strongly related to the reasons for choosing a topic of enquiry. A significant element of these choices,

certainly in my own case, and in the case of many other social researchers, is the way in which my own past experiences are influential in this regard. Though for many sociologists this may appear to contravene the perceived need for 'scientific objectivity', for others this is a reality which needs to be acknowledged, and indeed, may be the very *raison d'être* of social research.

In addition to the issue of the researchers' own experiences, illness narratives have been seen as important because of the importance of being a witness to the suffering of individuals, especially the chronically ill (Bury, 2001). This is regarded as of particular importance as a way limiting the overpowering influence of medicine in Western societies. Indeed, it has been argued that the findings which are made through narrative based research, and the ways in which it may bring together aspects of individual agency and wider social processes, can be an important impetus for changing both social policy and professional practice (Chamberlayne et al., 2000). In view of the poverty and social exclusion experienced by many mental health service users, this is potentially an enormous benefit.

Clearly, for any of the potential benefits of life history narrative research to materialise, the interpretation of the narratives is crucial. In focusing on the effects that emotional distress has had on the lives of individuals, I hope to highlight ways in which improvements in care can address some of the issues raised by participants in the study. Whilst ethical issues crop up throughout the research process, it is perhaps at the stage of interpretation that they come to the fore. In order to mitigate some of these issues it has been necessary for me to remain sensitive and reflexive,

and to bear in mind the potential effects of misinterpretation on the narrators. Clearly some fine judgements were necessary, in order to avoid overstepping ethical boundaries, whilst at the same time meeting the academic pressures to produce a meaningful thesis, but in order to minimize the risk of harm to participants, these principles are important. In raising the ethical difficulties which arose during the project in respect of the emotional effects on myself, as researcher, in carrying out this type of research, I may be regarded as self-indulgent, and perhaps unprofessional. Such reflections though, are important, not least because they have had a considerable influence on the form and the content of the end product. Thus, the reader needs to be made aware of the processes which result in what they are reading.

CHAPTER 4

EXPLAINING EMOTIONAL DISTRESS

INTRODUCTION

In Western societies during the past 150 years the causes, nature and treatment of emotional distress have been dominated by medical models, whether psychiatrically or psychologically based, and though not entirely free from challenge, from within and without these professions (Crossley, 2006), this domination remains today. Over the course of the last twenty or so years, challenges to these medically based explanatory models of categorisation and treatment have come from service user movements. Thus, whilst individuals who have experienced emotional distress and have either sought medical intervention, or have had medical intervention forced upon them, are likely to be aware of psychiatric and psychological explanations and treatments, they are increasingly likely, through their involvement with other service users, to have been exposed to some of the challenges to these models.

In this chapter I will concentrate on the causes which the narrators attribute to their experiences of emotional distress. In the light of the exposure to medical models experienced by the contributors, I will begin with the biological and genetic explanations favoured by psychiatry, followed by explanations which focus on childhood development and family influences, and then on to life events in adulthood as the cause of distress. I will highlight the specific ways in which narrators present their own understandings of the links between social stresses and distress. The main issues I will be examining then, will be childhood events and development, stressful

lifetime events, and the role of alcohol and recreational drugs, as both a contributory factor to emotional distress, and a way of coping with it.

CAUSAL EXPLANATIONS FOR EMOTIONAL DISTRESS

(i) Biological and genetic causes of emotional distress

All of the contributors to this study have been in receipt of some form of medical treatment for their distress, and all have at some time been prescribed pharmaceutical treatments, and so as this form of intervention is mainly based on biological explanations of the causes of mental illness, it would be expected that all of the narrators would be aware of these. Despite the problems associated with medical definitions and diagnoses, the biomedical model is an extremely powerful one in western societies, and the medical profession retains a considerable amount of power and influence in the creation of meanings, explanations and classification of those experiences which they, and many others, term mental illnesses. It is not surprising then, that the accounts of the contributors to this study often contain medical terms and medically influenced explanations when describing their experiences, especially when one considers that all of them had received some form of medical intervention at some time. Thus, references to depression, bipolar affective disorder, psychosis, psychotic episode, schizophrenia and many other medical terms occur frequently throughout the narratives. What is clear though, is that as they search for meanings in an attempt to understand their experiences, individuals draw on these medical terms and explanations alongside, combined with and often in contradiction to non-medical

ones. In the published account of his emotional distress, for example, William Styron acknowledges the need in our scientific, rational world to abandon terms such as madness. However, he writes,

Never let it be doubted that depression is, in its extreme form, madness . . . [and] that such madness is chemically induced amid the neurotransmitters of the brain, probably as the result of systemic stress, which for unknown reasons, causes a depletion of the chemicals norepinephrine and serotonin, and the increase of a hormone, cortisol. (1991: 46-7)

Clearly this extract contains an example of Styron's understanding of medical causes of distress, and thus is relevant to the issues covered in the previous chapter, but is also an account of how he understands his emotional state, as he combines the non-medical description of his experiences, that of a form of madness, with a complex biomedical understanding of the biochemical processes which psychiatrists use to explain depression. Des also acknowledges the biochemical aspects of his experiences, but within a complex framework of explanations:

I think maybe voices, I don't know, with me maybe it's a part of my brain that's just gone psychotic because it's had enough of the way the world is. Or maybe it's just gone to a certain point where it's snapped, and err, some part of it's just gone psychotic . . . so I think maybe these parts of my brain which I experience as voices, are maybe some part of my brain which have gone psychotic for whatever reason. Obviously, on a, on a scientific level *there'll also be chemicals*, but maybe it's because of something I went through . . . maybe it was because I was smoking too much cannabis, or maybe it's because I suffered a lot, or maybe, I don't know, there's no real answer, is there, really? [8-9]

So Des' search for meaning to his experiences, perhaps inevitably, returns to causal explanations, and incorporates the biochemical processes in his framework of understanding, but equal weight is given to social factors. This process of weaving medical categories and explanations into more social and lay perspectives is a common theme in the narratives, and reflects as much as anything the considerable effort individuals have gone to in order to give some meaning to their experiences. Colin told me how, in his own search for meanings, fellow service users had proved to be a far more useful source than had the mental health professionals, perhaps because they do incorporate a more complex multifaceted understanding of emotional distress, than the more one dimensional biomedical model. He went on to tell me,

There are as many varieties of mental illness as there are hot dinners, and that sort of thing, umm. Michael has been in and out of institutions all his life. I mean, a lot of his are self-inflicted wounds, although he's schizophrenic or whatever, you know, and you wonder what come first, chicken or egg, and it was a pretty dysfunctional family. [8]

Thus, in the meanings which Colin attributes to Michael's experiences, he incorporates blame for the 'self-inflicted wounds', the presence of a medical condition, schizophrenia, and his 'dysfunctional family'. Colin continued with his theme of self inflicted wounds, saying that *even* Michael had told him that in recent years, the patients in the local psychiatric hospital increasingly included, 'a lot of junkies and a lot of alkies [alcoholics]' [8]. The inference here seems to be that unlike Colin they are to blame for their problems, despite the fact that throughout his narrative Colin spoke of how he had used alcohol as a means of coping with his distress.

The relationship between alcohol and emotional distress is a complex one, as the (ab)use of alcohol may simultaneously be seen as the cause of, a way of coping with, and as a diagnostic category of distress. Matt, who has received diagnoses of both alcoholism and bipolar affective disorder, recognises the somewhat arbitrariness of the allocation of such labels when he told me,

I hang around with people that are like-minded today. You know, people, not only people with mental illness, or with, with people with drink or drug [problems]. I find that most people have got summat wrong with them [laughs], and we're talking, if we are talking about emotional err, imbalance, or emotional distress, you know, you don't have to be an addict or an alcoholic or a schizophrenic or any of these things, to have this. [3]

I detected a (welcome) dig at my own attempt to develop a label for those who had been labelled by psychiatry as mentally ill, as well as highlighting the continuum along which these experiences fall.

The medical explanation based on chemical changes in the brain, may be made more difficult to assess in the light of the effects of pharmaceutical treatments, and John, in trying to assess whether a reduction in the levels of his distress may be attributed to the medication he has been taking says

I think that the medication is doing something, although you, I don't know whether it's that that's doing it or whether it is the chemicals, whatever it is that causes the psychosis, you don't know what, whether they're not there anymore. [5-6]

The chemicals he refers to here are the chemical changes in the brain which medical explanations attribute to the cause of schizophrenia, and John is expressing uncertainty as to whether these chemical changes have been successfully treated by the medication he takes, or whether those changes would no longer have been present in his brain regardless of the medication. It is then, no more than a half-hearted recognition of the theory that his psychosis has chemical causes, and even this appears to be dismissed when he follows these thoughts with the assertion that ‘I can put psychosis down, I think, to loneliness really’. [6]

The other biologically based causal theory which has increasingly been advocated within the biomedical model of mental illness in recent times is that of genetic disposition. However, none of the men who contributed to this study specifically put forward genetic inheritance as a factor contributing to their emotional distress, although three of them included fairly lengthy accounts of one of their parents experiencing and being diagnosed with a form of mental illness. Pete speaks of his father experiencing depression, though not in the context of providing an explanation for his own distress, but of how witnessing his father’s distress made it difficult for Pete, who was only sixteen years old at the time, to cope with what was happening to himself. He tells how

I think my dad was already, was getting quite stressed out with his work as well, and when things were going wrong with me, he umm, he got quite in a state. It was like, I’ve got all these problems, and I’ve got to be strong for my dad, and help him, and he went on to anti-depressants as well. [2]

His father in fact, telephoned Pete from work on one occasion to tell him that he was thinking of committing suicide, and this was shortly after Pete himself had tried to kill himself. But Pete's account of these circumstances would seem to demonstrate his understanding of both his own, and his father's depression as resulting from a complex interaction of social forces, emanating from both within and without the family, rather than from any kind of genetic links.

Nick also shows a clear understanding of how complex family dynamics led to his distress as a child, telling me that,

As in many dysfunctional families, one child is, in inverted commas, perceived as, in inverted commas, *bad*, and the other child, in inverted commas, is perceived as *mad*, and my sister was perceived as *bad*, and I was perceived as *mad*. [6]

This alludes to psychological accounts of child development, and later in the narrative Nick goes on to explain in more detail the nature of the family dynamics which created this situation for himself and his sister, telling me.

Dad told me when he was elderly, he'd been diagnosed as paranoid schizophrenic in his early twenties . . . I wish he'd told me [before], then I would have understood more why he behaved towards us as he did. [7]

But, rather than see this revelation of his father's diagnosis of schizophrenia as a genetic explanation for his own distress, Nick goes in to considerable detail about his father's own 'dysfunctional family', and some extraordinarily stressful wartime experiences in order to explain his father's behaviour to Nick and his sister. Thus Nick builds a model of his father's experiences being the cause of his distress, which

then is passed on to Nick through his father's behaviour. The fact that both Nick and his father were diagnosed with schizophrenia may be interpreted by some medical practitioners as evidence of genetic inheritance, though Nick certainly sees it differently.

Jim's narrative potentially provides an even more compelling *prima facie* case for genetic inheritance of mental illness. He begins his narrative by stating, 'since 1988 I've had a diagnosis of what was called manic depression, now called bi-polar affective disorder' [1], and then goes on to immediately to explain,

my mother has also a diagnosis of manic depression, bi-polar umm, and she's had the, she's had the diagnosis, I think since she was at college, but she's been under a psychologist since she was eight years old, when she was caught stealing money from her mother's purse. [1]

Jim clearly identifies that he recognises that there are connections between his mother's diagnosis and his own, saying 'my feelings are that a lot of , that that's a family history if you like, of both my mother and myself having the diagnosis' [1]. But although on the face of it, Jim's expression 'family history' could be interpreted as genetic inheritance, Jim is quick to suggest otherwise. Of his mother's emotional distress he says 'I feel a lot of her issues stem from her, the way she was brought up' [1]. We do not find out whether Jim's grandparents were diagnosed with any form of mental illness, but Jim is identifying family upbringing rather than inherited genes as the likely explanation for his mother's mental illness. He then goes on to describe how he feels that his mother's experiences impacted on him as a child, describing how

I've had one parent, my father, who was a very, umm, disciplinarian type person, who I was quite in fear of, so I had a bit of a umm, in the relationship it was not that close, and then in my mother, it was my mother, although she was a very loving person, there have been times when I've, maybe every three years or so when I was growing up, when she was taken away from me, and you feel more on your own. [1]

Thus, Jim's focus as regards the effect of his mother's distress on himself, is on her absences whilst hospitalised, and the loss of emotional support that resulted, as it was not available from Jim's father. When Jim was 15, his father died after a year's illness, and his mother was, shortly afterwards, hospitalised again, which resulted in Jim's younger brother being taken into foster care, and so, Jim says, 'you've got a family that wasn't the strongest unit in the first place with all this illness going on, and then it's just scattered' [1]. Although Jim describes himself as 'OK mentally' at this time, the very fact that he begins his narrative with this part of his life, and then goes on immediately to describe his first 'breakdown', clearly connects the events in his own mind. But although Jim is identifying a connection between his mother's mental illness experiences with his own, it is the effect of these on his emotional development as a child which he identifies as the causal link, not the passing on of faulty genes. As we shall see in a later chapter, two adults living together, both of whom have been diagnosed with a mental illness, can lead to some difficulties for themselves, and for the mental health services. But having identified how the three individuals who have a parent with a mental illness relate this to their childhood experiences rather than their genetic inheritance, I will now examine how the other narrators described their childhood experiences, and how they connected them with their own emotional distress.

(ii) Childhood experiences

Clearly any discussion here, revolves around the age old nature versus nurture debate, and the accounts of the narrators discussed in the previous section would certainly come down on the side of nurture as being the most relevant factor. When I prompted Darren to provide his understanding of the causes of his life long battle with anxiety, he was perhaps more ambiguous, and on the topic of genetics Darren told me

I guess, yeah, my mother and father no doubt had certain predispositions which were genetic. I don't know exactly what they were, all I know is . . . well, they've got their own genetics, they had their own upbringing, I have some of their genes, yeah, the generations, with variations do persist. {8}

So in this part of his narrative, Darren is including both genetics and upbringing into his explanatory framework, but in other parts of his narrative he seems very to much to come down on the side of explanations which focus on childhood upbringing. Of his own childhood he says

Well, certainly with my childhood, I think childhood sets a pattern, you learn, I've learned lessons form childhood which I've only over time been able to put into words . . . so yes, I think that childhood is a source of some of it. [8]

But Darren appears to recognise the degree of determinism which this implies, stating that

I also understand it as I contributed to a proportion of the pattern myself, you know, or maybe I've made changes to the pattern myself. I really don't like seeing myself as a victim. [8]

Thus Darren seems to have developed a complex model regarding the causes of his emotional distress, which allows space for genetics, childhood upbringing and his own agency all acting as contributory factors. Despite this complex model, throughout his narrative Darren constantly refers back to his relationship with his mother, and how the guilt he has always felt for not being able to return the 'over-protective and a lot of . . . smothering love' [1] that he received as a child has contributed to his lack of self-confidence, anxiety and depression as an adult. Darren's comment that it is 'only over time' that he has been able to verbalise, and therefore, to fully comprehend the effect of learned childhood patterns of behaviour, may be connected to the long hours of talking therapy which he has been engaged in, as this aspect is clearly an important element of many talking therapies.

Childhood then, may be seen as a time when patterns of behaviour, which may or may not be helpful in dealing with the vicissitudes of adult life, are learned. For some though, childhood brings events which are traumatic, and which in themselves may result in emotional distress, not only at the time of the trauma, but in some cases throughout adult life. We have already seen the ways in which Nick's 'dysfunctional family', where 'there was abuse going on' [7] was identified by him as a major contributory factor to his distress. Pete, though at first focussing on the way in which the stress of schoolwork was a factor in his adolescent depression, later raises the fact that he had been sexually abused as a small child whilst being cared for by a family friend, that he had been severely teased at school because of his lack of height, and

that he experienced a period of considerable confusion about his sexual orientation during adolescence until eventually recognising that he is gay. Thus, after his initial identification of stress at school as the contributing factor to his depression, he then identifies a succession of potentially traumatic events which occurred during his childhood.

In Pete's case the emotional distress which resulted from these traumas manifested itself during childhood, as he attempted suicide on several occasions. For some though, the distress resulting from childhood traumas does not come to the fore until adulthood. Matt begins his account by describing himself as

I've always been an emotional person actually . . . as you hear things as you grow up, and err, you're told things, I was err . . . an emotional basket case from the start really.' [1]

He begins his explanation for this by telling me that he has found out as an adult that he was born two months premature, was 'bonded' with a neighbour rather than with his mother because she was too ill, and he says, at some time before the age of five, 'I had meningitis, err, so I had lots of mood swings and stuff' [1]. Matt seems not to have been aware of any of these things until he was going through a series of recovery programmes for his alcoholism and drug addiction in his 30s, which in turn led to him questioning his mother about his childhood, but he clearly regards them as stressful events which have contributed to his distress as an adult. But Matt goes on to relate an event which took place when he was 12 years old, and which he was clearly very aware of at the time. He tells how whilst on his first family holiday, he rushed into a room, pushing the door open as he did so, not realising that his father

was bending down behind the door, packing clothes into a suitcase. The door struck his father on the head, and to Matt's horror, knocked him unconscious. Matt ran away, to return some minutes later to find his father still unconscious, and so, he says, 'I raised the alarm, but I didn't tell anybody that it was me that knocked him on the head because I didn't want to be shouted at' [1]. His father was brought round with smelling salts, leading Matt to feel that 'I thought I'd got away with it' [1], but unfortunately for Matt, two to three weeks later, Matt returned from school to be told that his father was in hospital, seriously ill, and he died a few days later as the result of a brain haemorrhage. Matt was unable to tell anyone about his part in this tragedy, and he told me how

Carrying all that hasn't helped . . . I mean I didn't, I didn't know what I was carrying . . . unbeknown to me it was err . . . festering away, festering away [2].

This would certainly seem to represent a trauma which even the most emotionally balanced may have had difficulty in coming to terms with. Interestingly, Matt claims that the significance of this event in terms of his later dependence on alcohol and drugs, only became clear to him 'from the retrospect of having gone into treatment with my alcoholism' [2], and that as a result of that treatment, he now believes that his father's cerebral haemorrhage would have resulted from a blood clot in his leg, rather than from the blow to the head caused by Matt.

Psychological theories of mental illness have, of course, included childhood traumas as a causal factor, and talking therapies of various sorts have sought to uncover these traumas, and to enable the individual to find ways of coping with the memories, hidden or otherwise, of these events. As we have seen, for some, such as Pete and

Nick, the distress which results from trauma surfaces during childhood, whereas for others it may not occur until adulthood. In the context of male depression, Real suggests that 'childhood injury in boys creates both the wounds and the defences against the wounds that are the foundation for adult depression' (2003: 98). Childhood injuries though, take many forms, and whilst those experienced and described by Matt, Pete and Nick may be clearly recognised as being traumatic, for some such as Darren, the cause of the injuries is less dramatic and less clear. However, as Real suggests, seemingly insignificant events may represent 'slight childhood fissures, that later on, under sufficient stress, may crack open' (2003: 98).

(iii) Stressful events in adulthood

In the above section I have considered events which take place during childhood, a time of one's life when stressful events are seen to be particularly associated with emotional distress, but those that occur in adulthood may also have the potential to be just as harmful. It is not difficult to recognise that the end of a relationship, the death of someone close or financial difficulties may lead to emotional distress. Whilst being potentially the cause of distress however, many of these events may also be the result of distress, or may in fact impede recovery from periods of distress. In the context of financial difficulties on his return from his broken marriage in the US, Colin told me

I was on a very bad patch, for, well money problems are enough to make anybody depressed anyway . . . I suddenly came down to nothing, you know, I was a . . . I

came back (to UK), I was like a refugee in my own country, and umm, I was on the minimum jobseekers allowance . . . Your quality of life ain't much good!' [11]

Thus, Colin identifies the fact that though his depression may have been triggered by the loss a relationship, and the lifestyle which went with that, it is exacerbated by the financial difficulties which often result from emotional distress. But, it would seem, other life events which would not normally be seen as negative, may also result in episodes of distress for some individuals. Jim, for example, told me about his first experience of severe distress, which came after a difficult adolescence, but which he describes himself as having come through 'mentally OK', and a reasonably successful first year at university. During the summer vacation he worked in a theatre bar, which he acknowledges was slightly stressful because 'hundreds of people suddenly descended on you for about ten minutes' [1]. But rather than causing Jim to be depressed or anxious, it seems that this pattern of work somehow over-stimulated him, so that 'even in the space of about ten days I'd managed to get really high' [1]. This high state eventually led to Jim being sectioned and being diagnosed as having bipolar affective disorder. He spent a few weeks in hospital, but was then able, with some difficulties, to go on and complete his degree, and then to find full-time employment. He remained free of symptoms and describes leading, what most of us would regard as, a 'normal' life for someone in their early twenties. He then set off, with some friends, on a 'round the world trip', and he describes this by saying 'I really, really enjoyed this round the world trip, too much so' [4]. He describes having 'a really excellent time' [5] for about two months until he himself recognised that he was getting 'too high', and arranged for himself to be admitted to an Australian psychiatric hospital. He was eventually flown back to UK, escorted by a psychiatric nurse, and paid for out of medical insurance, and again made a complete recovery.

Jim then spent about ten years working and living a 'normal life', after which a reorganisation programme by his employers meant he had to relocate to another town.

As Jim told me,

this was enough to set me off again, not, not the stress of doing it, but the fact that I was, and I'm sure of this, but I was just so positive about things, I'm getting on with these people, I'm really enjoying myself, I'm really positive, I'm looking forward to it, and *bang*, you know, there's another, another episode. [6]

Jim summarises his experiences, saying

With all the times I've been ill . . . or hospitalised I should say, it's been getting on, getting high, not always for the same [stimulus], but nevertheless a high [1-2].

Clearly the relationship between cause and effect which is being described by Jim in his narrative, is not a straightforward one, a point he himself recognised when he told me that

I'm coming to the realisation that it takes a lot of work to come, to try and work out what all these life events have done to your psyche, if you like, and why you might have got into this state in the first place . . . for my first episode it was a stress related thing from my job, the second time, and this happened again 10 years later, it was due to just enjoying myself too much. [3-4]

The complexity of this cause and effect relationship is increased further when individuals are taking long term medication, and Jim has been taking lithium since first being hospitalised, and he describes the effect of this as,

You always have this kind of cloudy, I have this cloudy mind feeling from lithium, something that's dampening down your emotions, your thinking, everything, it seems to. [4]

Jim admitted to me that he sometimes took lithium 'slightly erratically', and that this was the case on each of the occasions that he finished up being hospitalised. Of this, he says

You could use it as ammunition, you could say that's why, that was the cause. But for me, what always come first is the . . . events in your life that have cropped up, and then you get a certain state of mind and then you might not take the drugs, but you can never prove that because it happens all in the space of a week, and you can never sort of demonstrate it. [7]

When read in the context of the effect that lithium has on his emotional state, Jim seems to be arguing that when really enjoying himself, he either does not feel the need for the lithium, or he does not want his enjoyment 'dampened' by the effects of the drug. There also arises from this a difficulty with many service users who are on permanent doses of medication, in assessing whether changes in the pattern of taking the medication allows the 'illness' to reoccur as would be consistent within the biomedical model, or whether the emotional state which follows withdrawal, is a result of the individual no longer being able to deal with emotions which are no longer 'cloudy' or 'dampened'.

(iv) Alcohol and drugs

Another issue which was raised in the narratives was that of drug and alcohol abuse. It has long been recognised that there are links between alcohol abuse and mental illness, and more links have been claimed in recent years between the use of recreational drugs such as cannabis and cocaine, and mental illnesses. Once again though, when the issues are examined closely, the precise nature of the relationship between substance abuse and mental illness is a complex one. Several of the contributors to this study recognised that the use of alcohol and drugs was linked in various ways with their experiences of distress. Thus, Des begins his narrative by telling me that he had his first major breakdown when he was eighteen, and that at the time

I was smoking pot every day and maybe the odd weekend I'd have maybe some magic mushrooms or ecstasy or something like that, which I was beginning to become aware of, that it wasn't totally good for me . . . because I was finding my motivation was lacking quite a bit, and err, my responsibilities were being left behind, kind of thing. [1]

Des seems clear about the links between his use of drugs and his distress. Later in the narrative however, he qualifies this viewpoint, telling me

I went through a lot of suffering . . . and my doctor thinks it was brought on by cannabis really, but I think it's a mixture of things. I think it has quite a bit to do with the drugs I was taking . . . but I think it also had a lot to do with the way I felt about the world at the time . . . all, all I was really focussed on at the time was the fact that, the amount of suffering in the world. [8]

Thus, Des' explanation for the cause of his psychosis is now a more multi-causal one, which recognises the role that both his drug use, and his views of the world were contributory factors to his distress, and may, of course, have been linked to one another. He recognises that his decision to start using cannabis was linked to his sense of identity, and that he placed a high value on the effect it had on him, stating, 'I think it used to make me deep and philosophical, and relaxed and calm and placid' [9].

This suggests that the original decision to use recreational drugs regularly may have been in order to achieve states of mind which he perhaps had been unable to achieve without them. This then would seem to resonate with the '*self-medication* hypothesis which sees all 'addictions as attempts to "correct" for flaws in the users ego capacities . . . and of substance abuse as a desperate strategy for dealing with self "dysregulation"' (Khantzian cited in Real, 2003: 275). Though this may overstate the case somewhat, for those who find it difficult to develop a satisfactory sense of self and identity, the use of mind altering substances may prove attractive. These difficulties in fitting into the world may, of course, be understood both as individual failings, and as an unsatisfactory social world. Alcohol, perhaps because of its legality, has been the most widely used drug for the purposes of self-medication, and the novelist William Styron describes how

I used alcohol as the magical conduit to fantasy and euphoria, and to the enhancement of the imagination . . . as a means to let my mind conceive visions that the unaltered sober brain has no access to. (1991: 40)

Here Styron is highlighting the use which has been made of alcohol in the cause of creativity, but he goes on to explain how he came to the recognition that he had also been using it 'as a means to calm the anxiety and incipient dread that I had hidden away for so long somewhere in the dungeons of my spirit' (1991: 40). This recognition comes to Styron only when he finds in middle age that he has developed an intolerance to alcohol, and now longer able to drink, he writes,

Suddenly vanished, the great ally which for so long had kept my demons at bay was no longer there to prevent those demons from beginning to swarm through my subconscious, and I was emotionally naked, vulnerable as I had never been before.
(1991: 43)

Styron suggests that depression has probably 'hovered over me for years, waiting to swoop down' (1991: 43), kept away by his use of alcohol, but what we can never know, of course, is what effect a life time of heavy drinking had on his susceptibility to depressive moods. Rather like being unable to assess whether Jim's distress resulted from not taking lithium regularly thereby allowing an inherent 'illness' to emerge, or from some sort of withdrawal effect.

We have seen how Matt discovered that the emotional problems he experienced during childhood could be alleviated, or at least covered up by the use of alcohol, describing how he 'found out that I could, I could not feel so bad about myself if I had a few pints' [2]. But in using alcohol in this way, as a form of self-medication, it actually became the problem, with Matt's addiction to the affects of alcohol eventually being diagnosed as alcoholism, and treatment being given for that diagnosis. Later in his narrative Matt reveals how he also used other drugs, saying, 'I

took a lot of world altering drugs, you know, not only opiates, I took LSD and mushrooms, anything. They were queuing up to trip with me' [9]. The use of the expression 'world altering' is interesting, suggesting that Matt saw himself as changing the world in which he lived, rather than changing himself. He goes on to say, 'maybe I wouldn't . . . if I knew how mentally ill I was, I wouldn't have took drugs, I don't know' [9]. This suggests that while he acknowledges that his use of drugs may not have been helpful in terms of his 'mental illness,' it already existed and so was not caused by the drugs.

Nick's narrative also reveals that he has used drugs extensively during his life, but as we have seen his distress began at an early age, and he locates the cause in his family upbringing. In fact it was through being a mental health service user that he first came to use drugs. When speaking of his time on the adolescent unit of a large psychiatric hospital in the 1960s, he describes how

Some of the young people had taken a lot of illegal drugs, umm some of the young people were anorexic, umm some of the young people had developed schizophrenic illnesses very early, some of the young people were just, well I say just, were just troubled, we were all troubled. [1]

The suggestion from Nick here is that taking drugs is one way among many of being 'troubled', rather than necessarily being a cause of mental illness. Nick describes in detail how he was regularly given barbiturates by other service users, and how on one occasion he was given LSD by a fourteen year old girl on the unit, and how it was 'very, very strange being under the influence of LSD in a psychiatric hospital' [3]. His narrative contains several accounts of being encouraged to take alcohol and drugs

by both service users and care workers in several psychiatric settings, though nowhere does he attribute this as a causal factor for his distress. Nick continued to use a variety of recreational drugs well into adulthood, but has not used them for about ten years. It is impossible to assess the affect of this use of drugs on Nick's emotional and physical wellbeing, when it is set in the context of a life taking mind altering prescribed drugs, many of which have dreadful side effects (see Breggin, 1993), and of his already being 'troubled' by the age of seven. In general though, Nick does not have a negative attitude toward his use of recreational drugs, and in fact told me,

The experiences I've had with illegal drugs were the most profound and ecstatic experiences I've ever had. I was one with the life force, I could see the life source flowing, it was flowing through me, flowing through my brain, my senses. [12]

This has the feel of a spiritual dimension to Nick's use of drugs, an issue which also arises in respect of his description of his psychotic episodes, and I will return to the issue of spirituality in the context of emotional distress in the next chapter.

Nick has more than thirty years experience of the mental health system, and in the context of illegal drug use in psychiatric units, he had some interesting views, telling me

Sometimes when I was young I wanted to take drugs, sometimes I didn't. Normally when I was in hospital I tried, well, I did, I avoided them. But there've always been illegal drugs, or ever since I've been in psychiatric hospitals . . . there've always been some patients who will bring illegal drugs in, the difference is now, is that dealers are targeting hospitals. This is different, when I first went

into hospital the drugs were brought in by patients on day leave and things, and I avoided them. Now psychiatric hospitals, the scene's changed so much, you know, dealers actively target hospitals. [15]

Nick suggests that in the 1960s and 1970s drug taking was a part of a counter-culture, and that those supplying drugs at that time saw themselves part of that counter-culture. Now, though, not only has the nature of the drugs changed, because they are 'cut with different things' [15], but

The dealers are largely, err, they're criminals essentially, no aspirations for the counter-culture, they're just trying to make large amounts of money, and umm, they actively target psychiatric hospitals these days. [15]

Though to an extent the debate as to the extent that illegal drugs may be a cause of mental illness is largely unresolved, it is clear that many mental health service users are potentially very vulnerable. In addition, as suggested earlier, there must be a great unpredictability in the outcomes of those who take a mixture of mind altering, illegal and prescribed drugs, and who are already emotionally distressed, and this makes Nick's comments worrying indeed. It also demonstrates that though one of the functions of detention in a psychiatric hospital is to afford a degree of protection to distressed individuals from the pressures and stresses of the outside world, the hospital remains to a large degree a part of that wider world. Nick's comments show how experiences of illness are mediated by the culture in which they occur, and so need to be understood in that context. Many of the experiences Nick recounts in his narrative, both in terms of experimentation with drugs and of psychiatric hospitals, relate to the 1970s, when LSD and other psychotropic drugs became widely available, and when mental health services were less 'user led' and perhaps, less well

scrutinised. Thus, because of Nick's long association with both the sub-cultures which surround recreational drugs, and the mental health services, his narrative serves as an example of the effects that social trends and transformations have on individual experiences.

CONCLUDING COMMENTS

Although clearly important, attributing causes to emotional distress is a complex exercise, in the main because of the various interconnected contributory factors involved, and is perhaps one of the areas in which medical explanations have proved to be as unsatisfactory as any other. When setting out on this study, it was not my intention to focus on the causes of distress, because in a qualitative study, using a small number of participants, it was not appropriate to attempt to show cause and effect associations in any way which could be deemed to be valid. However, as I was immersing myself in the narratives, it became clear that many of them contained attempts at causal explanation and so I felt it important to reflect these in the thesis. This search for explanation may be related to the stigma which society attaches to emotional distress, and to the absence of any satisfactory 'scientific' theories, leading those who do become mental health service users to seek the causes in order to exempt themselves from blame. The topics raised by the narrators include the medically approved explanations concerning changes in the chemistry of the brain, genetic disposition, though there is only passing acknowledgement of this, as well as social influences occurring in childhood and adulthood, and the contributors appear comfortable moving between these different frameworks. When I reflect on my own

motivation for carrying out this research, it was in part to gain insight into the reasons behind my own experiences of distress, and although like the contributors to the study. I would cite these same influences, they fall short of adequate causal explanations. in scientific terms at least, as many individuals experience the same, and far worse circumstances in their lives, with no apparent evidence of emotional distress. Several of the contributors raised the issue of their alcohol and drug use during their narratives, and some suggested that this may have contributed in some way to their experiences. However, even when I attempt to understand my own relationship with alcohol, I cannot separate the extent to which my distress led me to (ab)use alcohol, from the affects that such (ab)use have had on my emotional wellbeing, and the stories told by the men I interviewed contain these same difficulties. Thus, the search for the answer to the question, why me?, is never satisfactorily accomplished in this way.

Having addressed the issue of explanations for emotional distress in this chapter, I will now move on to highlight the various ways in which the experiences of emotional distress are revealed in the narratives of the contributors.

CHAPTER 5

EXPERIENCING EMOTIONAL DISTRESS

INTRODUCTION

Having examined some of the ways in which the contributors to this study sought to explain the causal factors behind their experiences of emotional distress, in this chapter I will focus more on how the narratives describe what it felt like, and what meanings were attributed to these experiences.

I will focus on the non-medical meanings which the narrators use to describe their experiences, using broadly what has been described as a hermeneutic phenomenological approach (Swinton, J., 2001). The intention behind this approach is to use the narratives to reveal how the narrators understand and explain the nature of their emotional distress, by accessing their 'inner experiences' (ibid, 99). I have chosen to carry out this exploration by dividing the experiences into particular types of distress, and perhaps inevitably, these types correspond with medical diagnoses. The reason for this is that this is largely how the narrators themselves categorise their experiences, but it is not my intention in doing this to suggest that the boundaries between different diagnostic categories are fixed in any way, nor to assume that the boundaries between 'emotional illness' and 'emotional wellbeing' are clear cut. Indeed, I will use the narratives to demonstrate the considerable overlaps that exist in these boundaries.

The chapter will begin with those experiences which in both medical and wider societal usage are termed depression, before moving on to look at descriptions of anxiety, a state which is closely associated with depression. At the other end of the emotional spectrum to depression are those states which are described as being 'high' or 'manic', and I will highlight those aspects of the narratives in which these experiences are described by the contributors. As we saw when examining the causal factors attributed by the narrators to their experiences, there are complex links between emotional distress and alcohol (ab)use, and I will next focus on the descriptions given by some of the narrators of their experiences of alcohol abuse.

For some individuals though, emotional distress takes a different form, and results in behaviours and thought patterns which are defined by psychiatrists as psychosis or psychotic episodes, and which often lead to a diagnosis of schizophrenia. This is a condition which includes a wide range of experiences, which can be very distressing for both those close to the individual, and to the individual themselves, and can often be chronically disabling. Schizophrenia has been described as

a psychotic illness, characterized by basic distortions of thinking and perception. A person may experience auditory or visual hallucinations that may comment on the person's behaviour, character and so forth. They may experience delusional thinking – that is, false, fixed beliefs. (Swinton, 2001: 145)

In the second part of this chapter, I will examine narrative accounts of psychosis in general, before moving on to accounts given by narrators of some of their experiences of auditory and visual hallucinations, commonly referred to as 'hearing voices', and explore the ways in which they express their understanding of these, and of their

‘delusional thinking’. At the end of the section, I will highlight ways in which individuals describe making connections or associations between phenomena, which would not generally be made by those not experiencing psychosis, and how it is these ‘false’ connections which may explain why their thinking may appear delusional. I will begin though, by focusing on the accounts that participants in the study gave of those experiences that have been defined as ‘mood disorders’.

EXPERIENCING ‘MOOD DISORDERS’

(i) Depression

The very act of describing emotions or emotional states is particularly problematic, and we can never be sure any two individuals are sharing similar experiences, even when they both ascribe to themselves, or have ascribed to them, the label of depression. This difficulty is increased because depression is closely linked to sadness, an emotion which most people experience from time to time in the normal course of their lives, and which they might have difficulty in distinguishing from depression if they have not experienced it. In what ways then do individuals describe an emotional state which has moved beyond sadness, which most people can relate to, to that which would medically be defined as depression, which most people would not necessarily have experienced. Styron writes of his own difficulties in finding the words to describe his feelings, and of how this exacerbated the levels of distress he felt when he was distressed, as it prevented those close to him, and even doctors from fully understanding the extent of his distress. He acknowledges that

such incomprehension has usually been due not to a failure of sympathy but to the basic inability of healthy people to imagine a form of torment so alien to everyday experience. (1991: 17)

Styron goes on to describe how the philosopher William James, who himself experienced depression for many years, also accepted the near impossibility of adequately describing the extent of the distress involved in depression, when he wrote in *The Varieties of Religious Experience* that 'it is a positive and active anguish, a sort of psychical neuralgia wholly unknown to normal life' (cited in Styron, 1991: 17). The fact that individuals such as James and Styron, whose professions are based on their skill with the written word, find such difficulty in conveying the precise nature of depression, serves to highlight the enormity of the task faced by those who do not have the range of vocabulary, or perhaps, the creative imagination of these two.

In one of his attempts to describe his feelings during an episode of depression, Styron writes,

I was feeling in my mind a sensation close to, but indescribably different from, actual pain . . . The pain persisted during my museum tour and reached a crescendo in the next few hours when, back at the hotel I fell onto the bed and lay gazing at the ceiling, feeling immobilised and in a trance of supreme discomfort. (1991: 17)

Thus, whilst Styron locates the source of pain as a 'feeling in my mind', which may include feeling it in his brain, the experience is clearly a wholly embodied one. This mind and body experience will be explored further in chapter 7. In the meantime, this description of distress which creates an immobilised state is one which is echoed by several of the contributors to this study. For instance, Colin describes how, on his

return from the USA after the break down of his marriage, a GP referred him to a mental health service day care centre, because, as he told me, he realised that he 'was having a major breakdown' [7]. This was in fact when I first met Colin, and he described to me how at this time,

The weather was nice, and I used to just sit in the garden. I was *virtually catatonic* . . . depression is like not being alive [7].

Interestingly Nick, who has been diagnosed as being schizophrenic for the whole of his adult life, also described times when he has entered a similar state. He told me

When I'm sick I become, when I'm very low I become catatonic, my body just stops, some neurological thing . . . when I get like that, my body's like that, it hardly moves, it's a form of catatonic schizophrenia, it's a depressive form of catatonia [14].

It would seem that this 'catatonic state' is one way of experiencing depression, and one assumes that individuals with a diagnosis of schizophrenia may have more reason than most to be depressed, given the impact that it has on their lives. Alternatively, it may be that in some individuals, periods of severe depression may result in experiences which are described as psychotic. This would certainly appear to be the way in which John interprets his own experiences, as he told me,

I suffered from bouts of being depressed . . . I think, I suffered . . . yes I think that was true, I think . . . I was becoming a bit more isolated when . . . I became self-employed, I . . . the social contact went, the day to day contact with other people disappeared and I became too introverted. I suppose it's true, I was feeling down and depressed at times. [7]

Thus, while John is clearly describing an experience of depression, the voices that he began hearing, and the behaviours that resulted from this, led to him being diagnosed with schizophrenia. John went on to emphasise that there were some aspects of his life at this time that were enjoyable, but returned to his theme of isolation:

but all of it was very much an isolated way of life, and . . . I think that probably led to me being, having bouts of depression, and eventually led to the psychosis. [7]

Two issues arise from this section of John's narrative, and they both serve to highlight some of the methodological difficulties of this study. Firstly, the hesitancy and repetitiveness with which John told me of his feelings at this time, gave me the impression that he may have been interpreting his emotional state as a form of depression for the first time. In fact he asked if he could end the interview very shortly after this section of his narrative, suggesting that he might have needed time to reflect on these thoughts. Secondly, he makes very little attempt to describe how he felt at this time, beyond the notions of loneliness and isolation. Thus, it would appear that the emotional state he is now interpreting as depression is very different from the catatonic states described by Nick and Colin in their descriptions of depression. Interestingly, John expressed the belief that the lifestyle changes which resulted from his psychotic episodes have in fact been beneficial to him, claiming

I believe that if I hadn't the breakdown, I think I would have continued living in [name of place] being, feeling quite isolated and excluded from things, and I think that I might have become . . . even more reclusive, and quite down and depressed about my living conditions. [6]

He describes his overall experiences by saying, 'I feel as though I've come through a dark tunnel in my life and come out the other side, and things seem a lot brighter' [6]. This could be interpreted as the 'dark tunnel' representing his depression, and the psychotic episodes and the treatments and life changes which resulted from them, as the means by which he found his way out.

One aspect of depression experienced during adolescence, which is highlighted by two of the narrators, is the feeling of complete exhaustion. Darren describes how he felt in the period leading up to his 'A' level years at school,

I just felt like, completely worn out . . . so kind of said, 'I don't want to go back to school at all' . . . and it was kind of a period when I just wanted to do nothing, felt capable of doing nothing, and I think that was quite, that was an umm . . . I don't know really, a turning point . . . because I think years of being depressed and unhappy kind of came to head then. Umm, I think I've been struggling ever since, to be honest [laughs]. [2]

It is not entirely clear whether Darren is suggesting that the feeling of being 'worn out' is the cause of his depression, or a symptom of it. As he describes this feeling as being the culmination of 'years of being depressed', it would seem likely that it is this period of depression which has resulted in his being 'worn out', and which in turn, has intensified the depression. In a similar way, Pete describes how, when he was at school

I can remember before I was, before I realised I was getting depressed, I can remember, I shouldn't feel that way. I had no understanding of what it was I was feeling, or why I was feeling like that. [1]

At this stage of his narrative, Pete attributes these feelings to the fact that 'I think I was just burnt out really, from all the work I'd done in previous years' [1]. As we saw earlier though, as the narrative progresses Pete reveals that being sexually abused as a child, being teased about his height at school, and difficulties in coming to terms with his sexuality are shown to be the major factors contributing to his depression. It seems likely then, that for both Darren and Pete, the descriptions they give of being 'worn out' and 'burnt out' are understood by them as the effects of depression, rather than the cause, although there is clearly a cyclical effect, as the intense tiredness they describe reduces their ability to keep depression at bay.

Both contributors go on at later stages of their narratives to describe how depression has affected their adult lives. Darren told me how he often finds work situations stressful because,

I am not very focussed. I find it very difficult to concentrate , you know, remember things, and yeah, all that sort of stuff. [3-4]

Later in the narrative he relates these difficulties to the fact that he often experiences 'low energy' which, he suggests,

I'm sure part of it is to do with err, controlling my feelings, repressing things. [7]

This would appear to confirm that the problems of poor concentration and low energy levels are understood by Darren as factors which both contribute to him feeling depressed, and to the way in which he experiences depression.

Pete also confirms that depression continues to be a factor in his adult life, and he told me,

I do sort of get down, well, I do really get down, well quite down at times. It really doesn't last very long, you sort of, I can sort of, I don't know . . . you just sort of work through it I think . . . I can't really pin it down as to why I get that way. [12-13]

This extract demonstrates how difficult it is for Pete to describe exactly what level of 'feeling down' he experiences, highlighting the difficulty in communicating emotional states to others. But his suggestion that he is unable to explain why he continues to feel this way, is to some extent contradicted, as he went on to tell me that he had recently used counselling services, and that

I say to myself, they don't get me down, you know, the memories that I have, there's just this feeling of horror, of dread that you have. There was a couple of times last year before I went to see them, when I was feeling suicidal again. [13]

This once again highlights the difficulties Pete is having in communicating the true extent of his distress, as few people would interpret his description of feeling 'quite down at times', as meaning he was 'feeling suicidal again'. The difficulty in understanding the messages being given by individuals as a result of problems of expressing feelings, clearly has an impact on therapeutic interventions, and one study found that 'part of the sense of abandonment and loneliness experienced by all of the participants related to the inability of others to understand and cope with the things that they were experiencing' (Swinton, 2001: 125). The accounts of Pete and Darren also suggest the existence of an almost constant level of 'covert depression' (Real, 2003) in addition to those times that it comes to the surface, and I will examine this

aspect further when I explore the relationship between masculinity and emotional distress in Chapter 8.

(ii) Anxiety

In the previous section, the account given by Pete of how his experience of depression is marked by feelings of 'horror' and 'dread', gives an indication of how for many, depression is often accompanied by feelings of anxiety, although for some individuals anxiety may be the prime diagnostic category which is applied to their experiences. The nature of the relationship between the two states seems unclear, whether it be that individuals who experience high levels of anxiety are prone to depressive episodes, perhaps as a result of the high stress levels which anxiety induces, or whether the uncertainty and loss of meaning associated with depression, may lead to high levels of anxiety. Styron describes how as depression took a hold of him, making it impossible for him to write, 'there were also dreadful . . . seizures of anxiety' (1991: 46). He tells of one occasion when out walking his dog, a flock of Canada geese flew over, a common enough sight and one which would normally have given him pleasure. On this occasion though, he describes how

I stood stranded there, helpless, shivering, aware for the first time that I had been stricken by no mere pangs of withdrawal but by a serious illness whose name and actuality I was able to acknowledge (1991: 46)

The state he is describing here is very similar to the description given by others of their depression, and how this reduced them to a 'catatonic' state, and it becomes

difficult to assess whether the catatonia described by others as a feature of their depression, is in fact a result of an associated state of anxiety.

Darren's narrative contains, as we seen, many references to periods of depression, and on the occasions that he sought medical intervention for his distress, he has been diagnosed with, and treated for depression, whether by drugs or talking therapies. But it is also clear that he himself recognises that anxiety forms an integral part of his distress, and at the beginning of his narrative he acknowledges that his emotional states are something which he learned from his father:

My dad as a role model, I guess, was a sort of a rather . . . someone who controls his feelings, and I've definitely, I'm definitely like that myself, so I think I learned that from him. *I'm quite a fearful man really . . .* [1]

Much of Darren's narrative tells of the ways in which he has organised his life so as to minimize his anxieties and fearfulness, whether by choosing work which is unchallenging and minimally stressful, or by denying himself intimate relationships. In recent times he has attempted to deal with his high levels of anxiety by practising yoga, and he told me that,

I started going to yoga classes because I recognised that I am somebody who does get very anxious and err, depressed. A big anxiety is a definite thread, so really it was, I just thought, yeah, yoga. Calm, that was to do with anxiety, so that's why I started going to yoga classes. [6]

It would appear that this strategy, in the early days at least, proved to be a successful one, as Darren progressed to become a yoga teacher, eventually running his own class.

But, as with other aspects of his life, this very success, rather than improving his sense of self worth and self confidence, appears to have resulted in heightened anxiety, as he told me

I still question myself, I still got very anxious before the class, and umm, and in some ways only half enjoyed doing it really. [7]

Thus, the calm which Darren sought from practising yoga is replaced by the anxieties and self doubts which teaching yoga seemed to hold for him. Although Darren gives many insights into those aspects of his life which lead him to experience anxiety, and is informative about the affects of anxiety on his ability to enjoy his life, he appears unable or unwilling to describe exactly how his anxiety feels. This may be because of the difficulty of finding words to describe emotional states, or may be because he assumes that my own experiences remove the necessity for him to describe his anxiety, which in itself has methodological implications. My own experiences of anxiety allow me to identify that anxiety is experienced not merely as a state of mind, but contain physical and spiritual elements, and I will explore these issues further in Chapter 7.

(iii) The experience of being 'high'

At the other end of the spectrum from depression and anxiety, of what psychiatrists call mood or affective disorders, is that state which is described as being 'high'. As we have seen earlier, for some individuals, emotional distress takes the form of an oscillation between depressive moods and out-of-control high states, a set of

experiences defined by psychiatrists as bipolar affective disorder. When I highlighted the ways in which contributors to the study searched for explanations for the causes of their distress, we saw how Jim's narrative identified the fact that being over stimulated was in some way responsible for his episodes of distress. For Jim, as for many others, a pattern develops whereby the effects of such over stimulation are that

You have a high, followed by a period of depression. I'm not sure I believe in this having to be the case. [6]

The doubts that Jim is expressing here about the inevitability of such a pattern, would appear to be based on his experiences of psychiatric intervention, where the intervention occurs as a result of behaviour during a 'high' period, and 'treatment' involves bringing the mood down, usually into depression, through the use of drugs, most commonly lithium. After he had been hospitalised while in Australia, and had received this form of treatment both there and back in the UK, Jim told me

I really didn't know what depression was, I think I had certain, maybe certain types of depression, mild depression if you like, in terms of developing and growing up, but when I came back from there [Australia], it was such a . . . I just, I think that was the first time I had suicidal thoughts really, then. [6]

Having been brought down into depression, medication in the form of an anti-depressant is used to gradually lift the mood to a level considered satisfactory by the psychiatrists, but as Jim makes clear, not necessarily to the satisfaction of the recipient of the treatment:

I spent the last, well, two years for a start, really depressed, not living to my potential, not working, drifting , muddling along, you know. [10]

Jim had told me during an earlier part of his narrative how, during one of these lithium induced periods of depression,

without telling anyone, I did a programmed withdrawal of lithium, because I was so depressed. I was looking for some way out it, from the depression. Errm, you might say an anti-depressant might have been one way of dealing with that, anyway, and when I got down to about a quarter of the dose I normally take, I was having all the *fast thoughts*, you know. [8]

It would seem that unlike the difficulties in describing states of depression, there is no shortage of ways to describe a 'high'. The forms of behaviour which resulted from what Jim describes as '*flights of ideas*' perhaps inevitably led to Jim being hospitalised for six weeks. A story which Jim told me about his experiences during this period in hospital, illustrates the nature of the problem faced by individuals locked into this cycle of highs and lows. He told me

I was in for six weeks, lost half my savings because I went out, I was on half hour observations, but they weren't really doing them, they weren't being particularly observant because I bought a car in the half hour [laughs], which err yeah, caused some amusement. I not only bought it, I drove it for the next ten days without anybody knowing that I had a car. [10]

Again, we can see from this that Jim's emotional state was such that it was deemed necessary for him to be compulsorily hospitalised, but he was clearly able to go through the complex stages of buying a motor vehicle, without presumably raising

concerns from the seller. The sense of exhilaration which got from this experience is clear in his telling of the story and he went on to compare his feelings during this high, with the states of depression described earlier, saying

But it's great though, I mean it's fantastic what you can do, and you realise that there's all this potential. [10]

It is this 'potential' which has been drawn on by many individuals with bipolar disorder in order to release their creativity, particularly in the fields of art and literature (see Milligan and Clare, 1993). I will return to other accounts given by Jim of his 'high' periods later in this chapter when I focus on accounts given by the narrators of their experiences of psychotic episodes, as there are strong similarities between the descriptions of both types of experience.

EXPERIENCING DRUG AND ALCOHOL ABUSE

We have already seen that there is a complex relationship between alcohol (ab)use and emotional distress, in that it may be viewed as a direct contributory factor in the aetiology of emotional distress, a means of 'self-medication' in order to stave off the pain of such distress (Real, 2003), or as diagnostic category in itself. Only one of the contributors to this study, Matt, has been diagnosed as an alcoholic, and in this section I will focus Matt's description of his experiences as an alcoholic.

Matt's drinking began at the age of about 16 as a response to, and way of coping with distress which resulted from a series of childhood events, including the responsibility

he felt for the death of his father. Although he is somewhat vague about the precise timing of events, it would appear that he drank heavily until his late 30s, at which time he stopped drinking for about 8 years after joining Alcoholics Anonymous (AA). He then had a relapse for an unspecified period of time, and at the time we met, he had not had any alcohol for about 4 years. He refers several times during his narrative to the fact that much of his childhood and adulthood is a 'black out' as a result of his heavy drinking. It would appear that some of his memories of events which took place while he was drinking have been recovered through the group therapy he received at AA, whilst others have been related to him by third parties. He told me one such story, which came to light when he visited a public house about 6 months after he had stopped drinking. The fact that Matt was in this pub drinking soft drinks attracted the attention of one of the locals and he told me about the conversation they had:

He told me a story, and I didn't remember, obviously it's a black out, obviously, you know. He said I was foaming at the mouth, I stood with a pint, cos I was on the zoobs you know, there was a pint in me hand, or a pint glass in my hand, foaming at the mouth, splashing everybody, saying 'beer, beer!' [laughs]. And of course, they bought me a pint . . . I don't know how, I mean I was just one of them guys, they always used to buy me beer, you know. [4]

Matt went on with his story, and perhaps unwittingly provided some explanation as to why people in the bar may have bought him beer, when he said

I was a bugger in the pub sometimes, you know, and when I got emotionally upset, or emotionally excited [I was] looked after, you know. Err, I won't say I was violent, but I've had my fair share of fights, but I'm not a violent person. I can be aggressive

depending on what mood the alcohol or drugs took me, err, but I'm so glad that I'm out of it. [4]

Although Matt seems to want to imply that it was his popularity which made people want to buy him beer, this description of himself as sometimes 'aggressive', and as having his 'fair share of fights' might suggest otherwise. It is clear also, that though he recounts many such events in his life in considerable detail, whenever these stories risk giving a negative view of Matt as a person, he is quick to remind me that these events took place during a 'black out', reminding me that this is 'obviously' the case.

There is no doubt though, that not knowing what you have done during long periods of your life, and perhaps even more so, not knowing what you might do during future black outs, must produce a stressful existence, perhaps resulting in continued escape through the use of alcohol. Matt highlighted this point when he admitted to me,

You know, one of my dreads, I don't have so much now because I've got nothing to be afraid of . . . one of my dreads was that I would wake up in a police cell, and they'd tell me I'd murdered somebody and I wouldn't know, in a black out. [8]

For most of us, this would be a remote possibility, and therefore, fairly low down on our list of dreads. However, two events in Matt's life make it possible for us to imagine that for him this was no illogical source of anxiety, but formed very much part of his everyday reality. The first point to consider is that, as we have seen, much of Matt's distress resulted from his belief that he was responsible for his father's death, thus being responsible for another death might have seemed like a real

possibility. The second point concerns an event which gave him every reason to believe that his worst dread had been realised, as Matt recalled how,

I tell you, I got so close to that. I woke up in [name of town] cells, I'd got me hand handcuffed, I had teeth out, all of them [showing me which teeth], and they'd gone, because they were capped they'd gone. Handcuffs, I was covered from head to foot in blood, and all I could do was scream the place down. I hadn't got a clue what was going on. Thank God they'd put the handcuffs on, my hands were bleeding. [8-9]

If one of the tools a listener needs to understand the experiences of the narrators is that of empathy, it becomes a difficult one to apply when the experiences being related in the narratives move so far outside our own life events. It is though, not difficult to imagine the outright fear that such a situation would produce. Matt continued in some detail to recall the events which led to him finding himself in this situation, though it is unclear whether he was doing so from his own recollection or, in view of his insistence that such events take place in a 'black out', from the accounts of others. He went on to tell me,

they'd filled me full of largactil cos I wouldn't stop, I wouldn't stop biting. That's where me teeth went, I bet they broke on people, and they had to fill me with largactil in the end, and I had a bottle and a half of vodka in me. And err, I got beat up apparently, or got hit, and I'd sat on steps in [name of town] and the police come to, to see if I was all right, and they said they'd take me home. I said alright, I mean I didn't know they fucking, they didn't know where I lived. Anyway, they were going to take me down the station. Well, I saw this police car and I went ape-shit. I took a swing at this copper and I fell through a plate glass window, you know. [9]

Despite the situation he found himself in, Matt said of the police, ‘but they were understanding, they were brilliant, you know’ [9], and on being released in the morning he went to his sister’s house and on being offered breakfast, he asked for a ‘half bottle of vodka and a bottle of orange’. [9]

This episode in Matt’s life highlights the dramatic and often dangerous nature of life as an alcoholic, but this cannot hide the fact that much of his life has been spent in far less dramatic, though perhaps equally distressing states of loneliness and despair.

When Matt was talking to me about his use of alcohol as a way of coping with his distress, he said, ‘you know, there’s that invisible line, and you just don’t know what it is, or where it is, and I crossed it’. [4] Although Colin has never been diagnosed or treated for alcoholism, he often recounts how during much of his life he has used alcohol as a way of coping with his distress, and a part of his narrative described one period of his life, in his mid 30s, when he came perilously close to crossing this ‘invisible line’. He was working in London for a firm where the manager was a friend of his, and Colin briefly described his life at this time:

It was a lousy job, I was sleeping on a settee in a slum, down in Battersea, and err, there was a girl down there who I was in love with. She didn’t love me, blah, blah, and all this. [1]

Despite the apparent attempt to trivialise the state of affairs which is implied by the brevity of the description, and the ‘blah, blah’, it is clear from Colin’s demeanour whilst telling me this story, that he had found this combination of circumstances very distressing. He went on to describe to me how this manifested itself at the time:

I was seriously drinking, seriously drinking and err, was drinking in the dinner hour, I would drink six pints, and err, umm, err, during the day I would, when I wasn't working there I would, being honest, would always have a chaser, have a pint and a chaser. I would drink, as well as the pints, you know, I used to drink a pint of vodka a day. Err, real drinkers don't eat, you know, I was starting to, I was losing weight and all this, and err, I was having black outs, and err, finally, err, opened the fridge to in the morning, find half a pint of vodka that you'd left, so you'd have something to drink. [2]

There are some clear similarities with Matt's story with regard to the 'black outs', and drinking vodka for breakfast, but in contrast, Matt's story contains descriptions of interaction with others, even if that interaction consisted of fighting them, whereas Colin's story invokes a picture of loneliness and desperation. His situation finally came to a head when, as he says,

One day I just cracked up down there and err, I phoned [names a friend] . . . and err, he come up, come over and picked me up off the floor . [2]

Colin went on to describe how his friends took care of him that night, and how he left London in the morning to return to the Midlands. It is clear that Colin views these events as some sort of epiphany in his life, which allowed him to gain an insight and understanding into himself, which perhaps had not been there previously, because he told me,

I was a wreck, you know. It was quite surprising, you know, that was the first sort of indication that I had, err umm . . . I was prone to, err you know, living on the edge or summat, breakdown, umm. And the doc came round, I dunno, and said, ooh, they could do this, could do that, didn't wanna . . . send me to hospital or do anything like

that. I recovered very quickly, umm, I stopped drinking, I mean instantly stopped drinking for, umm . . . a few months. [2]

There is perhaps some irony in the fact that at Colin's insistence, we shared a half bottle of gin during the time it took him to recount his narrative! It is uncertain what the most significant factors are in Colin's rapid recovery. It is apparent from his account that it came as a shock to him that he had come so close to crossing that 'invisible line'; that an understandable unhappiness at doing a 'lousy job' and living in poor accommodation, and his use of alcohol to deaden the pain of his existence, had brought him so close to 'breakdown' and the resulting psychiatric intervention. In addition, the very fact that he had friends who he felt able to call on for help, and who were prepared to respond, and that he had friends he could turn to on his return to the Midlands are clearly significant factors. For those not able to draw on such social networks, escape from the misery of alcoholism may prove more difficult. Finally, the fact that Colin is an intelligent and articulate man is likely to have been an influential factor in the doctor's decision not to send him to a clinic, thereby saving him from being burdened with the label of alcoholic. For those who lack these levels of social or cultural capital, the medical encounter may have resulted in compulsory hospitalisation under the Mental Health Act. As we have seen, even the possession of these protective factors was insufficient to keep Colin from becoming a mental health service user after his divorce.

PSYCHOTIC EXPERIENCES

(i) Form and content of psychosis

The behaviours and thoughts of those regarded as experiencing psychosis can be both disturbing and difficult to interpret or understand. However, it is the form that the behaviour takes which creates this difficulty, and gaining an insight into the context in which the individual themselves sets their experiences, can help in interpreting and understanding these behaviours. This requires separating the *form* from the *content* of their behaviour, in order to gain a deeper understanding of their experiences (Swinton, 2001). Des described to me how his childhood had been fairly unexceptional, and how he left school to go to college to study art. During this period, as we have already seen, Des began to use cannabis regularly, and other illegal drugs on an occasional basis, and also began to develop a strong interest in ecological issues. He told me how,

I started to think about the way we were living in society, that it was all, that it was very destructive. I was thinking that umm, the way we treat the planet was causing it a lot of harm, and that we were doing a lot of damage to it, which we should really be doing something about now. [1]

Des' way of doing 'something about it' was

to sort of move out of err, urban lifestyle and move into the woods, as a kind of rebellion against err, the modern way of living. [1]

Des told me that he obtained some benefits from having chosen this lifestyle, but that within a few months,

I was living a very disordered life . . . I was hardly indoors, I was outside all the time, doing different things, trying to get things together, going to see people, and things just started to really fall apart, really. I started to lose sense of what was going on.

[2]

As his life continued to 'fall apart', he found himself becoming more and more detached from the world, and he says,

I'd become very withdrawn, I was standing on the street for hours on end, not knowing where to go or what I was doing, or really what was going on at all, the sense of how someone lives generally from day to day had totally disappeared for me.

[2]

It is clear from this account of Des' experiences that this must have been an extremely distressing period in his life, not only for him, but also for others that he encountered at this time. The experience which Des is describing was diagnosed as a 'psychotic episode', though for Des, who had had no experience of mental health services or mental illness, this is unlikely to have been a term which would have helped him to understand the meaning of his experiences. Even if he had an awareness of the term, and the medical definitions attached to it, given the confused nature of his thoughts it seems likely that he would have sought meanings for his experiences which were more closely associated with his own beliefs, and which were understandable in the context of his life. It is perhaps not surprising then, that given his explanation for his changed lifestyle as being a search for spiritual

experiences, it is spiritual meanings which he attributes to his description of this episode in his life, as we will see in Chapter 7, when I consider in more detail the relationship between emotional distress and spirituality.

It is also clear that much of Des' motivation for embarking on a unconventional life-style was to escape the 'modern way of living' as a political act, and that to achieve this he had to break some of the connections with the world around him. He is clearly successful in making this break, but it is the very loss of a feeling of connectedness with the world which is at the heart of his distress. The paradox involved in this loss of connection with the world as a personal and political goal, and the distress caused by the loss of this connectedness is perhaps illustrated by two elements of his experiences at this time. On the one hand he told me that,

if someone was to speak to me, I couldn't really . . . it was only certain people who I could interact with, other people I would sort of . . . I wouldn't be able to hear, or I would be too distant and stuff. [3]

At the same time that he was experiencing this difficulty in interacting with some people, he told me,

another thing I was told that I did, which I have no recollection of, was just to go up to anyone's house and ask to have someone to speak to. [3]

Thus his inability to connect to, or interrelate with others is combined with an overwhelming need to so. It is perhaps not surprising that this pattern of behaviour eventually led to Des being arrested and sectioned under the Mental Health Act. An

important element of, and a partial explanation for Des' experiences at this time is his hearing voices, and I will return to this later in the chapter.

The absence of precise boundaries between different medical diagnoses is evident in several of the narratives. Thus, for instance, Nick, who has been diagnosed as being a sufferer of schizophrenia since adolescence described how at the time of his very early experience of using mental health services,

there was a lot of thought disturbance, depression, overwhelming anxiety, umm, no voices or visions at that time, umm, and umm, I had behavioural problems. [2]

From this description it would appear that one of several diagnostic categories could have been applied to Nick's experiences at this time. Throughout his narrative Nick refers to the fact that he had 'behavioural problems', or that 'my behaviour had broken down', or that 'my behaviour collapsed again', although rarely does he give any detailed description of exactly in what way his behaviour altered at these times. He does give one brief account of how

I once ran away from [name of the institution where he was in care] and I was, I wasn't, I hadn't taken illegal drugs or alcohol or anything, I was just ill, and I was in Coventry [about 20 miles from where he was in care], I was standing in the road directing traffic. [4]

Nick does not ascribe any particular motive to this behaviour, not does he describe his thoughts at this time, other than to describe himself as 'just ill', but the inevitable consequence was police intervention, return to care and more anti-psychotic

medication. Many of Nick's other accounts of episodes in his life focus on his inner psychic experiences rather than on details of his behaviour, and I will return to these in the context of hearing voices later in this chapter, and in the context of spiritual aspects of distress, in Chapter 7.

We saw earlier how Jim's emotional distress is often triggered by positive emotional experiences, possibly causing over-stimulation and resulting in a 'high' as part of a cycle which has been diagnosed as bipolar affective disorder, and that this is the same diagnosis as his mother has had since adolescence. Describing one of these 'high' periods, which occurred when he was starting a new job which had required him to move to a new town, and at a time when he was enjoying getting to know his new work colleagues, he described finding himself

in a supermarket car park, just completely lost as to what to do with myself, it was weird . . . when I say lost I don't mean I didn't know the way home, I mean I couldn't, I was sort of transfixed, or something like that, I just couldn't do anything, and I was just wandering around for about three hours. [6]

The description Jim gives here of being 'sort of transfixed' is similar to the descriptions of being 'catatonic' given by some of the participants in respect of severe depression, and highlighted in the previous chapter. It is clear from Jim's story though, that this was a 'high' he was experiencing rather than a depression. In addition, his description of 'wandering around' unsure of what to do or where to go, is very similar to the situation described by Des as a part of his psychotic episode. This similarity is confirmed by the fact that Jim told me that when his behaviour

attracted the attention of a security guard in a nearby office block, the police were called and they took Jim to a psychiatric hospital, and,

they were wondering, the psychiatrist was wondering whether to call what I had, psychosis or not. [7]

Both Des and Jim found themselves in a situation where they were unable to speak to anyone, but unlike Des, Jim is able to provide a rational explanation for this:

You've got like, there was a history of the police getting involved, and people pinning you down and injecting you and that kind of thing. It's no wonder that when your thoughts get slightly jumbled, you can't rationalise who its safe to talk to. [7]

This is not an explanation which is valid in Des's experience, as he had no such previous experience of police intervention. On this occasion no rough treatment took place, and once he found himself in the psychiatric hospital, Jim's power of speech obviously returned, as he describes how, after a conversation with the psychiatrist,

I can be quite coherent as well at these times . . . and he let me out. [7]

This was to be a brief reprieve though, as Jim explained,

I walked out of the hospital, and I was wandering round this garden picking, somebody's garden in the house, just there [indicates closeness], picking up crisp packets and trying to analyse the ingredients or something, and this woman sort of noticed me outside the house, and shortly afterwards the police picked me up again and brought me back. [7]

Again there is an element of similarity with Des' account of him randomly calling at houses, although whereas Des explains his behaviour as resulting from his need to talk to someone, Jim does not provide any sort of explanation for his behaviour. Another difference is that Jim at no point during his narrative describes hearing voices telling him what to do, this being one of the defining aspects of schizophrenia. He has though, it seems, had delusional thoughts, as he described when telling me about his experience of mental health service use in Australia:

I was having paranoid, you know, thoughts and so on, errm, and then I was walking toward the lift as if I was trying to go, and I was descended on by eight nurses or something, and pinned down and dragged over to a bed, and that was another time when I thought this was the end of things. I was injected . . . [5]

Having 'paranoid thoughts' is a frightening enough experience, but to be treated in this way, can only make it more so. The element of delusional thinking involved in this episode was described by Jim as he told that,

there was one fairly calming sort of nurse, I remember him, but the rest of them, I thought they were the Australian cricket team at the time [laughs]! [5]

What this also demonstrates is that at one level this is clearly an irrational idea, as there is no logical explanation for the presence in a psychiatric hospital of the entire Australian cricket team. But in Jim's seemingly delusional thoughts, there is a certain contextual logic, as he was in Australia at a time of the year when the cricket team would have been playing a test match series there, and as such are likely to have been in the news. Thus, being surrounded by a group of presumably young men one can

follow the logic of his conclusion. Not all of his delusional thoughts are quite so easily contextualised though, as Jim also told me,

also, I had delusions about being Jesus, or something like that. [5]

This raises interesting questions in relation to the distinction between *form* and *content* as defined within psychiatric phenomenology, in the context of religious or spiritual experiences of those suffering emotional distress (Jaspers as discussed in Swinton, 1991), and I will return to these issues in Chapter 7.

Although Jim does not describe hearing voices, it is a common experience of those diagnosed as schizophrenic, and is often used by these individuals to explain behaviour which from the outside is difficult to understand, and it is to these experiences that I will now turn my attention.

(ii) Hearing voices

Three of the contributors to the study gave vivid accounts of auditory hallucinations or hearing inner voices, Des, John and Matt, and all three have been diagnosed as having, and treated for, schizophrenia. Des first started hearing voices when he was sleeping rough and, as we seen, his life had started to become disordered, and these voices were accompanied by visual hallucinations. Though regarded by psychiatrists as evidence of 'mental illness', it should not be forgotten that during this period of his life, Des was using a variety of illegal, psychotropic drugs, was eating infrequently and irregularly, and though it was winter, he was sleeping rough in the woods. In

addition to all of this, his motivation for experimenting with this unconventional lifestyle was, in part, a quest for spiritual experience. All of these behaviours may be seen either as evidence of delusional thoughts as a symptom of advancing schizophrenia, or it could be understood in terms of this set of behaviours leading to disturbed thoughts. Des described to me, how,

I began to hear voices really powerfully, and they got more and more powerful as the months went on. [2]

For a short period, Des moved in with his mother because he felt he needed some support, but this did not improve matters, and he described how things deteriorated further:

But I was hearing the voices and hallucinations and visions and err, were getting really powerful, and delusions as well, I was having various sorts of delusions. Umm, I was sort of wandering the streets night and day, feeling as if I didn't really have a home, and if I was going home, the voices would tell me that they didn't want me there really. It was time to move on. [2]

Once again we can see that though the form taken by Des' distress was hearing voices and delusions, and as such recognisably 'psychotic', the content of his experience has a traceable logic to it. In the context of his life during this period, and in particular the uncertainty that surrounded where he was living and his professed aim of living differently, expressing concerns about 'going home' in another form would be regarded as entirely rational and understandable. With regard to the form these experiences took, Des went on to say,

I didn't even know they were voices, they were just, felt like, just felt like instructions to me. They were like instructions, and I believed in err, a lot of spiritual experiences, kind of thing, so I took it as a spiritual experience more than anything, and err, so I listened to it and took, and believed it all. [2]

So it would seem that at this stage, even the form that Des' experiences were taking could be regarded as 'normal', in that they could be understood as a part of his belief in, and search for spiritual experiences. As his 'disordered' life style began to result in a deterioration in his physical state, Des described how,

I did actually, which I was quite ashamed of myself, I did start stealing food from the shops as well, because I had no money, and I had no income. I wasn't in contact with any benefits agency and stuff . . . and err, well, my voices were telling me to steal, and I would go into shops, and in some strange state, and my voices would tell me, say, 'steal, steal', and I would steal a chocolate bar or something, and then I'd walk out and then, umm, I feel quite bad for it actually. [3]

Once more it is hard to fault the logic of the messages which Des was receiving from the voices, as they were encouraging him to find a way of eating, when it would have appeared to him that few other options were open to him. The guilt that Des expresses about this course of action could also possibly be somewhat assuaged by the fact that he was doing what the voices told him to do, and could be interpreted as some kind of battle with the socially conditioned side of Des which told him that stealing was wrong.

Des' behaviour eventually led to him being arrested and involuntarily detained and treated with anti-psychotic drugs in a psychiatric hospital, and after a few weeks in hospital was given assistance in finding suitable accommodation. This then led to a

period of a few months when Des was relatively free from symptoms, but then about six months before our interview took place, the voices had returned and, he told me

I've been back in hospital, just, late November, December last year because my voices started coming on really bad again, and I've been through quite horrible experiences over the last, well couple of months after that, because I was get . . . because the voices were very powerful and the content of what they were saying was very disturbing, and I was going through a lot of despair and stress, so I put myself in hospital again. [7]

It is clear when Des is telling me this that he does not wish to reveal the content of his voices on this occasion, and so it is not possible to relate it to the context of his life at this time. What is revealed though, is that he now appears to have taken ownership of the voices. Whereas in the first extract, when describing the gradual emergence of voices giving him instructions, he refers to them as 'the voices', in the extract from his later experiences, he calls them 'my voices'. This occurs despite the fact that the content of the voices is even less acceptable to him than was the case previously. This apparent ownership of the voices becomes more contradictory, as later in the narrative Des tells me that he has continued to be distressed by their content:

It's weird recently for me, it's like having little devils in me, in my brain. The content of them has been quite negative recently and err, it's given me a lot of anxiety and it's not very nice. I've got, at the moment I'm finding, with my voices, I'm just battling that my good side stays strong enough not to let any of these bad voices get the better of me. So that's what I've been trying to do, the last couple of months, is just trying constantly err, to reassure myself that these voices are not telling the truth, because if they are, then . . . it's not very nice really. [8]

So although Des now uses the analogy of ‘devils’ having entered his brain, thus externalising them and separating them from himself, he also at one point refers to them as ‘my voices’ again, and then moves on to an analogy which sees a battle going on between his ‘good side’ and ‘these bad voices’.

A major element in John’s experiences of emotional distress also involves various forms of hallucination, though unlike Des, he was not using illegal drugs nor had his life become disorganised. In fact, as we have seen, John attributes his experiences to having become isolated and lonely, and there is no evidence in his narrative of ever using drugs or alcohol to cope with this. It could be argued though, that both had become disconnected from the social world, but in very different ways. John also sometimes refers to the voices he hears as ‘my voices’, though he clearly identifies them as belonging to people he has known in the past. He began his narrative by telling me,

I’ve suffered a psychosis and it began in late summer of 2001. I started suffering hallucinations, hearing voices and seeing things, and err . . . it was of people I knew from the past, in my teens, late teens. [1]

John does not reveal the precise content of these hallucinatory experiences, and in fact states several times that he does not intend to do so, but he does make it very clear that they relate to an experience which he finds extremely distressing, describing how,

it also affected my concentration, and driving and work. I couldn’t eat sometimes, I couldn’t sleep at nights, sort of voices in the early hours of the morning, and it all came to head in mid-November 2001 when I sort of heard my voices and felt compelled to drive home. [1]

An interesting contrast with Des' narrative is that whereas Des suggests that not eating properly and a constant restlessness contributed to him becoming psychotic, John is clearly suggesting that the onset of voices led to him not eating or sleeping properly. Also, whilst John is able to attribute the source of the voices to actual people he can identify, Des saw them as some sort of devils fighting a battle with his good side. It is clear from the experiences described by both of them, that far from being an exclusively mental or psychic experience, the voices which they hear are no different in quality from 'real', externally produced voices. It also seems that there is something about the nature of the voices which makes them impossible to ignore, as John describes feeling 'compelled' by them to drive more than 100 miles to his parents' home, even though he recognises that this a dangerous course of action given the confused state of his mind.

As he proceeds with his narrative, John repeats several times that he is not prepared to disclose the precise content of the voices, but again tells me that they relate to an incident which took place when he was in his late teens, and which he still finds very distressing. He alluded to the incident, but said,

I don't want to go too deep about personal experiences . . . but err, suffice to say it was a very disturbing experience, and it involved, the psychosis involved a lot of name calling, and personal insults, err . . . from different people, and the voices sounded very real, people I know and . . . they, it seemed, they seemed as though what happened was real. [2]

John's narrative appears to be slightly confusing in respect of the relationship between the incident which took place in his late teens, and the voices which were

doing the 'name calling'. It is particularly unclear whether John is saying that it was this event which was 'real', or that the voices were 'real'. In addition to the content of his experience of hearing voices being distressing, it also becomes evident that John finds the form in which they occur as equally distressing, not least because he has no framework within which to give meaning to the experience. It was, he said,

as though I experienced some kind of extra sensory perception, some kind of contact between other people . . . and . . . therefore I didn't seek help straight away and I didn't think I was suffering any kind of illness . . . I'd never heard of hearing voices like that of being a mental illness, so all I could put it down to was some extraordinary form of extra sensory perception I was getting, where I was able to contact other people. [2-3]

John then goes on to confirm that the insults were about

certain things about my past they knew, which made me think even more that it was some kind of extra sensory perception. [3]

In order to confirm how real this contact with these other people appeared to him, John went on to tell me,

it also involved relations of mine, my parents, my aunts, uncles, cousins and . . . it umm, I in fact once telephoned my father once in France and . . . said to him, 'has my aunt Jackie, has Jackie', I said, 'said anything to you recently'. [3]

As this was in the middle of night, his father was understandably confused, and John explained himself by telling his father that he had been sleep-walking. It is again unclear whether the undisclosed incident involved all these family members, or

whether it was just the insults. It is clear though, that the voices are in some way convincingly external to him. The fact that the insults appear to reveal knowledge of the event that perhaps only he should know, and the overwhelming logic that whilst not in their presence he could not possibly hear their voices, forces John to the conclusion that it must be a form of ESP, rather than that the voices emanated from within himself.

In addition to the form and content of the voices, both Des and John comment on the quality of them. As we have seen, Des described how the voices were ‘really powerful’ and that they got ‘more and more powerful as the months went on’ [2]. This seems, in part at least, intended to convey an explanation for the fact that he was unable to ignore them and was, in some way, forced to obey them because they were so powerful. But it also implies that at times they were more powerful than at others, and therefore, possibly less compelling when they were less powerful. This is confirmed by John, who rather than describe the voices in terms of how powerful they were, focuses on how ‘real’ they appear. When he was bringing me up to date with how he has been feeling more recently, he told me,

I’ve suffered very little from psychosis, just *murmurings*. [2]

It would appear, then, that as well as the content of the voices changing in relation to the context of individual lives, the qualities which the narrators attach to their voices are also variable, ranging from ‘murmurings’ to being ‘really powerful’, and to being ‘very real’.

The only other contributor whose account included reference to their experience of hearing voices was Nick. As we have already seen, Nick describes those experiences which are generally interpreted by psychiatrists as psychosis in terms of his ability to enter into another world in order to escape the extremes of his distress. Nick calls this other world 'The Land of Dreamy Dreams', and his frequent visits there do not seem to him to be anything other than a rational course of action. He told me,

you will find an awful lot of people, people who don't have schizophrenia, or profound depression, or anxiety states, live in the Land of Dreamy Dreams. It's not an unusual thing, the only difference with people like me . . . from about 17, 18 or 19 I started hearing things, seeing things. [11]

Even though Nick had spent several years in mental health centres and adolescent psychiatric units before the age of 17, it would seem that the time when he began 'hearing things' is seen by him to be a significant one in terms of distinguishing 'people like me'. Although he speaks very little of his experiences of hearing voices in his long account of his life as a mental health service user, it may be assumed that it has played an integral part in his life, especially as he has carried a diagnosis of schizophrenia throughout his adult life. When he was describing how in recent times he has been relatively symptom free, he said,

I haven't had any voices since a year ago last Easter, that's a long time. [11]

This in fact means that if he first heard voices when he was 17, and apparently last heard them last year, when he was 45, that represents 28 years of hearing voices, during which time he tells me, one year free from doing so is 'a long time'. The fact

that Nick identifies last Easter as the last time he experienced hearing voices may also be significant, as he described the voices he heard as ‘quasi religious’. I will examine the significance of hearing ‘quasi religious voices in the section on emotional health and spirituality in chapter 7.

At least two further issues are raised by the narrators with regard to hearing voices. When Nick described his recent period during which he has not been hearing voices, he explained this by saying,

I’m lucky now, I’m largely symptomatically burnt out. [11]

The implication here would seem to be that he no longer has the emotional energy which is required to continue having the symptoms of psychosis. This in turn would suggest that it uses a considerable amount of emotional energy in coping with this, and possibly other forms of distress. The other issue to be raised is that although I have focused on auditory hallucinations, Des, John and Nick all at times speak of experiencing visual hallucinations, although none of them give any details of the content of such experiences. In addition, John told me about a brief episode of psychosis, explaining,

that was hearing voices, seeing things, hallucinations, which I’d had before, and olfactory hallucinations, which is being able to smell things, for example the smell of tobacco, the smell of coffee. A couple of times that happened, not very often. [2]

Unfortunately, John gave no details which allow me to contextualise the content of these experiences.

(iii) Making connections

We can see from John's experiences of hearing voices how they seem, to him at least, to connect an undisclosed incident from his past, with people from both his past and present life, and how this set of connections and the voices which are contained within them, form what he refers to as his psychosis. Thus, he talks of how his psychosis includes school friends who he has not seen for many years, his parents, aunts, uncles and cousins, all somehow linked into that incident in his late teens. Again, the reality of the voices of this network of people is highlighted by the fact John is driven to looking up the telephone numbers of some of them:

I also tried to phone several people who were involved in the psychosis [in order to find out] what was going on, and I phoned three people, but they all got the wrong numbers. [3]

One interesting observation from this extract is that John describes these people as being 'involved in the psychosis', highlighting the reality of this situation for him, even when he is not confused by psychotic thoughts, as well as indicating the reality for him of the connections between these people. This process of establishing connections or associations between people and between events, which would not be made by others, is also discussed by other narrators who describe themselves as having experienced psychotic episodes as part of their distress.

We saw in the previous section how Des described hearing voices which compelled him to do things, and which also told him very negative things about himself, thereby

causing him considerable distress. Whilst narrating one episode in his life, he told me how

I went through a big phase of depression, just staying in all the time. I wouldn't go out, I kept hearing voices, and thinking that the telly was speaking to me, and the radio was speaking to me, and the whole earth umm, knew what was going on with me. [3]

Thus, unlike John whose voices brought together school friends and family members, Des' voices seem to be able to connect radio, television and the 'whole earth' in some sort of conspiracy against him. Towards the end of his narrative, Des told me something of his philosophy of how he would like life to be:

You all live together as part of an integrated society, a kind of a, we're interdependent upon each other, and I think, I think it probably works best that way as well, really we can't live without each other, because we all need . . . to live together as a collective, kind of thing. We need to err, connect to each other. [11]

At the time in his life when he first became aware that things were going wrong in his life, he described how he had lost all connections with those around him, with the world at large, and to some extent with himself. In this context, the voices which he hears as talking to him from the television set and the radio, and the whole world knowing 'what was going on with me', may be interpreted as a representation of him remaking the connections with the world which were so important to him, and which he had lost. Thus, the content of his experiences is very much in accordance with, and explainable by, the context of his life. As to the reason the voices were saying such negative things to him, Des himself explains that

another delusion I had was that I had to be, I was supposed to be something special and spiritual, well that's not necessarily a delusion, but that's what I aspired to, that's what one of my ambitions in life was, to be a good, a good spiritual person, like. And for some reason, when I was going through my psychosis and that, I thought the whole world knew what was going on with me, and I'd let them all down because I was supposed to be this person which I wasn't being. I felt a lot of guilt about that.

[3]

Thus, the content of Des' delusions, if indeed that is what they were, though at first perhaps slightly strange, can be given meaning if we incorporate his philosophy of life, the reality of his life at the time, and if we see his experiences from his viewpoint. In other words, if we are able to fully empathise with him and his situation. This is similar to the way in which we saw Nick's account of his childhood experiences as emanating from and including world events, family circumstances and relationships, and his emotional state, all connecting into a coherent whole which gives meaning to his experiences.

The other contributor who described this process of making connections and associations between apparently unconnected phenomena, was Jim, but rather than this occurring as part of the experience of schizophrenia, for Jim this was how he experienced being 'high' in his cycle of highs and lows which is diagnosed as bipolar affective disorder. We have already seen an example of this in Jim's mistaken identification of a group of psychiatric nurses intent on sedating him as the Australian cricket team. Jim described the process by which this type of thought pattern could occur:

I began to get increasingly out of touch with reality, I suppose, and I would be talking to everybody I saw, and I would be getting really panicky about silly things that I'd made some connection. When I get, I'm sure in common with many people, when I get this high, one of the things you get is umm, connections between everything, and you just laugh after a while because you connect things. I mean it can manifest itself when the television is on, it's as if it's talking to you. I know a lot of people say that, but it does, because you, somehow in your brain, everything's firing on all cylinders, and you're just connecting everything together. [2]

It is this pattern of thinking which has often been seen as a source of creativity in the field of art and literature, as the inhibitions to creativity are removed and the mind makes leaps which connects previously unconnected ideas, and many creative people have been diagnosed with bipolar affective disorder. Jim gives another account of this process later in his narrative, as he describes the effects of reducing his dosage of lithium,

I was having all the fast thoughts, you know, there's this great phrase I read once, 'clang associations', you're connecting things which make no little sense to anybody else. 'Flight of ideas', that's another good one. [8]

The enthusiasm with which Jim describes these episodes demonstrates the degree of excitement he gets from being in this state of being high, at least until it reaches the stage of him losing control altogether, and even then it is likely that the reaction of those around him is the main cause of any loss of enjoyment. This enjoyment is clearly in sharp contrast to the misery which is at the centre of the depressive phase of the cycle. It is perhaps ironic that it has always been during one of these 'high' phases that Jim has been hospitalised and forcibly medicated.

CONCLUDING COMMENTS

The range of experiences which are included in the medical definitions of mental illness are wide and varied, and my use of the alternative term, 'emotional distress', does not reduce the variations in these experiences, but is intended to highlight the blurred boundaries which exist between medical categories. However, the exposure of the contributors to psychiatric interventions means that inevitably, the way in which emotional distress is experienced by individuals is influenced by medical interpretations. The main issue which arises in this regard is that medical understandings of the nature of emotional distress are insufficient in providing individuals with meanings to their experiences, and though some of the narratives show the influence of psychiatry, individuals draw on these in conjunction with social and lay interpretations. There are clearly close connections and overlaps here with the issues involved with causal explanations covered in the previous chapter, as the search for understanding experiences, necessarily incorporates understanding the causes of those experiences. What perhaps the examples of this search for meaning demonstrates is that with so many varied experiences consumed under the definition of mental illness, difficulties in reaching an understanding of those experiences is not facilitated in any way.

As the main aim of this study is to reveal the ways in which the life histories of individuals are intertwined with their experiences of emotional distress, I then moved on to highlight the accounts which individuals gave of differing forms of distress, focusing on depression, anxiety, being 'high', and alcohol abuse. These different forms of distress clearly coincide with medical categorisation of behaviours, perhaps

demonstrating the cultural influence which medicine exerts over both the accounts of the narrators, and also on myself in selecting these as sub-headings. Within all of these categories of experience though, it is clear that the narrators locate their distress within their social lives, more than they do within themselves. Whereas I might have hoped for phenomenological accounts of how the experiences felt to the individuals, revealing details of their 'inner experiences', the narratives are focused more on events in their lives, what they and others did in various situations. Two possible explanations may be given for this, the first of which is that in order to avoid directing the contributors as to which issues they included or excluded, I left this open to their own interpretation, suggesting merely that they tell me about their experiences of emotional distress in the context of their life stories. The second explanation is that all of the contributors were men, and as men relating their experiences to another man, constructions of masculinity inhibit such emotional openness, although the fact that most will have undergone some form of counselling may have been expected to mitigate this factor. Despite these reservations, I would argue that the accounts do give an insight into the ways in which the experience of emotional distress impacts upon the lives of the individuals, and of how they seek to give meaning to these experiences.

The sections of the narratives which illustrate the experiences of the contributors during periods which have been understood by them to represent psychotic experiences, highlight the potentially life changing nature of these experiences. Although psychosis is generally regarded as an indicator of schizophrenia, I have included the experiences of Jim during his 'high' periods, as these include very similar descriptions to those of the individuals who have been diagnosed as having

schizophrenia, once again showing the fuzziness between the boundaries of medical diagnostic categories of emotional distress. What is clear from the extracts of the narratives used to explore these experiences is that individuals have great difficulty, and spend a considerable amount of energy in their search for meanings for their psychotic experiences. The nature of psychotic experiences is perhaps best summed up by John, who told me,

it was very frightening and very complicated. [3]

CHAPTER 6

BECOMING A PATIENT AND EXPERIENCING TREATMENTS

INTRODUCTION

Biomedical explanations for the causes of mental illness rely mainly on changes which take place in the chemical activity within the brain, and the ways in which this may impede the functioning of the brain. This impeded functioning of the brain is in turn regarded as causing pathological thought processes and behavioural patterns, and it is the identification of these thought processes and behavioural patterns which are used to diagnose and categorise mental illness in the individual. This differs from the process in 'physical medicine' in two main ways. Firstly, although in physical medicine an initial diagnosis may be put forward on the basis of reported symptoms, in many cases, particularly in more serious or chronic conditions, this diagnosis will be confirmed by some form of physical testing, whether by visual means in the form of scanning procedures, or by some kind of chemical analysis. No such confirmation techniques exist for mental illnesses, despite the chemical basis for medical explanations. Secondly, for some categories of mental illness, diagnosis and treatment, and in some cases this may be involuntary treatment, will be based upon reports made by third parties, who may be family members or friends, but may in some instances be total strangers. The uncertainties which are contained in these diagnostic procedures have often been highlighted in order to demonstrate the 'fuzziness' which exists, both in the boundaries between those who are regarded as

mentally ill and those who are not, and in those between particular diagnostic categories.

I will begin this chapter by highlighting how this ‘fuzziness’ in the diagnostic process has been reflected in the experiences of one of the narrators, before moving on to explore the accounts contained in the narratives of various aspects of their treatments.

THE ‘FUZZINESS’ OF DIAGNOSIS

The experience of one of the contributors to this study, as revealed in his narrative, provides an insight into the effects that such ‘fuzziness’ may have in the intervention of mental health services. As has already been described, both Jim and his mother have been diagnosed and treated for bipolar affective disorder, and this may contribute to them having a greater understanding of their own, and each others emotional states. Jim described an occasion when his mother recognised that he was getting ‘high’, and so

My mum had called out the on-call people . . . for me, and when he got there [laughs] I opened the door and said, ‘Oh yeah, it’s my mum, she’s got bi-polar’ [laughs loudly], and he believed it . . . do you know what I mean? I was like I am with you here now, I mean no different really, but she was right, because I was about two or three days into a high period for me. So she spotted that, and *she got admitted!* [9]

Though this may be seen as just a case of mistaken diagnosis, it also highlights the state of mind which Jim is in when experiencing a ‘high’. One assumes he must have

appeared persuasive and articulate, contradicting many of the images of being mentally ill. Though it is clearly not possible to draw too many inferences from one account, it is possible that in addition to demonstrating the potentially unreliable criteria for diagnosis of mental illnesses, this story highlights three other issues. Firstly it shows the reliance which is often necessary on third party reporting of symptoms. It was Jim's mother who made the phone call which prompted the arrival of the 'on-call people'; there is no suggestion that Jim himself would have reported his symptoms nor that he agreed to his mother doing so. Further it would appear that the psychiatric nurses were more than happy to accept Jim's account that it was his mother who needed their intervention, even though Jim fully accepts that there was nothing wrong with her. This resulted in Jim's mother being involuntarily admitted to hospital, and to a degree serves to confirm the findings of Rosenhan's (1973) study with regard to diagnosis. The second issue to be raised is the degree to which patterns of behaviour which would be likely to result in a diagnosis, may be controlled and hidden from others. For a while at least, Jim was able to convince the psychiatric nurses that he was free of any symptoms to the extent that he was a reliable reporter of his mother's state, even though he was 'two days into a high', and was eventually admitted onto the same ward as his mother. Thirdly, it seems clear that the knowledge that Jim and his mother had acquired from their previous experience of mental health services played a significant part in the sequence of events which led to them both being sectioned under the Mental Health Act. This includes Jim's mother's recognition of the changes in his behaviour, his ability to ascribe the appropriate symptoms to his mother when talking to the psychiatric nurses, and his knowledge of what aspects of his own behaviour he should keep hidden in

order to avoid hospitalisation, albeit temporarily. It is quite feasible that without this specialised knowledge, events would have turned out very differently.

BECOMING A PATIENT

All of the men who contributed to this study had at some time been in receipt of some form of treatment for their distress, and many were still involved with such treatments. In this section I will examine their accounts of being treated, beginning with the stories they told of being sectioned under the Mental Health Act.

(i) Being sectioned

Of the eight men who contributed life history narratives, three had been treated involuntarily under the Mental Health Act. Although Nick has been sectioned on numerous occasions, he did not include any accounts of the sectioning process, almost certainly because being hospitalised has been just a part of his life since adolescence. As Nick told me

I was first admitted to [name] Hospital in about 73-74 . . . I used to go in for about, umm, 8 months to a year, come out, used to be out for about 4 or 5 months, then go back in for about another year, it used to be like that. [12]

Thus, although as we shall see later in this section, Nick has plenty of stories to tell about his times in hospital, he has little to say about being admitted. For Jim though, the experiences of being sectioned are central to his story. On the first occasion he

was sent to a psychiatric hospital, it was via a police station, where he says he was seen by a doctor, diagnosed with bipolar affective disorder, and then

they put me just in a police cell, and I think some of my spirit died that night, because I just, after screaming and screaming, because no-one explained what was going on at all, and I had obviously paranoid thoughts and all the rest of it. [2]

After spending a night in the police cell, Jim was transferred to a psychiatric hospital, where the sectioning process took place. This involved

this gathering of people, this huge gathering of people, I've had another one of those recently, they're great fun, umm. [2-3]

What Jim says he needed most of all at this stage was some help in understanding what had happened, of how he had come to be in this situation, but

instead of all that, it's just an admission type interview, and then you're on the drugs, and I suppose you don't look back really after that. [3]

When he was in Australia he went to the hospital as a voluntary patient, because he knew he was having 'paranoid thoughts' but despite this, he was still sectioned, and he told me how, because they thought he was trying to leave

I was descended on by 8 nurses or something, and pinned down and dragged over to a bed, and that was another time I thought this must be the end of things. I was injected . . . they don't really explain. [5]

On a later occasion, when both he and his mother were eventually sent to a psychiatric hospital, which again involved the police as well as social workers, he told me how

they'd handcuffed me, and they had to do it in this bizarre way, and they sort of pinned me down on the floor . . . I was in this most peculiar position . . . they made me kneel on the sofa whilst 7 of them [including 3 police, a GP, a psychiatrist, and a social worker] . . . I don't what they were trying to do really. [9]

Despite the heavy handed approach, Jim was not sectioned on this occasion, although as he observed

voluntary means voluntary until you want to leave . . . for someone having paranoid thoughts , that's so confusing. [10]

This also matches to some extent my own experience of admission to a psychiatric hospital, when I was advised that it was in my interest to submit to voluntary admission, but told that I would be sectioned if I did not agree to take the various drugs which were prescribed, thus confirming that Jim's point that 'voluntary' has a particular meaning in this context. Jim's experiences also show that on subsequent occasions, when he is aware that he is experiencing paranoid thoughts, the memories of his treatment at the hands of police, doctors and social workers, adds an element of fear in with all the other emotions.

Des' first experience of mental health services also involved being arrested by the police, and he told me how

they took me to the police station . . . and I found myself in a, well in delirious state, in a state of psychosis in a police cell. . . I was assessed by two doctors and they said, 'right, we're going to take you to {name of hospital}'. I don't remember much of what was said in there, other than asking what I'd been up to, and I think I couldn't even hardly answer most of their questions, I didn't answer and they said, 'right we're taking you to {hospital}' and I was sectioned. [4]

This account indicates the sense of confusion which Des experienced, both from his inner state, but also from the effects of being placed in a police cell, being questioned, and eventually being taken to a psychiatric hospital. This sense of confusion and fear continues in his account of being in the hospital, as he describes how

at first I kept running away, getting up and running away, but they kept bringing me back and I finally realised there was no getting out of it really. [4]

I can also recall when first admitted to the same psychiatric hospital, this strong desire to run away, a desire which is perhaps heightened by the knowledge that you cannot leave, especially when you have been 'sectioned'.

(ii) Psychiatric hospitals - fear or safety?

As suggested by Des' comments above, psychiatric hospitals evoke frightening images in the imaginations of people in Western societies, whether it be through the paintings of Hogarth, stories of the Victorian asylum, or films like *One Flew Over the Cuckoo's Nest*. Whilst the reality of twenty first century hospitals may be very different from the stereotypical images, they maintain their hold over the

imaginations of those who have not experienced them first hand, and for those who do have this experience, they contain a mixture of negative and positive experiences. As we saw in the section above, Des was very reluctant to remain in the hospital, and this reluctance was shared by his mother, who he says

had heard horrible ideas of [name of old Victorian asylum, only recently closed], and horrible stories, and she was like, I don't want my son in a mental institution, she had quite a lot of horror images in her mind of what these places were like. [5]

This fear only adds to the difficulties to those experiencing emotional distress, as the prospect of being sent to such a place, is likely to add to the difficulties in seeking help. But after his initial reluctance, Des is able to reassure his mother, telling her

it's not as bad as what people say, that some of these people, the people here, that people get on, it's all right, kind of thing. [5]

One of the things which makes the hospital 'all right', is the sense of security which the hospital may offer, after a period of confusion and uncertainty, as Des recognised:

I felt quite secure, which I hadn't felt for quite some time, living on the streets, sort of you lose sense of security. [4]

Though Des relates his loss of security to living on the streets, the confusion and anxiety of various forms of distress, and the uncertainty they bring, also contributes to feelings of insecurity. My own admission to a psychiatric hospital went through the same stages as Des describes, fear of being there, soon to be replaced by feeling secure, and a resultant fear of being discharged back into the world which had

produced the distress and insecurity. The importance of providing a transitional stage between hospital and living back in the community has been widely debated by service user groups and policy makers.

One of the things which produces the sense of security in hospital, apart from the separation from social responsibilities, is the support which is received from other service users. This point is often acknowledged within service user groups, though less often by health professionals, and was recognised by Colin, who told me

I used to relate the, err, system, it's like a lifeboat, you know, the stronger ones help the weaker ones and all this, and I've certainly got as much from patients as I've got from staff. [8]

In a somewhat ambiguous comment, Colin observed that when he first attended a day hospital, he found that he could not 'tell the nurses from the loonies, you know', leaving it unclear if this was a compliment to the service users, or a critical comment aimed at the medical staff. Once again my own experiences support Colin's observations on the value of other service users, both as important social networks at a time when these may be rapidly disappearing, but also as a source of knowledge about various aspects of mental health issues. These issues include accessing alternative or supplementary resources, information about medication, on the nature of various forms of distress, and on negotiating one's way through the system. Although this information should perhaps come from mental health professionals, in my experience this is often not the case. An example of this is given by Des, who said

That's one thing I was quite disheartened about when I first left hospital, is that I never really had anyone tell me what my illness would mean for me. [7]

Des goes on to say that he has gained more insight into his distress, partly through his own experiences, but also by hearing the experiences of others.

(iii) Ward rounds and consultations

One of the ways in which hospital inmates receive information about the expected course of their distress, and where treatments are assessed and reviewed, is at the weekly meeting with a consultant psychiatrist. However, this meeting almost always takes place in the context of a ward round, and this was described by Jim as follows:

I don't know where I rank on the scale of being out of, out of your mind, sort of thing, but I was thinking this was, when the panel of, I suppose it was only a ward round really, thinking about it now, but you don't know at the time what the hell's going on. You've got to see a psychiatrist, but not just one psychiatrist, a whole load of people round a table, and I was thinking that was like a, a space station or something like that. [3]

Though the reference to it resembling a space station clearly reflects the state of mind that Jim found himself in, the appearance in front so many people, in semi-formal setting, is not ideal when this is often the only occasion on which the patient can express how they are feeling, and raise issues of importance to them. I found myself

often unable to say anything on these occasions, even though I had often spent the whole week thinking about what I might say.

Another issue raised by Jim which resonated with my own experiences, was that of bed time routines. He was in hospital in Australia over the New Year period, and he recalled how

it was New Year's Eve, and I was the only one up! There was this Scottish nurse who was hectoring me to go to bed and I said, 'it's New Year's Eve, I'm staying up for New Year's Eve for goodness sake!' . . . I desperately wanted to as part of my recovery. [5]

My own experiences confirm that Jim's experience is either one that is peculiar to Australian psychiatric hospitals, or to it being New Year's Eve. At about 10.00pm the medication trolley would come round, we would all queue for whatever drugs we had been prescribed, and this seemed to include either sleeping pills or tranquillisers for everyone, and then everyone was pressurised into going to bed. This is clearly about the management of the ward and making the job of the night staff easier, more than it is about the well-being of the inmates.

(iv) Refusal and acceptance: the ties that bind

The one contributor with a vast store of knowledge and stories about psychiatric units, extending over a period of more than 30 years is Nick. He has been resident in adolescent units, secure units in Birmingham, a Victorian county asylum, and a

modern hospital built in the 1990s, and so has seen a wide array of types of institution as well as been witness to changes which have occurred over time. In chapter 8, I shall highlight the stories Nick tells about the abuse he has been subjected to by individuals in these institutions, but some of his experiences reflect more systematic responses to his distress. In one such story, he told me how one of his responses to his distress has been to not eat, and that on one occasion when he refused to eat his Sunday lunch, the staff liquidised the food and insisted he ate it. He went on to describe how he told them

‘I’m not drinking that, it’s slimy green stuff’. They forced me to drink it, of course my tummy couldn’t take it, I hadn’t eaten for about five or six weeks. I vomited it up, then the nurse said, ‘you WILL clean that up Nigel, you will mop that up’. I said, ‘I’m not mopping it up, you made me drink the stuff.’ Anyway, they started hassling me and in the end I cleaned it up. [13]

This incident took place in the late 1970s, and clearly reflects attitudes of that time toward those with distress, but although such treatment is unlikely to occur now in hospitals, not least because they are open to scrutiny, instances of both deliberate and unintentional cruelty do occur¹.

Despite the instances of abuse that Nick told me about, he also spoke very affectionately about life in hospital, especially in the county asylum, and spoke of

¹ This event in Nick’s story clearly has ethical implications. I discussed these with Nick and discovered that one of his present carers had raised the issue with him, and asked if he would like to take action against the perpetrators. Nick was adamant that he did not feel able to cope with this course of action, and in view of the many years that have passed, felt it better to let the issue rest.

forming good relationships with both patients and staff. He told me

I liked some of the nurses, some of the nurses were quite creative and intellectual themselves . . . Sister Blake was an astonishing character, as we said earlier on, there wasn't so much violence in those days [1980s] in these hospitals, and Sister Blake was a night sister and she would visit, visit us all. It was like a little village, a little community, and she would go round the grounds with this big cape on, and she was a white witch, and in those days the boundaries weren't so well defined between the nurses and the patients . . . Sister Blake and I would stay up all night talking about poetry. [12]

So although Nick gives some examples of a regime of psychiatric treatment which seems brutal and cruel, and which fits the public perception of the asylum and the fear generated by this perception, he also gives insights into a far more human relationship between medical staff and patients, and of a 'little community' which many current service users regret no longer exists.

(v) Continuity and change

Nick and other service users also talk of the changes which have taken place in the nature of psychiatric hospitals, and in the change in those using mental health services. Colin commented on the violence and level of drug taking which is now more prevalent in psychiatric units, and Nick told me that

ever since I've been in psychiatric hospitals there've always been some patients who will bring illegal drugs in. The difference is now, that dealers are targeting

hospitals . . . the drug scene's changed so much, you know, dealers actively target hospitals. [15]

One thing that has not changed significantly is the potential for individuals to feel stigmatised through having suffered emotional distress, and of being a service user. Although Des speaks of how after his initial reluctance to be in hospital he eventually found it beneficial, and found the company of other service users helpful, he told me of his feelings after being in hospital for the first time:

I still felt quite segmented, because for the breakdown I'd had, and err, err, I dunno, I suppose it was getting to me a lot, the fact that I sort of had mental problems. [6]

Des suggests that his distress is making him feel isolated from society, which I interpreted as being a result of the stigma he felt, and his feeling of segmentation contributed to the relapse in his emotional state which he experienced, and it is through his involvement in service user groups that he has addressed this issue.

DRUG TREATMENTS

There are two main issues which are subject to debate with regard to the drug treatments for emotional distress, the effectiveness of the drugs and the side effects associated with them.

(i) Efficacy: a qualified endorsement

All eight of the contributors to this study have taken, or are taking medication prescribed as a result of their distress, and all apart from Colin include some discussion on the medication they take. It is perhaps surprising, in view of the controversial nature of these drugs, that very few entirely negative views are expressed about them. Thus, Des told me that

I was very elated, very hyper, kind of hyper manic and going through so much mental activity growing up, that I couldn't, I didn't know how to deal with it. But things started to calm down, going on the medication was probably the main thing. I think I was on, when I first went in they put me on risperidone which would sedate me a lot throughout the day. [4]

Though this calming effect is likely to have been beneficial to Des' emotional state in the short term, it is less clear when such medication is taken over a longer period, or even permanently. John told me that he had been taking the same antipsychotic drug, risperidone, for about two years, and that

It has helped, it's odd because the medication made me feel . . . I have been taking medication when I've heard voices before, and the medication hasn't made much impact, and err which makes me think that it hasn't been much help, but I'm pretty sure it has, and I haven't had murmurings for about six months now. [5]

This can only be seen as a qualified endorsement of the effectiveness of the treatment, and John goes on to qualify this further when he suggests that he is unsure whether the absence of hearing voices is as a result of the medication, or because they are just

no longer present. This difficulty in assessing the benefits of drugs taken permanently is one often debated (see Breggin, 1993) and it is often unclear whether the return of symptoms when treatment is stopped should be understood as a return of symptoms which had been kept at bay by the drugs, or whether they result from withdrawal symptoms.

(ii) Unpleasant side-effects: the biochemical self

Jim has raised this issue in respect of the long term taking of lithium as a mood stabiliser, but also raises the issue of side effects in relation to the taking of prescribed drugs. These may of course be unpleasant, and Breggin (1993) gives many details of these. Jim suggested that in recent years the side effects of antipsychotic drugs have been reduced, arguing

to their credit, they do seem to have improved the drugs a bit because . . . at least last time I was in hospital I didn't get any bad physical side effects really . . . that first time I certainly had quite, umm, yeah, quite bad side effects. [3]

Jim gave no indication of the nature of these side effects but did go on to qualify his statement about the improvement in the drugs, saying

I've been on lithium on and off, but very, very much mainly on, ever since , and that's 17 years now. It's a good job they know what the long term effects are – they haven't got a clue have they? Yeah, well they're very careful to check the blood levels, and they panic. [3]

The knowledge that you are in danger of being poisoned must contribute to levels of worry which are associated with having a 'mental illness', and all that involves. With

regard to the prescribed antipsychotic drugs used to treat schizophrenia, and on occasions the 'highs' of bipolar affective disorder, in a court case in the USA in the 1980s, the judge gave his opinion that

At the heart of this case is the virtually undisputed allegation that a person medicated with antipsychotic drugs has a 50% risk of contracting tardive dyskinesia ,a disease exemplified by twisting tongue movements, puffing cheeks, smacking of the lips, sucking movements of the mouth, and face and body movements characterized by continuous rocking motions, tremors and bizarre postures, and other symptoms, and which at this time is incurable. (cited in Breggin, 1993: 93)

Thus, many of the bodily attributes of the more severe forms of emotional distress are heightened by the treatments given for them. Similarly, bodily reactions to the entirely physical electro-convulsive therapy (ECT), include shaking and a shuffling walk. Recent improvements in the antipsychotic drugs used in the treatment of schizophrenia has resulted in a reduction in the unarguably embodied side effects, though during my time spent in psychiatric units, similar physical side effects were still widely to be seen. Due to the nature of the sample used in this study, which was based on the fact that the participants were relatively symptom free, both the type and the quantity of drugs they were currently taking was in accordance with this, and only relatively mild physical side effects were in evidence when I carried out my interviews. In addition, in my experience individuals rarely discuss the worst excesses of the physical side effects of their medication, possibly because they are not fully aware of them, because of the way in which the drugs change their perception. It is also possible that the presence of the side effects of medication is so much a part of the lives of mental health service users that they barely warrant a mention.

Another issue raised by taking these drugs over a long period of time is the effect they have on the nature and identity of the individual. Jim told me that he thought the latest antipsychotic drug he had been prescribed was a big improvement over those he had taken previously, but that

it makes you a bit slow, dulls you, tires you a bit. [10]

Similarly he identifies the effect of taking lithium, as giving him a 'cloudy mind feeling', and 'something that's dampening down your emotions, your thinking, everything' [4]. Thus, taking these medications changes his nature, and it could be argued, prevents him from realising his potential as a person.

The antipsychotic drugs taken by several of the contributors, are then potentially problematic because they are taken over a long period of time, often permanently, and therefore any side effects or changes in the personality of the individual may also be long term. For many mental health service users though, drugs such as antidepressants may be prescribed for lesser periods, typically one to two years. Darren summed up both the benefits and the drawback of taking antidepressants when he said

they definitely do take the edge off, take the edge off one's discomfort and pain, but they also take the edge off everything. That's the problem with them really. [5]

Pete begins his account of taking antidepressants by describing the positive effects, telling me

I don't think I would have got better without it, I really don't. I can remember when it started to kick in, it did, I don't know, I just felt like I had a bit more space, it did sort of feel artificial in a . . . I don't know, it's kind of strange, it definitely did work.

[2]

Despite this certainty that the antidepressants were successful in alleviating Pete's depression, he went on to point out that there were negative outcomes as well:

But coming off them, they just stopped me, and I can remember having, oh it's so weird, I can remember staring at a wall and seeing it spin in front of me, and waking up in the night with cold sweats and stuff, for about three or four days I think. [2-3]

My own experience of ceasing to take antidepressants was similar, but what I found particularly difficult, as do many others I have discussed this with, is dealing with the return of emotions which no longer have 'the edge off'. After almost 12 months of not having to deal with any heightened emotions, good or bad, I had somehow lost the resources to cope with them. My experience suggests that this is a time when individuals are especially prone to relapse, either into depression, or into a 'manic' episode. There is another issue though, with regard to antidepressants which is perhaps hinted at in Pete's narrative. The depressive episodes he describes took place during his adolescence, and one of the antidepressants prescribed for him was seroxat, and he makes the observation that

they kept me on those tricyclics for ages, I'd only just started the seroxat when I . . . tried to kill myself for the second time. [3]

Though clearly it is impossible to draw any cause and effect conclusions from this statement, and Pete makes no attempt to do so, in view of the debates which have taken place about the issue of seroxat and adolescent suicide, Pete's comments are a reminder of the depths which depression can reach, and of the complexity of the relationship between emotional distress and drug treatments.

(iii) The 'expert patient'

One final comment on the issue of drug treatments and emotional distress is warranted. When I was admitted to a psychiatric hospital and encouraged by the psychiatrists to start taking medication, I found it difficult to obtain any meaningful information from medical staff about how long I would have to take the various drugs I was prescribed, nor any realistic assessment of potential unintended consequences. At a time when I was extremely vulnerable and anxious, this lack of information served to increase my anxieties. An important part of hospital routine is that of the drug trolley, which was taken round the ward four times a day, and we all queued for the particular cocktail of drugs which had been prescribed for us. I was astonished by the vast number of types of medication that some of the patients were taking, and as I became more comfortable in my surroundings, I discovered that all of the information I could possibly want about any type of drug used in the treatment of emotional distress could be found by talking to other service users, some of whom had been in the system most of their lives. Knowledge of the intended and unintended effects, the general view as to the efficacy, and possible alternatives could all be discovered. Though clearly it is important not to overstate the case for the 'expert patient', this

source of knowledge was of great importance to me. This knowledge about the various medical treatments is also reflected in the narratives of the contributors to this study, and Nick's expertise in this area is even apparently recognised by the medical staff, as he told me

so I'd be on stellazine [and] amitriptyline and doctor Walsh would say, 'for the anxiety, do you want diazapam or Librium?' I would normally go for Librium, I preferred that. [4]

TALKING THERAPIES AND OTHER INTERVENTIONS

Just as all of the participants had taken prescribed medication as a result of experiencing emotional distress, many have also taken part in various forms of talking therapies, whether it be through psychologists, group counselling sessions, or one to one counselling. Interestingly, though, they have very little to say about this aspect of their treatment, possibly because of the intimate details of their lives which are touched on by these therapies, but also perhaps because they have found them less problematic. As Pete's difficulties began during his adolescence, and seemed at least to involve his school work, he was sent to see an educational psychologist, and Pete's assessment of the benefits of this are somewhat mixed:

I can remember it was sort of helpful really, I can remember coming out of them feeling a bit more positive and wanting to do things, but it didn't last, that feeling just didn't last for very long at all . . . looking back on it now, I still feel that things

were still getting worse. I think that the root of the problems weren't getting dealt with, you know. [1]

Later on in his narrative, Pete gives an equally equivocal account of sessions of family therapy undertaken with a psychologist, but is much more enthusiastic about the benefits of his use of Safeline in respect of his experiences of being sexually abused. He does not though, give any indication that he has suffered any negative consequences as a result of any of the talking therapies he has experienced.

Darren also only has positive things to say about his experience of talking therapies, telling me

I should say over a lot of this period I've had, I've had counsellors and psychotherapists. I've been going to a psychotherapy group, which is, which is useful I think, you know, bit by bit things do get clearer, bit by bit. [5]

Though stopping short of ringing endorsement, he makes no criticism of these therapies, and he hints at one of the fundamental differences in the experiences of many service users between drug therapies and talking therapies, when he told me

I've been referred by GPs [for counselling] but I mean, it's always been my choice to go, you know. [5]

This choice is often absent for those prescribed with drug treatments, especially those on a section.

Matt is perhaps the most enthusiastic supporter of talking therapies, suggesting that group sessions with Alcoholics Anonymous were a vital part of his recovery from alcoholism. In addition, when Matt's mother was dying, an event which for many reasons had the potential to reverse Matt's recovery, he told me how group therapy prevented this, telling me

I'd actually prepared for my mother's death, I went to meetings and I shared it, cos she was a slow death, and I shared it for about 3, 4 months, 5 months, and I shared it at every meeting I went to . . . and I got lots of good guidance and stuff, so when my mother died I was ready for it, if you can ever be ready. [3]

Colin also found talking to a psychologist useful, less because of the 'guidance' he received, but because it demonstrated to him that at a time of him being 'extremely distressed', the fact that he was given time with a psychologist made him feel that 'they must have thought I was worth saving' [7]. He points out that it is not just the form of therapy which is important, as much as the human qualities of the individual therapist, and he told me of his experience with a case worker:

I found her very helpful, you know, caring, somebody you can talk to, you feel like some of them were just going through the motions. [8]

Des similarly suggests that these human qualities are important, arguing that he has found these qualities in service user groups, describing how

having people there to speak to, and knowing that it's best to share your problems, knowing that it's best to talk things through . . . to get through the bad times . . . having the support there really helps. [10]

He goes on to say about MIND,

so I thought it would be a good idea to get involved here, which has been very supportive for the last, nearly 2 years now, errm, I started out with the newsletter, then with the volunteer coordinator, he's very helpful, he's been very supportive, he's really helped me a lot actually, and the whole organisation has welcomed me in and, errm, given me a lot of support [6]

Des is highlighting here the need for those being supported in the community to feel part of a community, something which mainstream mental health services has often failed to provide. Though generally complimentary about the medical services, he does nonetheless also criticise them for being unwilling to accept alternative forms of treatment, and suggests that meditation, Raiki, crystal healing and tai chi may all offer useful alternatives.

CONCLUDING COMMENTS

Psychiatric institutions have a certain notoriety in the public perception of them, and the views reflected in the stories collected, certainly contain incidents which may encourage such notoriety. However, the overall picture is more complex, with many individuals recognising the benefits of security, and of the sense of community which the hospitals may produce. Forced hospitalisation by a section under the Mental Health Act, is generally seen as undesirable. The range of treatments used in the mental health services is extensive, and includes surgery, electro-convulsive therapy (ECT), a vast array of ever changing chemical products, and the various forms of

psychologically based talking therapies. None of the contributors raised the issue of surgery or ECT, although I am aware that Nick has experienced ECT, and while I was in hospital several patients were treated in this way. The issues raised in respect of drug treatments include their effectiveness, side effects, and the involuntary administering of such interventions. The narratives include some recognition that short term benefits may accrue from drug therapy, but concerns are expressed about the long term taking of medication. Changes in the identity of individuals occurring as a result of these drugs, is also raised as an issue by several contributors, particularly when taken over a long period of time. Talking therapies are generally seen as potentially helpful, and none of the narrators made negative comments about such therapeutic interventions. This would seem to reflect the generally held view in service user groups that this type of intervention should be made more widely available, although cost cutting exercises in the Health Service in recent years has reduced their availability.

CHAPTER 7

MIND, BODY AND SPIRIT

INTRODUCTION

In chapter 5, I concentrated on some of the accounts given by the contributors to the research of their experiences of emotional distress, and one of the aspects to emerge from their narratives, is the way in which individuals search for meanings in their experiences. In particular, two strands emerged from these searches for meaning, and it is these that I will develop further in this chapter. The first of these concerns the philosophical debate which has occupied scholars for many years, that of the linguistic separation of, and relationship between mind and body. This has a particular relevance and significance in relation to emotional distress, which is understood as a malfunction of the mind from within psychiatry, psychology and from many lay perspectives. The psychiatric, biomedical model, as we have seen, views the mind as a direct function of the brain, and so focuses on the chemical and neurological changes which take place in the brain, and concentrates treatments on remedying these changes. Within various psychological models the explanations revolve around the belief that unhelpful patterns of thought, and the resulting patterns of behaviour, arise as a result of learned responses to particular stimuli or stressors, and treatment is based on the individual being assisted, through various forms of talking therapy, to 'unlearn' these patterns. Thus, in very different ways both psychiatry and psychology view those experiences I am calling emotional distress, as pathologies or malfunctions of the mind, and hence the widely used description throughout western societies of these experiences as 'mental illness' or 'mental distress'. Unsurprisingly, both in view of the dominance of these understandings, and

as a result of the fact that those who experience emotional distress will almost certainly have had a high exposure to both psychiatric and psychological models through the medical profession, these understandings are often a significant part of the meanings which individuals themselves use in describing their experiences. However, the narratives often reflect other interpretations of these experiences, incorporating more holistic, embodied understandings of them, and it is these aspects that I will explore further in this chapter.

The second theme to emerge from the narratives was that of spirituality, and the various ways in which some of the contributors invoked the notion of spirit in their search for meanings in their experiences. In earlier times of course, when the church was a dominant force in society, religious or spiritual explanations of 'madness' were prevalent, but in these more secular times scientific explanations have replaced spiritual ones. However, it has been suggested that 'while spirituality remains a peripheral issue for many mental health professionals, it is in fact of central importance to many people who are struggling with the pain and confusion of mental health problems' (Swinton, 2001: 7). In this context, spirituality is not necessarily 'viewed as a specifically religious concept' (ibid: 11), although for some it may be, but as part of a broader search for meanings in our lives. As has already been seen, the narratives which form the basis for this study suggest that emotional distress may often be the result of individuals losing, or failing to discover, meanings in their life experiences, or indeed, as a way in which some individuals search for meaning. Thus, the basis for an association between spirituality and emotional distress can be seen to be a relevant one. Again, this returns us to the other concern of this chapter, the mind/body dualism, as it is argued that 'the human spirit is seen as an integrative

presence that permeates and vitalizes *every* aspect and *every* dimension of the human person' (ibid: 16-17, italics in the original), thereby indicating that mind, body and spirit cannot exist separately.

MIND/BODY EXPERIENCES

(i) The body, depression and anxiety

We saw in Chapter 5 the difficulties that the contributors to the study found in describing their distress. Those individuals whose experiences include depression, seemingly unable to convey the true extent of their 'psychic pain', were more willing to attempt a description of the physical manifestations of their distress. Thus, these descriptions include accounts of them being totally paralysed, or 'catatonic', though clearly this state is not the result of any physiological damage. Styron gives his own account of the process which leads to this state, describing how for him it began with

slowed down responses, near paralysis, psychic energy throttled back close to zero.

Ultimately, the body is affected and feels sapped, drained. (1991: 47)

This would appear to suggest that the body is involved in an enormous amount of exertion in dealing with, or responding to the emotional turmoil which represents the experience of depression, for the body to feel 'sapped' and 'drained'. The effect of this is heightened because unlike other forms of physical exertion, the body gets little or no respite, not even from sleep, which is either denied completely, or does not replenish the body's energy levels as it is intended to. Though sleep takes us out of

our conscious selves, our psychic experiences continue in the form of dreams, and these dreams are often a continuance of, rather than a respite from emotional distress. I will return to the issue to sleep later in this section. The bodily exertions in dealing with depression can become so overwhelming and persistent that they dominate our lives, yet we can become unaware of them. In my own experiences, it was only during my stay in a psychiatric unit, when I was given an aromatherapy massage, that I became conscious of the state of my body. The clenched buttocks, tight shoulder and neck muscles, and rigid facial muscles had all become so much a part of my experience, I failed to notice their presence.

In Styron's account of the relationship between his depressed thoughts and his bodily responses, he describes how

in ways that are totally remote from normal experience, the gray drizzle of horror induced by depression takes on the quality of physical pain. (ibid: 50)

This appears to be suggesting that the pain he experiences is not in his body, and therefore, physical, but merely has the same qualities. Others though, identify their bodies as the location of the pain, as illustrated by the work of Real (2003), who has himself experienced depression, but who also is a therapist working with men who are depressed. He gives an account of a therapy session with a man whose 'covert depression' has frequently been expressed through anger and violence, and when asked to try to identify the precise location of the physical manifestations of his emotional state, which has been brought to the surface during the therapy session, says,

It's here (pointing to his stomach) like all tied up in knots . . . It's like a band around my chest, my heart. (2003: 92)

As he focuses on this band around his chest, he identifies that it is fear that he is feeling, and the very recognition of this fear causes a constriction in his throat, making it difficult for him to breathe. Real's interpretation of this reaction is that although these physical manifestations have been brought to the surface during the counselling session, they are in fact ever present in the man's life, but are not always recognised or acknowledged.

The recognition by Real's client that he is experiencing fear as a part of his depression, is a common experience, and links in with the relationship which exists between depression and anxiety, and which we saw in Chapter 5. It is often this anxiety which is recognised by individuals who have been diagnosed as depressed, in the form of physical symptoms, and which I described as being part of my own experience earlier in this section. Darren describes some of the ways in which he experiences anxiety in his every day life:

the knot in the stomach, the racing heart. [long pause] Interesting, one of my, this hasn't happened recently which I'm really surprised about, I get a little tic, I used to get a little tic in my eyelid, it was definitely a sign of, you know, I'm under stress. [8]

I have also experienced precisely the same thing during periods of depression and anxiety, and although a comparatively minor symptom, it did serve to constantly remind me of my emotional frailty, and acted as a sort of warning to avoid emotional issues.

(ii) Physical illnesses and emotional distress

The narratives also contained accounts of other physical ailments experienced by the participants in the study, adding another important dimension to in relation to the embodied experiences of emotional distress. Pete, for example, described how, in the period leading up to his first episode of depression,

I was shaking so much at the time, and so I was given Beta Blockers. [2]

Thus, it would appear that Pete's shaking was first treated as a physical complaint, though it turned out to be the symptoms of depression. When discussing various aspects of his childhood, and the part they may have played in his severe bouts of depression as an adolescent, he suggested that one of the factors that led to his depression was that,

I used to get teased a lot because I was really short, umm, I was put on a course of [name of medication] because I had really big problems with asthma, and it stopped me growing. Every one of my mum's side of the family is over six feet tall and both of my brothers are much taller than me, umm yeah, from when I was about 10 till I was 18, I also had growth hormone injections, inject them every day, umm. Yeah, so I used to get teased a lot about my height. [4-5]

Thus, Pete is linking his experience of depression to a chain of physical problems which begins with asthma, the treatment for which restricts his growth, which in turn leads him to being treated with growth hormones, which themselves are unlikely to be without physical side effects.

In a similar way, when Matt begins to tell me why he thinks he has experienced problems with his emotional wellbeing, the very first piece of information he gives me is that

I've always been an emotional person actually, after, as you hear things as you grow up, and err you're told things . . . I was born premature, I was born two months premature . . . so there was a struggle for life right from the start . . . I don't know how long I was in hospital but I know I was very ill. [1]

Thus, the very first explanation he gives for his emotional difficulties is his birth, which at various times he links to the problematical nature of his relationship with his mother. In particular he told me how because both he and his mother were ill as a result of the premature birth,

I wasn't bonded with my mum, I was bonded with err . . . one of our neighbours. [1]

Thus, the fact that both he and his mother were ill at the time of his birth, is used by Matt to explain the fact that he considers himself to have always been 'an emotional person'. The next physical problem that Matt identifies as causing his emotional state is that

I later found out that as a small child, three, four, five I honestly don't know the err . . . the time, I found out, when my mother died I found this out, that I had meningitis, err so I had lots of mood swings and stuff, I don't know if that was for that or whatever, I don't know, but I came out of it luckily, because you can go blind or deaf . . . so as I say, I was a sickly child, err, and I was attached to mum, I didn't want to leave my mum, you know, I think that's why I screamed a lot and shouted a lot. [1]

Matt then, is associating his premature birth and his childhood meningitis with both his relationship with his mother, and with his difficulties in controlling his emotions, which together with other childhood events, he links to both his becoming an alcoholic and being diagnosed with bipolar affective disorder. In Matt's narrative, it is the bodily experiences of his birth and having meningitis which lead to his emotional distress, and as we have seen, his experiences of being an alcoholic were told in extremely physical/bodily terms.

Colin had an entirely different experience with regard to physical illness and emotional distress. Several years after returning from the USA after his divorce, and having spent all of that time in various degrees of depression, and receiving a variety of antidepressants and different forms of counselling and psychological treatments, Colin had a stroke. Although a relatively minor one, he spent several days in hospital and when he came out he described to me how he had great difficulty in walking, and that he felt as though he had 'aged thirty years overnight'. Even for an individual who had never experienced depression, this is an event that could quite easily lead to a bout of depression, and with Colin having spent the last few years being treated for depression, the risk of a worsening of this state must have been considerable. However, he describes how

when I had my stroke, almost two years ago, that was quite remarkable because it happened so slow. It put me in hospital for about ten days, I come out Christmas Eve, sort of walking, couldn't smell, couldn't taste anything or anything like that, my speech was slurred, couldn't type, couldn't read or anything, and err, but then I realised I wasn't depressed! I thought, hey, I'm not depressed, first time in years. [9]

The absence of the depressed state which had hung over him for so long gave him a feeling of elation, despite the physical symptoms which the stroke left him with, but this elation was considered to be a problem by the psychiatric professionals. Colin describes how the community psychiatric nurse, who was part of a crisis team, visited him in his flat,

and he came back three times in one day or something, and he came back and says, 'I know you're elated', and I says, 'of course I'm fucking elated, I'm not depressed', you know, and err . . . he started asking me, 'have you planned any harm on anybody?' 'No, no'. 'Have you planned any harm on other people?' 'No, no', and 'do you think you're anybody famous?' [9]

Colin was able to see a funny side to this, both at the time, and while he was relating the story to me, and in fact on the next occasion that the nurse visited him, he opened the door wearing a cardboard Napoleonic hat! But beneath the humour that Colin was able to recognise, there was also a potentially serious side to these events, as he told me,

they were trying to say I was bipolar and whatever, but what did frighten me . . . because I was laughing and giggling once, they were actually thinking of sectioning me, you know. It did bother me that you could have a stroke and be sectioned, you know. [9]

In telling me this part of his narrative, Colin seems to be suggesting that it was the absence of depression which resulted in such a high state of elation, whereas clearly the psychiatric nurse interpreted his behaviour as a psychotic episode and that his previously depressed state had somehow switched to being bipolar. Which of these

interpretations is the more valid is difficult to assess, but clearly in some way the stroke had induced both physical and psychic changes in Colin, and some of the behaviours which resulted from these changes certainly bear resemblance to that which may appear from the outside as evidence of psychosis. He described some of the changes to me, some of which were the result of his difficulties walking:

when I went out I had to talk to myself crossing the road, to warn myself of buses and things, and tell myself there's a kerb, a kerb coming up. Woolly mammoth, I used to call buses woolly mammoths . . . I went out and err, it was like I'd never seen a tree before, and stuff like that. It was amazing truly, it was almost as if I had x-ray vision, I could see how things were made, listening to music was amazing, time was dislocated . . . I used to have tinnitus and that's gone now . . . Oh since the stroke, yeah, I'm sure my hearing was, practically all my senses were increased, apart from smell. [9]

The stroke that Colin suffered clearly has bodily effects, as he describes changes in his ability to walk and speak, and also changes in his sensory perception, but all of these changes occur as a result of damage to the brain caused by restricted blood flow to the brain. In addition, Colin also describes how his mood changed from various levels of depression to one of elation, and how his behaviour would have been seen from the outside as strange, and perhaps as evidence of mental illness. This would suggest support for the psychiatric model which sees affective disorders as resulting from changes which occur in the brain. I would add a note of caution though, with regard to this conclusion. First, shortly after the stroke, and he was clearly far from elated, and was in fact extremely tearful, as he told me

I think I was crying because . . . errm, because me dad had stokes you know, quite a few strokes. I said [to a friend] I was crying because of my dad, I think, you know. I can remember him like, not being able to speak, and stuff like that . . . and I can remember my mother not having the patience to talk to him and stuff like that . . . so, yeah, I think that was just a reaction to the stroke. [10]

In fact then, it would seem that for a while he became more distressed, whether this was because of his memories of his father's strokes, his mother's lack of sympathy for his father's condition, or his fears that he was on the same trajectory of his father, who had a succession of strokes. Equally, the elation that followed may have been as a result of his realisation that he had survived a life threatening situation and was gradually making a full recovery, or that he was now someone recovering from a stroke, rather than a mental health service user suffering from depression. This latter explanation is given some credence by the fact that as we have seen, Colin's experience had been that life-long friends had drifted away after his severe depression set in, and that he had understood this to be because of the stigma attached to mental illness. In his narrative, he tells of how he telephoned several of his friends to tell them about his stroke, suggesting perhaps that he wanted to inform them of his new identity status, of someone recovering from the effects of a stroke, rather than a psychiatric patient. The fact that the elation got out of control, certainly from the viewpoint of the psychiatric professionals, is also not surprising as the contrast between even a moderate degree of elation, following on from several years of depression, must have been difficult to control emotionally. Whether as a result of medication prescribed to treat what the psychiatric nurse regarded as a psychotic episode, or because of the gradual realisation that as he recovered from the effects of the stroke, nothing had really changed in his life, depression returned to Colin, and as

is often the case it was what he describes as ‘a very, very bad depression’ [10]. Thus the trajectory of Colin’s experience, from depression, to stroke, to elation and back again to depression can be seen as a complex mixture of biological processes and social influences, all of which are experienced by Colin as thoroughly embodied events.

One of the embodied experiences which Colin describes as occurring during his period of high elation after the stroke was the effect on his ability to sleep. He told me how in the period immediately after the stroke,

I used to dread going to bed because I wanted to go to sleep and couldn’t, I just lay, I played my whole life back within a week, right back, certainly past two. I can remember me dad being, not being there, not being there because he was in the army, I’d be about one and a half or summat, and err, everything, everything came back, and I used to sit there at night sort of giggling . . . and I think I went about a week with about two hours sleep, you know, and they put me on various things. They put me on that horrible respiridon, which apparently is liquid cosh, and that’s horrible.

[10]

Once again there is a complex chain of events, with the stroke apparently resulting in high elation, and the increased level of mental activity which results from this elation leading to Colin being unable to sleep. This lack of sleep in turn will have affected Colin’s mental and physical states, and the medication which he is given acting as a ‘liquid cosh’, and presumably therefore, impacting on these states.

(iii) Sleep and emotional distress

We saw earlier how one of my impressions of the psychiatric hospital was the number of different medications taken by the patients, and that perhaps the most common types of medication were various forms of sleeping tablets. One of the 'symptoms' of depression and anxiety is the change in sleeping patterns, whether it be inability to fall asleep, or waking during the night or very early, and not being able to get back to sleep, and in fact questions about sleep patterns are used by psychiatrists as part of the diagnostic process. My own experience of depression certainly included changes in my sleeping patterns, and these remain now, even during periods when my mood is not depressed. Interestingly though, only one other participant in the study discussed sleeping patterns, with Pete telling me that during his severe depression as an adolescent,

I think because I was just a kid then . . . they were probably a bit more reticent to umm, put me on antidepressants. Umm, I was having lots of problems sleeping as well, I just couldn't sleep at all, so they put me on an older type . . . tricyclics, I think they were, [2]

Thus, though reluctant to prescribe antidepressant drugs because of his age, it was the sleeping difficulties that he was experiencing, which led to him being prescribed with them, and to the type of antidepressant which was prescribed. It was also these drugs, incidentally, which Pete used in one of his attempted suicides. Perhaps the absence from the narratives of other participants of discussion of sleep is explained by either them taking forms of medication which either as their main purpose, or as a side

effect, induce sleep, or that disrupted sleep patterns for some have become such a part of everyday experience, they do not warrant mention.

From my experience of working at MIND, for many individuals with a diagnosis of a mental illness, patterns of sleep have a considerable impact on their lives. It is common practice to avoid organising appointments or events in the morning because, whether as a direct result of their diagnosed condition, or of the medication they are taking, many individuals find it difficult to wake and function in the mornings. Sleep then, is an integral part of embodied experience, which may be disrupted by the onset of emotional distress, or by the drugs prescribed for its treatment, changes in the pattern of sleep may be used for the diagnosis of some types of distress, principally depression, and such disruptions inevitably contribute to levels of distress in some individuals. Styron's experiences reflect some of these associations between sleep and distress. He tells how about two years before the onset of his depression he had been prescribed Ativan, a tranquilizer of the benzodiazepine family to help him sleep at night, and that he only found out later that such drugs are known to be 'capable of depressing mood and even precipitating a major depression' (1991: 49). Thus, for Styron, difficulties in sleeping and the treatment for this may have contributed to his depression. He also suggests that of all the symptoms of his distress,

most distressing of all the instinctual disruptions was that of sleep, along with a complete absence of dreams. Exhaustion combined with sleeplessness is a rare torture. (ibid: 48)

Not only was his night time sleep severely disrupted, his habit of taking an afternoon nap was also affected so that

to the injurious sleeplessness to which I had been afflicted each night was added the insult of this afternoon insomnia, diminutive by comparison but all the more horrendous because it struck during the hours of the most intense misery. It had become clear that I would never be granted even a few minutes' relief from my full-time exhaustion. (ibid: 18)

(iv) Searching for physical explanations for emotional distress

We can see then, that whether it be the direct symptoms of the distress, in the form of changed sleeping patterns, loss of voice, libido and appetite (Styron, 1991), changes in behaviour or the physical affects of alcohol abuse, or the affects of prescribed medications, the experience is almost always an embodied one. In addition to this, physical illnesses and disabilities may also in themselves lead to emotional distress, reminding us that the relationship between the mind and the body may take place in both directions (Real, 2003). Whilst for some individuals, the presence of physical problems are clearly identified as a cause of distress, others search for such problems as a means of explaining it. Darren told me how his anxiety and depression often results in low energy levels, but that he has searched for physical rather than psychological explanations for this:

I haven't been able to find what's wrong, well if there's like, physically, if there's also something I could do, that would, umm, alter my metabolism . . . on various occasions I've been to my GP, you get sent for the usual blood tests, fine, everything always come back fine, you know. Just recently I've been to the GP again, and had a larger battery of tests done, you know, really all the tests in the book, and they've all come back fine. [7]

Darren's search for physical explanations for his low energy levels has also extended to seeking the help of a nutritional therapist, though again with no success, leading him somewhat reluctantly to accept that

just getting anxious and getting scared, that uses energy. [7]

The physical manifestations of distress, and the desire to search for physical explanations are again described well by Styron, who tells how

I felt a kind of numbness, an enervation, but more particularly an odd fragility – as if my body had become frail, hypersensitive and somehow disjointed and clumsy, lacking normal coordination. And soon I was in the throes of a pervasive hypochondria. Nothing felt quite right with my corporeal self; there were twitches and pains, sometimes intermittent, often seemingly constant, that seemed to presage all sorts of dire infirmities. (1991, 43-44)

Styron goes on to point out that the links between melancholy and hypochondria go back as far as the seventeenth century, with the words often being used interchangeably. His explanation for this is that

this condition is part of the psyche's apparatus of defense: unwilling to accept its own gathering deterioration, the mind announces to its indwelling consciousness that it is the body with its perhaps correctable defects – not the precious and irreplaceable mind – that is going haywire. (ibid: 44)

The stigma which has for so long been attached to experiences labelled as mental illness might also contribute to this need to search for physical explanations. As we have seen, whilst some may take this route, others express their distress, or perhaps

transform it, through the abuse of alcohol or recreational drugs, or find ways of separating their mental being from their bodily and social experiences, often resulting in a diagnosis of psychosis. Others may seek to find spiritual meanings to their distress, and it to this aspect that I will now turn.

EMOTIONAL DISTRESS AND THE SPIRIT

One way in which the mind/body dualism has been challenged is through the concept of emotions, which are seen to incorporate mental and bodily experiences as a whole (Williams, 2001). Other writers have suggested that the spirit may also be a useful concept in integrating both the social, worldly experiences of individuals, and their inner psychic experiences, whereby ‘the human person is seen to be an inextricable continuum of body, mind and spirit’ (Swinton, 2001: 37). As discussed in the introduction to this chapter, in this context spirituality is wider than that of religiosity, but is more ‘a common human experience that forms an integral part of every person’s striving to make sense of the world and their life within it’ (ibid: 23). As we have seen in previous chapters, the emotional distress of many of the individuals who participated in this study may be seen as an inability to ‘make sense of the world and their life within it’, and their experiences of distress as a search for meaning, thus making the concepts of spirit and spirituality of particular relevance in this context. The psychiatric hospital in which I was a patient had within the building a chaplaincy, and a part-time chaplain to deal with religious needs of the patients, although it appeared to me to be little used. Indeed, none of the participants in this study expressed any interest in formal religion either in their past or present lives. Perhaps

the closest that any of the narrators came to such an interest, and perhaps the most surprising, was Nick, who as a self-declared Marxist may be expected to hold negative views of religion. He describes how during the period of his adolescence, when he spent most of time as a patient in a Birmingham psychiatric unit,

I started going to the local Catholic chapel in the grounds of the umm, hospital, and I think I had a, I started getting, very much liking the symbolism of Catholicism . . . and I got to know a priest called Lionel . . . and Lionel set up a group called Young Catholic Adults . . . and I used to go to this group, and at the end of this group Lionel would take us all down, I forget the name of the pub . . . and he would buy us all pints of Guinness. I'd drink those and then Lionel would take me back to the hospital, and umm, they were quite good there, the Young Catholic Adults, they were very friendly to me. [5]

It is difficult to assess from this account, to what extent it was Nick's spiritual needs which were being met with this involvement with the Catholic Church, or if it was his social needs. The idea of a priest taking an intelligent, but clearly very emotionally disturbed adolescent, to a public house, buying him beer, and returning him to the psychiatric hospital, seems slightly shocking. But it does seem to highlight the more liberal attitudes which were generally held at this time, the early 1970s, a point illustrated by the fact that Nick also describes how several of the psychiatric nurses in the hospital also used to take him to the pub and buy him beer.

Though clearly not entirely about his spiritual needs, Nick's involvement with the Catholic Church during this period of his life, may be understood as part of his search for meanings in life, at a time when his life experiences would have been difficult to

give meaning to. In addition to attending the Young Catholic Group he also told me how

I used to go to St Chad's cathedral and I had long hair, my hair was down to here and I wore jeans and everything. I wasn't a Roman Catholic but I used to like going into the cathedral and seeing the statues and the candles and all the symbols, it struck me these symbols, it struck me that the symbols of Catholicism was far more profound than Protestantism . . . I used to like going there and talking to the priest. [5]

When one considers that Nick's childhood experiences had included abuse in the family home, a succession of care and psychiatric institutions in which he also experienced abuses of various sorts, and a rapidly changing world, in which many events impacted on his understanding of how the world is, it is not surprising that Nick's search for coherent meanings included religion. But this search for meaning also included alcohol (ab)use, various psychotropic drugs (including LSD), poetry and ultimately, what Nick describes as his retreat from this world into 'The Land of Dreamy Dreams'. In common with many others who experience psychosis in some form or other, religious themes are often dominant in these experiences. This was also the case for Nick, who told me

The voices I used to hear were quasi religious voices, and the last voices I heard were a year last Easter, and it was, it sounded like a horrible man, and this horrible man said 'St Peter is of the dark way'. [11]

The nurse to whom Nick told this described it as 'bizarre' and Nick agreed with him, though set in the context of his fascination in the psychology of Catholic symbolism, it is perhaps less so. Only one of the other narrators describes religious content to

their psychotic experiences, and that was Jim, who describe how on occasions he ‘had delusions about being Jesus, or something like that’ [5]. It is more difficult to explain this within the context of Jim’s life, as he makes no reference to religion playing a significant role in his life, and he also seems unable to understand where such a delusion comes from, as he added, ‘I wish I could get to the bottom of why you get these things’. [5] Although he does not discuss at all having any involvement in formal religion, Jim does acknowledge the existence of his spirit, as he describes how one of the effects of being locked in a police cell after being diagnosed for the first time as having bipolar affective disorder, was that ‘I think some of my spirit died that night’ [2], a claim that he repeats in respect of some his later experiences of being manhandled and restrained before being forcibly hospitalised.

Other narrators make passing reference to the spiritual aspect of dealing with their distress. Darren speaks at length about yoga and of how he took this up as way of dealing with both the physical and spiritual problems related to his depression and anxiety. He told me that

yoga is to do with, you know, it complements the sort of psychotherapy, and the self investigation, because I mean, a lot of yoga is about self study and . . . trying to bring together the disparate parts of your being, making whole what is fractured, you know.

[6]

Interestingly here, Darren is defining his distress as a fracturing of his whole being, and comparing the role of yoga and psychotherapy in repairing this fractured sense of self. The study of self which he says is an important element of yoga, is clearly a sort of spiritual quest for meaning, and later in the narrative, Darren told me that he

also tries to read what he describes as ‘the kind of spiritual stuff’ as a way of seeking what he calls ‘some sort of compassionate acceptance for yourself, you know, all the bits that you don’t like’ [9]. Although Darren has occasionally sought medical help for his distress, he has almost certainly devoted more time and energy in seeking spiritual help.

Matt gives no indication of any connection to a formal religion, though his narrative is sprinkled liberally with the word God, normally by way of blessing those he has hurt. But when describing how he now deals with emotional difficulties now that he is recovering from his alcohol addiction, he said

what I tend to do is come home, find a quiet corner and get on me knees and pray. Not that I’m a religious person, but I believe, I believe that Alcoholics Anonymous has given me something that I never had, which is a god of my understanding. I don’t know if you know anything about their programme, but that’s what they gave me, and it works. [5]

Thus Matt seems to be saying that the absence of a spiritual side to himself in the form of ‘a god of my understanding’, was at the root of his distress, and that having been provided with this through his attendance at Alcoholics Anonymous meetings, he is now better equipped to cope with those situations which may result in distress. This equates with the self study of Darren’s yoga, although for Darren as yet, it has not been as successful as Matt’s god.

The participant whose narrative is most concerned with the spirit and spirituality is Des, as he describes the whole of his journey into and through schizophrenia, through

spiritual understandings. He described how this journey began when he started to feel that the way we were living was damaging the earth

and because of my spiritual beliefs as well, sort of believing the earth is a living organism and things, and I believe the sort of spiritual statement of how we are living is quite depressive for our true living spirit, kind of thing. [1]

As we saw in Chapter 5, these spiritual beliefs resulted in Des leaving town, and all aspects of modern living, to live in the woods, smoking cannabis and fasting, because he says, he believed it had spiritual benefits. This combination of ways of living, though in line with his spiritual beliefs, Des now attributes to the onset of his psychotic experiences, including the hearing voices. These voices, possibly because of Des' strong spiritual beliefs, were interpreted by him as spiritual in nature. He says

I took it as a spiritual experience more than anything, and err, so I listened to it and took, and believed it all. [2]

This sense of the spiritual nature of the voices, combined with Des' strong spiritual beliefs heightened his distress, as the following quotation illustrates:

I was doing anything that the voices told me to, and they told me to do loads of horrible stuff, and err, it wasn't very good. And I was just following like, instructions . . . I believed it was a spiritual experience, I was sort of caught in a trap that way, that I respected the voices as something spiritual and divine, and something godly which they wasn't really, which I'm beginning to find out more and more . . . that they're not to be listened to and they're something definitely to combat and

break down and disintegrate and not to really take anything what they say with any real validity. [4-5]

Des describes himself as being 'caught in a cage of my previous beliefs', in that not only did these beliefs lead to him adopting patterns of behaviour which at the very least contributed to his psychosis, his very belief in spirituality gave greater weight to the voices which were part of this psychosis. Despite this, belief in the spiritual dimension to our experience continues to be an important element in Des' quest to understand his experiences. When discussing the various ways in which mental illnesses have been explained he told me

I did actually like very much Aidan Schinger's [a service user campaigner] perspective, calling it *spiritual conflict* because I believe calling it illness all the time is quite degrading, but when you call something spiritual conflict, I think it gives more, err, grace to the individual, to the sufferer, umm, and so that it what it is, it's like a spiritual conflict. [7]

He goes on to explain how this has the possibility of locating the problem in the world in which we live, rather than within the individual, thus he says, giving 'more empowerment to the individual' [7]. Des utilises this concept of spiritual conflict in the way in which he has coped with recent episodes of psychosis and voices, telling me how he is

just battling that my 'good' side stays strong enough not to let any of these 'bad' voices get the better of me. [8]

Thus, since his first experience of hearing voices, when he describes them as ‘something godly’, he has now learned to regard them as ‘bad voices’, and he is drawing on his ‘good side’ to fight the spiritual conflict within him,

Having in the previous section highlighted some of the ways in which individuals experience emotional distress as an embodied experience rather than an entirely psychological one, in this section I have focused on how some individuals draw on the notion of the spirit and spirituality to discover meanings in their experiences. This would seem to support the view that ‘more and more it is being recognised that human beings are *whole* persons whose physical, emotional, social and spiritual needs are inextricably interlinked’ (Swinton, 2001: 17-18). Potentially, this may have considerable significance in the lives of individuals who experience emotional distress, as they seek to find coherent meanings to their experiences, in the context of continuing uncertainty. This may be particularly so in view of the fact that the most powerful framework for providing such meanings comes in western societies from medicine, which locates the causes of the distress within the individual, and to a large extent ignores, or devalues explanations which draw on social, cultural and spiritual frameworks. Clearly, the acceptance of this broader understanding of the causes and experience of emotional distress (or spiritual conflict), has implications for the treatment and management of distress, a point I will return to in Chapter 9.

CONCLUDING COMMENTS

Whether or not we have been diagnosed with a 'mental illness', we are all aware of the physical aspects of various emotional states, whether it be sadness, anxiety or fear. It is not surprising then, that when these emotional states become extreme, to the extent that they lead to psychiatric intervention and diagnoses, that they are wholly embodied experiences, and as such threaten the very nature of the 'self'. Equally, considering the behavioural changes which occur during experiences which are diagnosed as psychotic, it is to be expected that these psychotic episodes are experienced physically and bodily, and not just psychically. Again, because psychiatric intervention, whether in the form of pharmaceuticals, ECT or, in the past, surgery, are all aimed at modifying the functions of the brain, and the messages it passes out to the body, these interventions would be expected to be experienced by individuals as bodily experiences. These were certainly my expectations when beginning the process of collecting narratives, such expectations being formed by my own experience of depression, and by my knowledge of other mental health service users. However, although accounts which include the embodied nature of emotional distress are contained in the narratives, and these are highlighted in the first section of this chapter, they are less prevalent than I would have expected. This may be a methodological issue, resulting from the question I asked of participants, which invited them to tell me their life stories in the context of their mental health experiences. Accordingly, the narratives contain details of the lives of the individuals, including many experiences which result from, or lead to emotional distress. Little emphasis is placed, in general, by the participants on how these feelings felt. Another possible explanation for the relative absence of embodied experiences, is that they are

so much an accepted part of their experiences, they do not require much elaboration. Linked with this is the fact that such is the overwhelming nature of emotional distress, the physical aspects of it seem relatively unimportant, and perhaps are hidden in the subconscious. I am aware of the fact that when asked to talk about my own experiences of depression, I give very little detail about physical aspects, though they are an integral part of the experience. Thus, I would argue that the relatively small number of references to the embodied nature of emotional distress contained in the narratives does not lead to a conclusion that they are absent, and that those narratives which do contain details of such experiences, give an insight into the physical nature of distress.

In an attempt to reflect the embodied nature of those experiences defined as 'mental illness', I chose the description 'emotional distress' as a preferable term. However, on reading through the narratives, it became clear that many of the individuals were interpreting their experiences in spiritual terms, thus enabling them in their search for meaning in their experiences, to incorporate social, physical/embodied and psychic elements to them. In earlier periods, when religion was a major force in society, a position which is perhaps held by medicine, religious connotations were frequently attributed to 'madness'. It is interesting then, that in these times when religion plays a lesser part in society, and though none of the participants discussed their religious beliefs, that spirituality should be so prominent in their narratives. Of particular interest is the concept employed by Aidan Schinger, and discussed by Des, of 'spiritual conflict', which would seem to have the advantage of avoiding many of the stigmatising effects of 'mental illness.' As all of the participants in this study were men, it is not possible to conjecture on how this focus on the spiritual elements of

emotional distress would have been reflected in the experiences of women, but in the following chapter, I will address the relationship between masculinity and emotional distress.

CHAPTER 8

EMOTIONAL DISTRESS, MASCULINITY AND RELATIONSHIPS

INTRODUCTION

In the preceding chapters, I have examined the narratives of the participants in this study from a variety of standpoints, in an attempt to show how they themselves interpret and understand their experiences of emotional distress. What has yet to be addressed however, is that all of the participants are men. No consideration has therefore been given to how their experiences have been shaped by their gendered identity, and how their masculinity has been affected by their experiences.

Though most of the studies on men's health are based on physical illness and accidental injury and death, there are clearly implications for the emotional health of men. As we shall see, several of the participants first experienced emotional distress in adolescence, and in this chapter I will examine their narratives from the perspective of how they now see their gendered identity in their adolescent past.

Another aspect of the construction of hegemonic masculinity in western societies is the constraint on men not to express emotion. In the context of emotional distress this may lead to many men internalising their emotions to the extent that they are no longer able to control them, at which point they may emerge in the form of violence, drug and alcohol abuse, or in patterns of thought and behaviour which become diagnosed as a mental illness. In addition, 'the requirement that men should be independent, strong, self-reliant and emotionally restrained make it particularly difficult for men to seek psychological services' (Lee and Owens, 2002: 15), thereby

leading to a situation in which the intervention by others becomes necessary once the distress reaches a severe level. The other side to this, of course, is that the experience of emotional distress, and of becoming a mental health service user, may in themselves threaten masculinity, and this will also be explored in this chapter.

In Connell's (1987) concept of hegemonic masculinity and the gender order, there are three structures which serve to maintain men's dominance over women, and these are labour, power and cathexis. In order to explore these themes further in this chapter, I will examine the ways in which the narratives reveal how these men understand and explain their masculine identities in the context of their emotional distress. I will then go on to highlight how many of the contributors spent a considerable amount of time talking about their fathers and mothers, and the relationship between them. Finally, I will move on to examine the aspects of the narratives which are concerned with 'cathexis', including 'sexuality, desire, marriage and other intimate and personal relationships' (Pilcher, 1998: 9).

MASCULINITY AND EMOTIONAL DISTRESS

In this section I will highlight three aspects integral to masculine identity formation: childhood and adolescent experiences in the development of a gendered identity, societal disapproval of emotional expression for men, and the experience of paid work.

(i) Childhood, adolescence and masculinity

Of the eight men who participated in this research, six identified some aspect of their childhood or adolescence which they regarded as contributing to their experiences of emotional distress. In relation to masculinity this is perhaps significant, as it is in this period that a gendered identity is formed, through the process of socialisation, in the family, through the media, and within the setting of the school. For some of these men, childhood was not so much traumatic in the sense of containing what would generally be regarded as life changing events, but they express feelings of not fitting in. Thus, John described how

I didn't have a very happy childhood, I didn't enjoy school . . . I was quite a loner at school . . . I wasn't bullied at school but I felt a bit excluded in some ways, and I felt very lonely. [2]

Similarly, Colin talked of being

only child, umm, very much a loner, an individual, that sort of thing. [1]

Darren also described himself in his childhood as

I didn't have many friends at all, I was the kind of kid who would stay in and not play out, very conscientious about doing my homework. [1]

So it can be seen that all three, during that time of life when identities are being formed, and in particular, gendered identities, experienced feelings of exclusion and isolation. Within the framework of Connell's gender order, they could be said to fall

into the category of subordinated masculinity (1987), and perhaps more generally as 'failed masculinity'. Their narratives reveal how this isolation in childhood continued to impact in adulthood, with John continuing to live a lonely life eventually leading to him experiencing psychoses, and Colin leading an unsettled life in which he says

basically I'd never, what with the nuclear thing early on, and riding motor bikes, I never expected to live past 40 anyway, so I had a pretty cavalier attitude to life. [3]

This can be interpreted as a risk taking attitude to life as he strives to present a hegemonic masculine identity in the face of uncertainty. One of the men Colin often talks about is Ernest Hemingway, a hyper-masculine man if ever there was one, and it is significant that Colin for a short while lived in a cabin in the woods in USA, wrote a novel whilst drinking a bottle of whisky a day, and after a whirlwind romance got married. It was during this time that he came close to the masculine identity that he had been striving for, and when it was lost after the divorce, Colin's life collapsed into the depression which has plagued him for the past 10 years. Darren describes himself as 'quite a fearful man really', and has spent most of his adult life in the grips of anxiety and depression, which are traits not associated with successful masculinity.

Nick described how he was physically abused at home, and suffered name-calling at school. He tells how

I liked it at school, I used to stay at school as a way to escape from my family, but some of the kids at school, not all of them, but some of them started calling me Nutty Nick, Nutty Nick, and umm . . . I'd gone to the land of Dreamy Dreams, then they started calling me that, I was living in a world of books. [10]

The reaction of some of the schoolchildren may be seen as punishment for his failure to present an acceptable masculine identity, a love of poetry and books and living in your own world are not part of the make up of hegemonic masculinity, and the abuse at home would further undermine masculine identity formation. As if abuse at home and verbal bullying at school were not enough, Nick was also abused sexually and physically in the various care settings he was placed in during his adolescence¹. He tells how

I seem to attract these abusive men. I was abused at [name] Assessment Centre by a male care worker, umm one of my social workers at [name] tried to touch me . . . then this nurse abused me twice at, once he tried to abuse me at sectioning . . . and the man who tried to abuse me in the bath . . . a few weeks later he made these advances and I was getting better, and I was sitting in one of the common rooms in [place] I had long hair, I was a hippy, and umm, he came in and he said 'I'll show you what aggression is Nick', and he had my hair because it was long , and he pulled me off the bench, he was pulling me across the floor by my hair, and I was trying to keep up with the pulling of my hair. It was horrible. [14]

In another incident which took place when he was 13, he describes how he was in a catatonic depression and so needed assistance to take a bath, and a male care worker took him to the bathroom and

He'd put this bleach, these big containers of bleach in the bath, and some water, not a great deal of water, he'd undressed me . . . he'd said 'All people who use drugs are dirty', and he put me in the bath, and he'd taken me out of the bath, and it burnt all round my genitals, the bleach. It really hurt, and umm, it was horrible. And I was

¹ See footnote on the ethical considerations of these events on page 148.

scared, I didn't tell my house mother, I certainly wouldn't have told my real parents.

[15]

To have been subjected to abuse at home, to be called names at school, and then to have been sexually and physically abused whilst in care, clearly would not have allowed Nick to have developed a secure sense of identity, and certainly not a masculine identity which conferred power and authority. The fact that all of his abusers were male, could also have contributed to difficulties in forming an acceptable masculine identity, and as we have seen, led to Nick retreating into his poetry and an inner world which he created for himself.

Pete's childhood also included an incident in which he was sexually abused as a young child, and was also subjected to name calling and teasing at school. This was mainly focused on his small stature due to medical problems, thus highlighting the importance of the body in the construction of masculinity, and again we can see how Pete was forced to seek an alternative masculine identity to the hegemonic version in order to cope. He told me how

I used to get teased a lot about my height, just sort of coping, I used to get, we got into computers . . . it was just a way of fitting in with things, I was just helping people type stuff up . . . by making myself be useful to other people, it kind of meant I was left alone, in a way, you know, and it also gave me places to, you know, more or less hide, you know, during the lunch breaks, cos I could go into the computer room. [5]

Pete then, creates a space for himself to avoid being teased about his failure to present an acceptable version of masculine identity, though as we have seen, this failed to

prevent him suffering severe depression and making several attempts at taking his own life. The confusion he experienced at this time about his sexuality is clearly associated in complex ways with the difficulties he faced with regard to his masculinity. The childhood experiences of Nick and Pete in particular, illustrate the dilemma faced by many adolescent males. Strive to adopt a hegemonic masculine identity, which itself has been shown to be potentially harmful for one's health, or seek alternative masculine identities and risk isolation and approbation from other adolescent males, which also can be health endangering, particularly in respect of emotional health.

Matt also faced difficulties in childhood, mainly around the guilt he felt at the part he played in his father's death. But unlike Pete and Nick, Matt responds to his distress in ways which can be interpreted as conforming to, rather than escaping from, hegemonic masculinity. Thus he told me how

I look back now, and I know I was a bit of a bully, I was bullied, and as they say, you know, you bully, once bullied, then you become a bully. I asked my sister how I was when I was a kid and she said I used to beat her up. That was quite shocking really, I expected her to tell me how much I loved her and stuff. [1]

Later in his story, Matt admits that he also sexually abused his sister during his adolescence², and that

² Once again this raises ethical difficulties. In view of the many years that have passed and the guarantee of anonymity provided to the participants, I felt it inappropriate to take matters further. This however, should not be taken as evidence that I condone or excuse these behaviours, and emotional distress is no excuse for such actions.

I left home quite early, I wanted to get laid, I wanted to stick dirty pictures on the wall, you know, and I wanted to stay out late. I didn't get to stick dirty pictures on the wall, but I certainly got laid, I thought it was great. [7]

His response to the distress he felt was to seek power and authority through violence, particularly toward women, and to display overt heterosexuality in ways which can be construed as exaggerated versions of constructions of hegemonic masculinity. His (ab)use of alcohol can also be interpreted as a particularly masculine way of dealing with his emotional distress, and as we have seen, Matt explains later episodes of violence toward his wife and others, as being a result of his drinking.

(ii) Emotional expression and masculinity

One of the things that boys learn on their journey toward manhood, is that society expects that they refrain from expressing emotion in many areas of their lives, as suggested by the well known phrase 'big boys don't cry'. I became especially aware of this in the period following my period in a psychiatric hospital, when I was seeing a counsellor once a week. She was constantly pointing out to me that though I was articulate in describing events in my life which had impacted upon me emotionally, and that I was always prepared to seek explanations for my experiences by intellectualising them, what I never did was to allow my emotions to come to the surface, or even quite often, to express how particular experiences *felt* to me. It is clear in reading through the transcripts of the narratives collected for this study that though they contain many details of emotional experiences, they rarely go into detail as to how those experiences actually felt. Clearly this may be as a result of methodological issues concerning the question asked of them, but focusing on events

rather than on feelings is a masculine response to being asked for a life history, even in the context of emotional distress. A few of the participants showed some awareness of this. Jim for instance, told me that what he wanted from the counselling he was currently receiving was to discuss things that had happened and

say well, you know, there are such concrete reasons why these, why these things happen, and also you can put things in place and do something about them, you know. [10]

This rationalisation and instrumental approach to difficulties, even emotional ones, seems to be a highly masculine approach.

Darren recognised the difficulties he has in expressing his feelings, and suggests that this is as a result of patterns learned during childhood, particularly from his father. He told me how he often finds himself

having difficulty expressing myself, expressing what I want to say, expressing my feelings, and feeling it's ok to express my feelings, because often I think I can't just express my feelings because frankly, if I could express my feelings I would tell everybody to 'fuck off', you know, so, because that is sometimes how I feel. [6]

This inability to express feelings is clearly not due to any lack of vocabulary, as Darren is an extremely articulate man, and it is therefore more to do with him not 'feeling it's ok to express my feelings'. This prohibition on emotional expression by men is what Real (1997) claims is responsible for many men experiencing either covert or overt depression.

The participant who talked most about his emotions and his emotional states was Matt. He describes himself as an emotional man, someone who has difficulties in controlling his emotions, and also recognises the problems that sometimes causes. He describes the circumstances of his father's death, and says

I suppose emotionally, when I lost it emotionally, when I say I lost it emotionally what I mean is, when I had no control over my emotions, was when my father died, he died when I was 12. [1]

Matt saying that he had no control over his emotions is clearly how he felt, and is perfectly understandable in the light of the sudden death of his father when he was only 12, and especially given the circumstances of his death. However, he did in a way control his emotions because for whatever reason, Matt was not able to express his emotions verbally, as it was to be another 25 years before he was able to discuss with anybody, the guilt he felt concerning the part he played in the death of his father. Thus, the lack of control over his emotions of which he speaks, would appear to mean that he was able to express his emotions through the recognised masculine forms of violence and sexual abuse, but not in more feminised forms of verbal or emotional expression of his feelings. As an adult, he describes how he often does react in an emotional way to situations in his life:

if I get upset, or somebody says something to upset me, and I kind of confront them, like I was to talk, they say I'm being over sensitive, you know . . . I just sob all the way through it, and what happens is people get confused because I react then I sob. A man ain't supposed to show his emotions. I can't help but show my emotions, I'm emotional, I've got to fucking show them. I never wanted them, please take them away, I don't wannum. [7]

The implication by Matt is that the problem is not with the way he responds emotionally to situations, but the way in which others respond to his emotional expression. This response is, in part, because he is a man, and he later went on to say

I'm forever apologising when I haven't done anything wrong, I'm fed up of being guilty if that makes sense. I was saying earlier, talking about a man ain't supposed to cry, I can't help crying, you know. That's all right Matt, get in touch with your feminine side. Fuck the feminine side, I'm a male, you know. [8]

Here, Matt is clearly expressing his frustration at the societal prohibition on men showing their emotions. As we have seen, the main way in which Matt sought to cope with his emotions was through the use of alcohol, a common male strategy. However, he told me when talking about his emotional states

You know, I used to do self harm, where I used to cut the badness out, you know. My body's a mess, you know, but I don't do that, I haven't done that for a long, long time. [7]

Unlike alcohol abuse, self harm has generally been regarded as a female response to distress, relating to their perceived lack of control over their lives. If we interpret Matt's inability to control his emotional responses as a feminine characteristic, then self harming can be seen as a coherent response. This mutilating of the body is also another clear demonstration of the physical, embodied experience of emotional distress.

(iii) Masculinity and paid work

Perhaps traditionally in western societies, the single most important source of masculine identity and power, has been through paid work. It is then, perhaps significant that only one of the participants was in full-time work at the time of the interviews, and that was Darren. But far from experiencing work as a positive contributor to his sense of self, he frequently describes his jobs as sources of difficulty in his life. He speaks of only taking jobs which do not stretch his ability, and says

I'm sure many of the jobs I've done, I've used them to just kind of deaden myself really. [3]

Although Darren continues to work despite his often negative attitude toward it, others told me that they were unable to do so. Matt explained

I can't work, my head won't allow it one hundred per cent , you know, paid work, I mean. I find that very hard to explain to people, because the man should be the breadwinner and, but I can't. [9]

This is a good example of the impact that Matt's distress has had on his masculine identity. However, at no stage during his narrative does he speak of a time when he has carried out paid work, thus bringing into question the precise nature of the relationship between his emotional distress, paid work and his masculinity. Colin, on the other hand, makes frequent references to the various jobs he has done, whether it is to describe the unpleasantness or tediousness of them, or the excitement and danger

of working as a motor cycle test rider, both of which serve to confirm his conformity to the ethos of being a wage earner, however difficult the circumstances. However, in the ten years that I have known Colin since the onset of his severe depression, he has never suggested that he is willing or able to take on paid employment, and now that he is in his sixties it seems that he is unlikely to do so.

Jim spent several years in full-time paid work after leaving university, working for the same company, firstly in Nottingham, and then in York. He talks of the various interactions between the stresses of several changes of location of his job, successfully dealing with these, but still having an episode in which his mental health condition deteriorated to the extent that he spent several weeks in a psychiatric hospital. Jim describes the sequence of events which took place around this time:

They'd moved us all in the April, across from York to Crewe, I was sick two weeks later, and then back to work two months later. Six months later in the following January, 'sorry, you're redundant'. I mean, I think some people might have said, might have tried to pursue that and said, 'well, are you sure you're not making me redundant because of my illness'. I, I don't know, I had a negative, I always have quite a negative opinion of myself, and particularly the work I was doing there, I wasn't really getting on with it as I'd hoped. [7]

There are two related issues which emerge from this section of Jim's story. First, it seems that Jim did not develop a positive sense of identity from the work he was doing, but rather it appears to have reinforced negative views of himself, contrary to the notion that paid work is a source of power and authority for men. Second, it highlights the subtle ways in which stigma can operate in the field of mental illness. Jim is uncertain whether he was chosen for redundancy because of the two months he

had spent away from work because of his 'illness', and was therefore discriminated against, or if it was merely because he was 'below average at that work anyway' [7]. Either way, the experience could only serve to increase his negative opinion of himself. At the time of our meeting, Jim had not worked for two years, and describes himself during this period as 'really depressed, not living to my potential, not working, drifting, muddling along' [10], thereby further reinforcing negative opinions of himself. He expresses doubts about his ability to ever return to full-time work, saying

I mean, there's no reason why I couldn't do a full-time job, it's all psychological, do you know what I mean, it's errm, but it's been such a long time now since I did a full-time job . . . I could do part-time, but then I don't get the independence back because I'd never be able to afford . . . [11]

This highlights that it is through paid full-time work that independence is achieved, and when this is not available, in Jim's case, mainly as a result of his experiences of emotional distress, another important component of masculine identity is lost.

John also describes how work contributed to his distress, and how the distress he has experienced has negatively affected his ability to work. He told me

when . . . I became self-employed I . . . the social contact went, the day to day social contact with other people disappeared and I became too introverted. I suppose it's true, I was feeling down and depressed at times . . . I think that probably led to me being, having bouts of depression, and eventually led to the psychosis . . . I can't see myself working full-time again, I think I've lost the drive to become, err . . . well to work full-time and to have that drive and energy to sustain a full-time job. [6-7]

It is unclear whether John believes that the loss of drive and energy is as a direct consequence of experiencing emotional distress in the form of psychosis, or is the result of the medication he takes for schizophrenia.

Thus, it can be seen that the importance that has been placed on paid work in the construction of masculine identity may result in emotional distress where such work is not available, or where it fails to produce such an identity, and equally the experience of emotional distress may lead to an inability to do full-time work, and thus deny men access to this source of masculinity. I will now move on to examine another important source of masculine identity formation, that of the family, and in particular, relationships with parents.

PARENTAL RELATIONSHIPS

When I began the collection of the narratives which form the main source of data for this study, having asked for an account of their life history in the context of their experiences of emotional distress, I anticipated that for many of the men, childhood and adolescence experiences would be an important element of those stories. However, I did not anticipate the degree to which they would include detailed and often very long accounts of their relationships with their fathers and/or mothers. The only man who did not do this was John, who has lived with his parents since the onset of his psychosis, and though he told me his parents were in some way a part of his psychotic experiences, he told me nothing about his relationship with them, either

during his childhood or as an adult, other than to describe them as supportive during his problems.

(i) Absent or abusing fathers

Des talked of his relationship with his mother since the onset of his psychotic episodes, describing her as 'very supportive' even though she 'suffered a lot' as a result of his psychosis. He only briefly talked about his childhood, but did tell me

my mum and dad separated when I was nine, and that probably had quite a lot of pressure on me. I didn't really see him afterwards, only very rarely since I was nine really, which is a shame as well, because I would have loved to have more of a father figure, because I've lived, my brother went in the army when I was, when I was about ten, so I've lived with my two sisters and my mum since I was, since early teenager . . . I mean I've benefited a lot probably in a feministic (sic) way, being with my mum, but when it comes to probably masculine influence . . . he was a good dad when I had him, but there were difficulties between him and my mum when they separated . . . I'm not sure of the complications, but I didn't see my dad much. [11]

Thus, although Des makes no suggestion that his experiences of emotional distress are in any way related to the absence of a father figure during his adolescent years, he does suggest that the lack of 'masculine influence' did impact on his development. This would seem to contradict Real's assertion that 'the boys who fare poorly in their psychological adjustment are not those without fathers, but those with abusive or neglectful fathers' (2003: 141).

Nick does speak of being abused by his father when he was a child, and he does connect this to the distress he experienced as an adolescent, which in turn led to an adulthood spent almost entirely as a mental health service user. Though I had asked all the men in the study to tell me their life story, Nick elected to speak at some length about his father's life. He started his account by saying

My parents weren't bad people, they weren't bad people at all. Dad had had pretty awful experiences, he came from a dysfunctional family, he told me this when he was elderly. I wish he'd told me when he was a younger man, and umm, dad told me when he was elderly, he'd been diagnosed paranoid schizophrenic in his early twenties, and he told me how his family collapsed and how he'd been sleeping rough on the embankment in London. [7]

He then went on to relate in great detail his father's wartime experiences, all of which had only been told to him when his father was an old man, and his father's experiences were certainly extremely traumatic. Nick finishes his long detailed narrative of his father's experiences by saying

And you know, when you put it all in all, dad's experiences, you know, I'm not really surprised that the man was a bit unusual. [10]

What Nick's account of his father's experiences suggests is that traumatic events not only affect those involved directly, but are also transmitted through the generations. Although Nick does not explicitly suggest that his father's experiences were responsible for his own emotional distress, it is clearly implied by his choosing to include those experiences in such detail in his own narrative. It also seems clear that

the pressure on men not to express their emotions or to speak of their emotional experiences, would have prevented Nick's father from telling his son of these events earlier in his life. We can only surmise what effect this knowledge would have had on Nick's development as an adolescent, and whether his life would have turned out differently. It is clear though that Nick grew up with an image of what it is to be male through the example of a father who was abusive and 'a bit unusual', an image which was to be confirmed by the abuse he suffered in various institutional settings.

(ii) Domineering mothers

None of the other participators went into quite the same detail as Nick about the experiences of their parents, but several did raise the issue of their relationship with one or other parent. We have already seen how Jim's relationship with his mother was complicated by her own diagnosis of bipolar affective disorder, leading to her being hospitalised and away from the family for several weeks at a time. Interestingly, Jim relates his mother's experiences of distress to her own childhood, and to the fact that her own mother was

a very domineering person, controlling person . . . and I mean this might be a bit personal to her, but it affects me too, because throughout my whole life I've had, I've had one parent, my father, who was a very umm, disciplinarian type person, who I was quite in fear of, so I had a bit of a umm, in the relationship it was not that close, and then in my mother . . . although she was a very loving person, there have been times when I've, maybe every three years or so when I was growing up, when she was taken away from me, and you feel more on your own, and it's a different way of growing up really. [1]

Jim's father died when Jim was only 15, and his mother became 'ill again', leaving him, he says as the 'oldest, sort of, compos mentis person in the family at that stage' [1]. Thus once again, Jim traces the roots of his own distress back through the generations. He also clearly links his own emotional distress to the lack of an emotional relationship with his father, a relationship which may be interpreted as conforming to hegemonic masculine ideals.

Darren spoke about the relationship between his mother and father and the ways in which that has affected his own sense of self. He describes his mother as

over protective and a lot of rather, kind of smothering love from my mother and with that, my impression was that she always wanted a lot of love back from me, and that, and I think this has something that has definitely stayed with over the years, umm, that somehow I can never quite give enough love to her. Somehow she always wanted more, err, and I think this went on . . . beyond childhood, into teenage years and beyond that. [1]

He highlights the affect that this has had on his life, when he told me how he spent a period in his thirties living in a town in the north west, and he describes his time there as

very, very good, I really loved the place, liked the town, I liked the countryside, I liked being near the sea, and think that, I think that is something that is important to me, that being in the right sort of environment, I think that's quite nourishing. [4]

Despite these positive comments about his time there, he says there were also 'long chunks of time when I was quite depressed' [4], and that eventually he left there

to come back here, really because . . . really because of my mother. I'll blame everything on my mother, not because they asked me to come back or . . . but I knew that they would like that and there's a sort of a, I think I've done this thing which, you know, moving away from my mother, moving back towards her, back, away, it's just kind of like just flipping, flopping backwards and forwards. It's another way of trying to please her, I think . . . yeah, I don't know, just kind of make up for the fact that somehow I didn't give her enough love before, you know . . . just classic . . . [4]

The Freudian implications of this are clearly not lost on Darren, and a large part of his negativity toward himself can be understood as some sort of frustration at what he sees as his failure to break away from his mother's influence, and develop a masculine identity. This, as we have seen, has affected his employment history, and as we shall see later in this chapter, has had a profound affect on his romantic life, both of which have further undermined his masculine identity.

Darren's failure to break away from his mother's influence is also entwined with his relationship with his father. He recognises that although he understood his mother more than he did his father, the particular form of masculinity that he has developed has largely been inherited from his father, of whom he says

my dad as a role model, I guess, was a sort of rather . . . someone who controls his feelings and I've definitely, I'm definitely like that myself, so I think I learnt that from him. I'm quite a fearful man really, err . . . I tend to identify with my mother and sympathise with her, particularly when my mum and dad had rows, which they did, usually frequently, umm. I didn't see my dad's point of view at all, partly because he couldn't express it, he just got frustrated and angry . . . so I ended up resenting my dad, in my teenage, later teenage years, even younger than that. I was quite disrespectful to him at times, and it's only later on that I've kind of realised that,

that he found it difficult to express himself and was scared and so on. And in his later years, a few years before he died, I did get to know him a bit better. [1]

In gender terms then, Darren found that he identified more with his mother than his father when he was young, and resented his father because of his inability to express his emotions other than through frustration and anger, but acknowledges that despite this resentment, he has himself adopted these typically masculine traits. He has also come to recognise that his father's inability to express himself emotionally, concealed the same fear and anxiety that he is aware of in himself. Thus it could be said that society's pressure on men not to reveal the fear and anxiety they feel, means that other men, and their male children, grow up believing that their own fears and anxieties are a threat to their masculine identity, thereby potentially leading to either overt or covert depression (Real, 2003), or other forms of distress.

Matt also describes having a strong attachment to his mother and related several incidents when even brief separations from her caused him pain as a child. He told me

I was very attached to mum, I didn't want to leave my mum, you know, I think that's why I screamed a lot, and shouted a lot. I remember school, first day at school was err, in the finish my sister had to stay with me, err so that's how I started out life really, err . . . I always felt different. [1]

This feeling of being different could be interpreted as the unwillingness to break the attachment with his mother, whilst the societal pressures to do so lead to fear and anxiety about his being able to conform to these pressures. For some men this may result in high states of anxiety throughout life, whilst others deal with this by over

compensation, by becoming or performing exaggerated forms of masculinity, and either of these directions have the potential to lead to emotional distress. As we have seen, in many ways Matt took the hyper-masculinity route, using alcohol drugs and violence to mask his distress. Matt's situation though, became more complex because, as we have seen, he grew up believing he had played a part in his father's death. This situation became more difficult when his mother remarried soon after his father died, mainly, as Matt now recognises, for reasons of financial security. Matt clearly found this difficult, in part because of his strong attachment to his mother, but also because

my mother married again when I was 14, she married a bloke . . . she was 44 and he was 24, and I was . . . 14, so I'd got friends his age from my brother, you know, and obviously he wasn't going to replace my dad, nobody could. [2]

Matt dealt with this situation by giving both of them 'a fucking hard time' [2], including

when I had a few too many drinks, I'd come home at 12 o'clock at night and sit on the end of the bed and tell him what a prat he was, you know, I was a right bastard. [7]

He only became reconciled with his mother and step-father thirty years later when his mother died, a reconciliation which has played an important part in his recovery.

This confused set of family relationships has been repeated with Matt's own son. Matt was vague about the precise stage of his life when his son was born, but for some reason his son was not made aware that Matt was his father, as he told me

He didn't know I was his dad, and I'm still seeing him. Err, I was his mate, I was his mate up till 15. . . He just thinks I've disowned him, I don't know. I can't, I have met him on a few occasions and we've spoke, but we haven't spoke about anything deep, you know. . . It's like father like son, you know . . . It's such a shame because he's got, he went through the drink, the drugs and everything else and I used to counsel him through his mum, if you know, through his grandma, not counsel him, but you know, like it was such a shame that we couldn't get together because we had so much in common. [6]

Thus, even though Matt did not raise his son, and had minimum contact with him, his son appears to show remarkably similar behaviour to his father, or perhaps found similar masculine responses to life's stresses, a fact that Matt seems to find simultaneously distressing and reassuring. The fact that his own alcoholism was in some ways to blame for him not being able to bring up his son, is seen by Matt as a loss of a masculine role in his life, as he told me

I'm a male, you know. I haven't been able to protect my own, but I would, I know that. I just protect him from afar, you know, I see him from a distance, he don't know. [8]

Matt seems here to be reasserting his masculinity by saying that although it may appear that his distress has prevented him performing his masculine duties, in his own mind he has found ways of keeping his masculine identity intact.

(iii) Relationships between parents

Over the years that I have known Colin, he has often talked about his father, always in affectionate terms, and has on several occasions related how he was with his father when he died. During the interview that I recorded he told me that his

parents had taken in a lodger, while I was still . . . I was only about 17. My dad built his own house, and my parents had taken this lodger in, err you know, it was to do with my lodger, I don't know what the relationship was, but she'd umm, they'd just, she just sprung this lodger on me, you know, I never got on with the chap, you know, that's probably why I buggered off all over the place. [4]

When they were older his parents sold the house, and bought two retirement homes, one for themselves and one for the lodger, and Colin told me

they gave me just less than half the house sold for . . . me mother forced the sale on me dad. Just before he died, he said he shouldn't have sold it [*he sounds very emotional at this point in his narrative*], err anyway, so I had no reason to come back here cause me father was dead, me mother was living with this lodger, you know. [4]

It was at this time that Colin met the woman he was to marry within a few days of meeting her, and he implies that having 'no reason to come back here' may have contributed to that decision. What is clear is that Colin finds the treatment of his father by his mother in relation to the lodger and the sale of the house, very distressing. His mother's apparent dominance over his father is in contradiction to expected gender relations, and clearly can be seen to threaten the masculinity of his father, and this process was to be repeated in Colin's own relationship with his wife

during the break up of their marriage, leading to the severe episode of depression from which he has never really recovered.

In a similar way to Colin, the family dynamics can be seen to have particular relevance to Pete's experiences of emotional distress. The relationship between his parents appears to have been a significant factor for Pete, and he recalled very clearly how when he returned home from hospital after his first suicide attempt

my parents argue so much, and it used to be really quite stressful. I can remember coming home the first . . . from the hospital the first time and my parents arguing all night and I was just sitting in my room, just sitting in the corner looking. [4]

Hearing parents argue can be upsetting for children at any time, but at this particularly sensitive time for Pete it must have been especially so, particularly as he would have been aware that the arguments would in all likelihood have been about him. Pete seems particularly concerned how family life impacted on his two brothers, because immediately after the description of his parents' argument he went into a discussion about the differences between them. He returned to the matter later in the narrative, telling me that

I think the home life did affect both of them, definitely my middle brother to a greater extent. [5]

He continued from here with a fairly lengthy description of what his two brothers had made of their lives, and how they were affected differently by emotional issues. In part, Pete's concern is partly, it would seem, about how his suicide attempts might

have impacted on his brothers. But there would also seem to be an element of trying to understand how the differences between them, might have resulted in them coping differently with many of the same stresses experienced by himself. An important element of these differences would be about masculinity, and how all three of them have developed different masculine styles, particularly in view of Pete's confusion during his adolescence about his sexuality.

Pete told me how he had developed an interest in gender issues in recent times, and this may have been fuelled in part by the contrast between his mother and father in the way that they dealt with emotions, and the fact that in many ways this reversed traditional gender constructions. Of his mother he says that when he first began experiencing depression, he was aware that

my mum especially just wouldn't have understood what I was going through and that would have been one extra stress on everything. [1]

The apparent inability of his mother to recognise the distress Pete was experiencing was confirmed after his first suicide attempt:

I gave them [the hospital] my mum's phone number at her work, and I can remember well, she told me this after, quite a while afterwards, she told them that, you know, she was absolutely certain that they'd got the wrong number, that it wasn't me, you know . . . It probably wasn't the very first thing that she did, but it sticks out in my mind, that as soon as she saw me, she said 'you know this will be on your medical records'. [2]

The lack of awareness of her son's emotional state, and the focus on the practical consequences, rather than on his emotional needs, could perhaps be understood as masculine rather than feminine responses in the way that gender is ordinarily constructed in western societies. Pete returns to his mother's lack of emotional expression later in the narrative, and also reveals that despite the somewhat clinical reaction to his distress shown in the previous extract, it did invoke an emotional response in her:

My mum never thinks that there's anything wrong with her though. My mum has this really, my mum comes from the north of Shropshire, she's from a really rural background, and her parents . . . are these insanely stoic people, you know, and my mum's a lot like that. I've hardly ever seen her cry, the first time I can remember seeing her cry was when she came in and saw me . . . when I tried to kill myself for the first time, and she was crying then. [6]

His mother crying is clearly such an out of character event that Pete recognises it as such even through his own distress. This extract also highlights once again how the construction of our sense of selves does not just occur in our own lifetime, but can be traced back through previous generations. Thus Pete's search for an acceptable masculine identity in the face of childhood abuse and a confused sexual orientation are strongly associated with his experience of emotional distress, but these things are also mediated by his mother's difficulties of emotional expression, which in turn relate back to her family upbringing.

If it is from their fathers that boys learn how to be men, then again Pete's experience has been far from straightforward. He told me how his father had been badly affected

by one of his friends killing himself by jumping of a bridge into the river in their home town, and round about the time of the onset of Pete's depression, his father had threatened to do the same, because of work related stresses. Pete told me that though his father was a little more understanding than his mother about his suicide attempt, his own frailties caused problems for Pete:

I think my dad was already, was getting quite stressed out with his work as well, and when things were going wrong with me, he umm, he got into quite a state. It was like, I've got all these problems and I've got to try to be strong for my dad, and help him, and he went on to anti-depressants as well. [2]

Thus, Pete's father's emotional state may be seen as both a role model for Pete's development of a masculine identity, and as something which places further pressure on Pete to cope effectively with his distress. Pete's expressed need for a more conventional father figure is revealed later in his narrative, as he told me

my dad tries to be, he, I think he's pretty lonely as well, and he tries to be more like a friend, you know, even then though, always offering us money and stuff, you know. I don't know, it would be nice if he was just [sigh of exasperation] more like a dad, you know. [6]

Pete's experience of his father's non hegemonic masculinity, and his apparent yearning for a more conventional father figure, are interesting points in view of his experiences of emotional distress as an adolescent, and it is a moot point whether Pete's emotional stability would have been enhanced had he learned his mother's response to emotional issues.

MASCULINITY, INTIMACY AND ROMANTIC ATTACHMENTS

As mentioned in the introduction to this chapter, at the time I collected the narratives from the eight participants in this study, none of them were in intimate relationships. As ‘cathexis’ is one of the structures identified by Connell (1987) which is crucial in maintaining the gender order, this absence of intimate relationships in the lives of the participants can be expected to have a significant effect on their masculinity. In this section I will focus on the accounts given by the participants of their intimate relationships, or absence of such relationships, and the ways in which they relate these to their experiences of emotional distress

Two of the men interviewed, Jim and Des, made no mention at all of intimate relationships, so it is not possible to surmise whether or not they have had such relationships in the past, or what their views are on the matter. Both were currently living with their mothers. Another man, Nick, lives in a flat on his own now, but during the whole of his adult life he has lived either in institutional settings, mainly psychiatric hospitals or group homes. During the course of his narrative, Nick occasionally mentions young women who he had encountered in these settings, and describes himself as being ‘quite fond’ of a couple of them, although he gives no indication of having had an intimate relationship with anyone. John, on the other hand, cites not having an intimate relationship as a contributory factor in his emotional distress, telling me

I suppose what might have helped cause the psychosis was not having a girlfriend.

Err, I think, you see, I haven’t had a girlfriend, a proper steady relationship with a

girlfriend in my life . . . I think part of me was a bit emotionally taunted by that fact, and I think that's probably what led to part of the psychosis. [4-5]

John's description of himself being emotionally taunted by not having a girlfriend reveals both the psychological importance of relationships, and the societal pressures to do so. In gender terms, it confirms Connell's (1987) argument that hegemonic masculinity requires heterosexuality as a fundamental aspect, and that failure to demonstrate heterosexuality through intimate male-female relationships results in failed masculinity, and in John's case, emotional distress. Interestingly, John goes on to reveal

it's very strange, but I feel that now, since the psychosis, the aftermath of it and this present day, and for the last . . . two years, I haven't felt the need, or desire for a partner, I . . . err . . . not frustrated by not having a partner, I'm not, it doesn't make me feel that I'm missing out on anything. [5]

It is difficult to interpret John's loss of desire for a partner. It may of course, be as a result of the dampening affects of the anti-psychotic medication that he continues to take. On the other hand, it may be that as a result of having experienced emotional distress and becoming a mental health service user, he may feel that his 'failed' masculinity is beyond rescue and so he no longer feels subjected to societal pressures to achieve hegemonic masculinity.

Only one man, Pete, is openly gay, and as we have seen, he spent his adolescent years trying to understand his sexual orientation, telling me

I can remember feeling, going all through secondary school, knowing that I wasn't . . . umm, well I definitely wasn't straight anyway, but I didn't understand what, what all that was about. [7]

Though he does not bring this issue into narrative until half way through his story, having previously linked his adolescent depression to the stresses of schoolwork, he implies that this confusion over his sexual orientation was a factor in his distress. Perhaps interestingly, Pete moves straight from this discussion of his sexuality to say

I have some memories as well from, I can remember when it would have been when I was about five, umm, five or six I think it would have been . . . [7]

and goes on to reveal that he was sexually abused by the boy friend of an aunt. This event appears to have been buried during Pete's childhood and adolescent years, and he has only begun to address it in his mid-twenties, since he 'came out' as a gay man while at university, and he has received counselling in order to deal with his memories of being abused. Pete's relatively new found identity as a gay man has clearly been important to him, and in an email to me before we met, he describes how he has become active in gay politics and that

since coming out, it's become a very important part of my life to want to try and understand why I grew up in an environment that made things so tough for me, and why some people make things so tough on others. [1]

His memories of being sexually abused still sometimes result in Pete experiencing periods of depression, and he describes himself as 'trying to work through it' [13], adding that

yeah, I had a boyfriend last year, and that was part of the reason, umm, part of the reason I went out with him was I'd have someone to help me through this in a way. We split up, and I don't know, it was really kind of stressful. [13]

Pete's coming out, having an intimate relationship and becoming an active member of the gay community, thereby creating a stable gendered identity, albeit a subordinated one within Connell's (1987) framework of a gender order, appear to be important resources in learning to cope with his distress, but as this extract implies, relationships themselves can produce stresses which may serve to exacerbate emotional distress.

The effects of a relationship can be seen most clearly in Colin's story. His narrative is one of constantly moving on in terms of work and where he lived, with no settled relationships, until in his late forties, he meets an American woman, they decide to marry within four days of meeting, and are married within three months. Colin describes this period of his life as 'pretty idyllic', and he told me that he 'felt settled for the first time' [4]. However, the relationship did not last, and within about three years they separated, and Colin described how

I had to pack everything I owned, could carry, in three bags . . . I was extremely upset, you know, sat there with the cats, went err, went down to feed my dog . . . I couldn't take him for a walk, it was just too distressful, and err, I think if I'd had a gun that night I'd have probably shot meself, you know, I was in such a state. [6]

Just telling me about these events caused Colin to become visibly upset, and it was clear that it was a very distressing and painful ending to the relationship. However,

the focus of Colin's narrative is on the end of an idyllic lifestyle, living in the woods in a log cabin, surrounded by animals, riding motor bikes with his male friends and the writing of his novel, more than it is about his relationship with his wife. He appears to be describing having, for the first time in his life, found a style of living which fitted with his own version of masculinity, only to have it taken away, and that having lived a life punctuated by disruptions, and never feeling settled, he had found a dream, only to lose it. After Colin's previous episodes of distress, he describes himself as bouncing back quite quickly, but in the ten years since this time, Colin has been a mental health service user, experiencing various levels of depression, and has not formed any intimate relationships. He maintains his masculine identity in part by telling stories of the times he has test driven and raced motor cycles, though he has not ridden a motor cycle for more than ten years.

Matt spoke about the relationships in his life in the context of his alcoholism, and told me:

I've had relationships, I don't do relationships very well, err which, and I'm saying it's not surprising when I hear my own story, if you understand what I mean. Err, it's not that I can't love and it's not that I can't give, err, I'm afraid I expect a hell of a lot, my ideals are quite high. [4]

Thus Matt is suggesting that his inability to do relationships well is as a result of his 'own story', by which I understand him to mean his alcohol and drug use, and because of the high standards he sets for others. He later went on to give examples of his failure to 'do relationships', and speaking of his wedding day said:

I had a marriage from, well I don't think Monty Python could have made it any better. No film in me camera, we both got absolutely paralytic and I slept with the presents. [4-5]

If the wedding day was a disaster, married life does not appear to have improved, as Matt went on to tell me:

I'm afraid I was quite, well I was very bad in our relationship. I'm not going to justify it, I can't justify it, I've beaten her up on more than one occasion, and I'm not going to justify it. [5]

Despite repeating that he was not going to justify it, Matt did suggest that his wife 'has her own emotional problems too' [5], which does seem like a mitigation, if not a justification³. Matt's failure to succeed in relationships can be seen to have found expression in a very masculine form, abuse of alcohol and drugs, and violence. Later in his narrative he gives another explanation for his difficulties in maintaining relationships, saying

People were disowning me, not disowning me, people wanted to love me, but they couldn't, well I didn't love myself, you see, I was on self destruct in the end. You know, I just couldn't handle the emotion of life itself. [9-10]

This extract reveals what may be regarded as part of the male condition, the need to be loved, and the difficulty in loving oneself.

³ The same ethical implications apply here as to the footnote on page 195.

This was also an issue raised by another of the contributors, Darren, who places much of the blame for his anxiety and depression on his relationship with his mother. He extends this blame to the difficulties he experiences in forming and maintaining relationships, as he told me that

it's no surprise that I haven't had more than one long term relationship in my life, because I'm basically, you know, it's clearly obvious that I need to separate somehow from my mother . . . my dependency is still there really. [5]

The very essence of the transition from childhood to manhood is in this separation from the mother, and Darren's failure to successfully make this separation impacts on his emotional well being, and on his masculinity with regard to intimate relationships. Darren describes how he felt at the time he left school, saying

I was petrified . . . very kind of immature, scared, hadn't had a girlfriend for . . . a period, quite scared of that. [2]

This fear of not having had a girlfriend, and perhaps, of not achieving hegemonic masculinity, seems to be matched in Darren's case, by a fear of intimate relationships, as he explained:

my pattern tended to be, has tended to be that, well, not make any effort [laughs], you know, even if I like somebody, because the assumption is that I'll be hurt, that the girl will laugh in my face . . . and also a sense that, like I was I think, you know, guilt about sex, which probably comes from my parents in some respects . . . I've made some progress, but still pretty scared of intimate relationships, will back off, rather than get involved. [3]

Thus for Darren, the emotional distress which he experiences in the form of depression and anxiety, is associated with his relationship with his mother and his fear of intimacy, and therefore, his sense of masculinity. As suggested by the first of these extracts from Darren's narrative, he has had one intimate relationship his life, one that lasted about a year, and which Darren explains by saying

I think I must have had a period where I was less controlling myself, really, even to get into the relationship, I think I must have let go of something. [3]

But this period of relinquishing control over his emotions was not to last, and Darren describes how he

kind of tensed up again, and kind of felt, started questioning everything, you know, 'is this the right relationship?' 'Do I really love this person?' You know, all this kind of crap, really, and umm, I ended . . . ending the relationship basically . . . I just ended up saying to [partner's name], you know, 'I don't love you', which was not actually true, it was just a way of escaping from the scariness of being involved in an intimate relationship. [3]

Darren immediately regretted ending the relationship, and continues to do so, but was unable to resurrect it. He describes the main difficulties which he experience in the relationship as

We didn't talk to each other enough, umm, there were sexual difficulties as well, which we didn't kind of . . . get to grips with. [3]

We can see then, that Darren's difficulties with intimate relationships revolve around his failure to break away from his mother and achieve a secure masculine identity, but

also stem from typically masculine failings of being unable to discuss and 'get to grips with' emotional issues in the relationship. The ending of the relationship resulted in Darren having a 'kind of mini breakdown', thus again highlighting the association between intimate relationships and emotional distress. Darren ends his narrative with sentiments similar to those expressed by Matt, saying

Love must be the answer . . . and of course, often the most difficult person to love is yourself, so it's a bit of a conundrum really. [9]

Although Matt and Darren are very different men, and their masculinity and experience of intimate relationships could hardly be more different, they both come to the same conclusion that the inability to love themselves is part of the explanation for their difficulties in relationships, and is a contributory factor in their emotional distress.

CONCLUDING COMMENTS

Throughout this chapter, I have focused on those aspects of the narratives which reveal associations between the masculinity of the participants and their experiences of emotional distress. In this regard, adolescence is an important time of life, as this is the time during which masculine identities are largely formed. Many of the stories revealed what may be considered to be 'failed masculinities', and these often could be seen to be carried into adulthood. Some of the stories contained events which are clearly recognisable as traumas, but for some of the men, the very fact that they failed to construct a masculine identity in line with societal expectations, could be traumatic in itself, and trauma in adolescence, whether severe or mild, has been shown to be a

major contributor to emotional distress in adulthood. What these stories reveal is the frailty of masculine constructions, as they constantly have to be defended against challenge, from within oneself and from others. What is also shown is that some men react to adolescent trauma by creating hyper-masculine identities for themselves (as did Matt and Colin), whilst others seek alternatives to hegemonic masculinity (for example, Nick and Pete), but that either direction may result in emotional difficulties, and in some cases, emotional distress.

In reading through the narratives, I was reminded of my own adolescence, and how I was quick to learn what was expected of me in order to be regarded as a man by those around me. However, I always had the feeling that these qualities did not exist within me, and so I felt obliged to learn how to perform them, and this creates a very insecure sense of masculine identity, and the feeling that I may be 'found out' at any time. If we regard this as a form of trauma, then the 'overt' depression which I experienced later in life, was a manifestation of the 'covert' depression I had been experiencing since adolescence. One of the ingredients of hegemonic masculinity is the limitation which is placed on emotional expression, and so the emotions felt in response to traumas are difficult to reveal to others, thus in many ways heightening their impact.

What the narratives show in respect of the participants' experiences of paid work, is that for those men who had carried out paid work during their adult lives, the expected sense of power and authority which this is generally considered to provide for men, was absent. In addition, many of the men had been denied access to paid work because of their emotional distress, and so were denied access to this aspect of

masculine identity. The issue of the stigma which is attached to those who have been diagnosed with a 'mental illness' also becomes relevant here, as many employers are reluctant to employ mental health service users. There is then, a complex set of relationships between emotional distress, masculinity and paid work.

Having asked the men to talk about their own lives in the context of their experiences of emotional distress, the narratives showed that several chose to include details of the lives of their parents. These accounts appear to show how emotional distress may be transmitted between generations, not by way of genes or learned behaviour, but because the difficulties encountered by parents in coping with emotional distress, may produce difficult relationships with their offspring, which may in turn lead to their own emotional distress. One of the issues which arose in this context was the description of dominant mothers and passive fathers given by some of the men (Colin, Darren and Pete). Again, this is an issue which I could identify with, as I can remember resenting my father for allowing himself to be dominated by my mother. The main message which emerges from the narratives in this respect, and the one which emerges from my own experiences, is that it is the failure of fathers to express themselves emotionally, and therefore to explain themselves to their sons, which we may find most difficult. As we saw in Nick's account, he felt that if he had known more about his father's emotional state when he was younger, he may have responded differently to their relationship

One of the men, Darren, spoke at length during his narrative about his failure to effect the separation from his mother, such separation being a fundamental aspect of successful masculinity, and of how this failure caused emotional problems in his life.

Separation from the mother is, of course, an element of psychoanalytic theory, but Real (1997) suggest that this separation may lead to problems in men's lives, as it is this process which is seen to be the basis for men being constrained from emotional expression, which in turn may lead to emotional distress. Thus, it can be argued that both failing and succeeding in the process of separation from the mother, may lead to emotional problems for men.

Several of the narratives contained details of the men's experiences of intimate relationships. One of the ways in which Darren explains how his life has been affected by his relationship with his mother, is in his fear of intimate relationships, and the resulting failure to maintain them. The stories the men told demonstrated how not having intimate relationships may be a significant factor in their experiences of emotional distress, as may be the ending of such relationships. Equally, emotional distress in turn may lead to problems in forming or maintaining intimate relationships. As intimate (heterosexual) relationships are such an important aspect of successful masculinity, we can see how there exists a complex set of associations whereby failure in intimacy may be equated with failed masculinity which is turn associated with emotional distress. The very construction of successful masculinity may create a simultaneous need for, and fear of, intimacy, and as two of the contributors pointed out, a man's need to be loved, but an inability to love himself. Indeed, this inability to love oneself may be at the very heart of emotional distress.

CHAPTER 9

BIOGRAPHICAL DISRUPTION REVISITED

INTRODUCTION

In Chapter 2, I outlined the arguments made by Bury (1982) that chronic illness may be best understood as ‘biographical disruption’, and suggested that this also be a useful concept in respect of emotional distress. In asking the participants to the study to give a life history account of their experiences of emotional distress, it was anticipated that the narratives they gave would contribute to assessing this suggestion. In this chapter, I will draw on some of the key themes and issues which have emerged from the interpretations of the data, which have been carried out in the previous five chapters. As such, this chapter will take the form of a ‘discussion chapter’ in which I will revisit and reflect upon the meta- theme of ‘biographical disruption’, and its applicability in understanding the experience of emotional distress. Thus, I will be addressing the question as to whether emotional distress can be understood as biographical disruption, and looking at the other relationships which may exist between these two concepts. It is my contention that biographical disruption is a key concept in gaining an insight into the lives of individuals who experience emotional distress, as these experiences can only be fully understood by looking at how they emerge from, and have an impact on, the life-histories or biographies, of those individuals.

EMOTIONAL DISTRESS AS BIOGRAPHICAL DISRUPTION

Bury suggested that in conceptualising chronic illness as biographical disruption, it was important that due consideration be given to the timing and the context of the onset of the chronic illness. This, it seems, is equally true of the onset of emotional distress, and if due consideration to timing and context is given, the experiences of Justin, Jim and Colin (and indeed, myself) may be understood in just such terms. Thus, Justin had established a life in the south of England, was self-employed and may have imagined that the future trajectory of his life had been established. Similarly, Jim had completed his first year at university, and despite his mother's diagnosis of bipolar affective disorder, he describes himself as coming through adolescence reasonably unscathed, and had begun making plans for his future. In Jim's case, he was to rebuild these plans after his first experience of emotional distress, and do the same again on several other occasions, and it is only now that he is beginning to face up to the fact that his future may not be as he anticipated it. Colin, has also had his biography ruptured, having built an 'idyllic' existence in the USA, he has spent the last 10 years living on Social Security benefits, and now lives in supported accommodation. My own experience of emotional distress has included a divorce and bankruptcy, which in turn resulted in the loss of my home and business, and the loss of most of my friendship networks. The connecting factor between the four of us is that our first major experience of emotional distress occurred in adulthood, when we had established a biographical trajectory for ourselves.

To some degree then, the appropriateness of Bury's notion of biographical disruption, should come as no surprise, as many of the same conditions apply to experiences of

emotional distress, as to chronic illness. Thus the interpretation of the narratives in chapters 4-8 contain various examples of emotional distress leading to financial hardship, difficulties in maintaining relationships, and loss of paid employment, which may in turn lead to financial difficulties, but for men in particular, may result in loss of status. Even where paid employment is not lost, there is evidence, particularly in Jim and Darren's narratives, that the effect of distress may inhibit the type of work that individuals feel they can undertake, thereby restricting their ability to fulfil their potential. This in itself may be seen as a form of biographical disruption. The additional factor in the experience of emotional distress, over and above those found in most chronic illness conditions, is the stigma which is attached to experiences fall within the sphere of 'mental illnesses'. In addition to exacerbating the difficulties outlined above, this may often lead to a sense of a 'devalued identity', both in the eyes of others, and in one's own eyes, resulting in further disruptions in biographical trajectory.

Another factor which links emotional distress and chronic illness is the degree of chronicity which may be involved. Thus, for those individuals diagnosed with schizophrenia, their distress was seen as a 'life-long process', containing regular periods of hospitalisation, and permanent reliance on prescribed drugs. This can be seen in the lived experience of Nick, and in the revised expectations of Justin, Des and Jim. Whilst the experiences of those diagnosed with 'mood disorders' were less likely to have this expectation of permanence, the very knowledge that you may be susceptible to bouts of depression or anxiety, may act as a limiting factor in the choices one makes in life. This may then, be interpreted as a form of biographical disruption, as the biography may not be as it would have been without this knowledge.

Indeed, the very nature of the experience of depression may be interpreted as disrupting one's biography, as the accounts of the experiences contained in chapter 5 clearly illustrate. In particular, Colin's description of depression resembling 'not being alive' reinforces this point, and the fact that this experience may result in suicide, may be seen as the ultimate rupture in one's biography.

A third connection between the experiences of chronic illness and emotional distress, is that the two conditions may be linked in various ways. Thus, it is not unusual for individuals who have their lives broken by chronic (physical) illness, to then experience some form of distress, with perhaps depression being the most likely. Accordingly, any disruption that these individuals experience in their lives as a result of their physical illness, may be exacerbated by this distress, both in terms of what they are able to achieve in their changed circumstances, and in how they and others see them. However, the reverse of this may also happen, as when Colin's stroke appeared to lift his depression for a period of time (see chapter 7). We also saw in the same chapter that conditions labelled as 'mental illness' contain many physical symptoms, thus adding another dimension to the potential similarities between emotional and physical illness experiences.

The first stage of the process that Bury (1982) identified in the disruptive process of chronic illness, is that where the individual finds themselves asking the question 'what is going on here?' We saw in the narratives of the participants in this study, how during their first experience of emotional distress in particular, they expressed similar sentiments, with Pete for example, saying that at the time 'I didn't know what I'm feeling, or why'. In the context of depression, Karp describes this as a potential

‘identity turning point’, which is experienced as a ‘period of inchoate feelings’ (1996: 57). We also saw in the accounts of psychotic experiences, how the strangeness of these experiences left not only the sufferers themselves unsure what was going on, but friends, family and total strangers were often equally confused. Though medical explanations were generally given only limited recognition as to their usefulness by the narrators, in the early stages of distress they may provide some relief from the confusion. I certainly found this in relation to the explanations I could give to others of my behaviour, that being able to describe myself as having an ‘illness’, for a time at least, released me from some of the responsibility for my actions. After this initial release though, the effects of stigma meant that being a patient in a psychiatric hospital was more likely to disrupt my biographical aspirations than it was to limit the affects. The other aspect of medical intervention which was highlighted by the narratives, as being useful in understanding ‘what was going on’, was the contact it provided with other service users. This resulted in several of the participants establishing themselves as members of a ‘mental health community’, but the degree to which this may be interpreted as biographical disruption is, perhaps, dependent on the degree to which this replaces being a valued member of the community more generally.

The second aspect of biographical disruption which Bury (1982) identifies in the experience of chronic illness is that in which individuals find themselves needing to reformulate their biography and rethink their sense of self, and in experiences of emotional distress this would appear to be particularly salient. An important aspect of reformulating the biography, is the process by which explanatory frameworks are developed, as part of the process of giving meanings to experience. We saw in

chapter 4 how the narratives suggested that all of the participants in the study chose to include aspects of their lives which they considered likely to have contributed to the onset of their distress. For some, this took the form of relating childhood traumas and family circumstances, whilst for others the focus was on stressful events in adulthood, including problems forming or maintaining relationships. Thus, it could be argued that in the process of searching for explanations and meanings for their experiences, they could be seen to be reformulating their biographies, the narratives themselves being an important element in this process.

The relevance of this second level of biographical disruption to emotional distress, may be especially strong where the nature and the severity of the distress leads to intervention from psychiatric services, bearing in mind the stigma with which most diagnostic categories are subjected, and which more generally, is attached to being a psychiatric patient. Within the biomedical model, many physical illnesses may, to a large extent, be seen as a mechanical malfunction of a particular part of the body, and that malfunctioning body part may be separated from the 'self'. Thus, an individual may rationalise their situation by claiming, 'it is not a problem with me, but a problem with my liver, heart, joints etc'. In the case of physical illnesses, it is perhaps the resulting inability or difficulty in carrying out prescribed or expected social roles which creates the threat to self, and thereby causes biographical disruption. Clearly though, different illnesses carry more or less potential for such a threat, depending upon the specific cultural values and meanings which are attached to them. In the case of emotional distress, it is often because social roles are not being performed that flags up the fact that there may be 'something wrong', a

recognition which is often made by others rather than by the individual themselves. A particular diagnostic label may be applied based on the ways in which an individual deviates from the performance of such roles. Despite the persistence with which the medical profession explains the causes of emotional distress as chemical imbalance, they are not diagnosed on this basis, and experiences which result in a diagnosis of 'mental illness' are to a large extent an 'illness' or malfunction of the 'self'. Thus, whilst chemical and other physical treatments are interventions which treat a malfunction of part of the brain, it is the 'self' and the ways in which it connects with others, which is recognised as the problem. It would seem then, that such experiences are highly likely to force individuals to reconceptualise their biographies and their sense of self, in order to make sense of what is happening to them.

In chapter 5, where the accounts given by the participants of their experiences were highlighted, there is evidence of 're-thinking of biographies' taking place. This was clearly the case for those experiencing schizophrenia, and both Des and John, for example, had reached a stage where they recognised that dealing with their condition was going to be a 'life-long process', and they were going to have to construct their lives around managing it. Jim too, having on several occasions recovered from psychotic episodes, and returned to his previous social and working life, seemed to accept that he was unlikely to return to full-time work. As was discussed in chapter 8, the decisions taken by these men as they come to terms with the long-term effects of their distress, impact upon their sense of masculinity, which is of course, a fundamental aspect of their sense of self and identity. **Though it might be assumed that this is always going to be a negative impact, this may of course, not be the case.**

Charmaz (1995) suggests that for some men, chronic illness provides an escape from the limiting factors of hegemonic masculinity, allowing them to live their lives in ways which are more in keeping with their beliefs and sense of self. Des' experiences, particularly in respect of his involvement with MIND, would appear to be an example of this. In my own experiences too, though my experience of depression caused considerable changes in my biographical trajectory, and certainly led me to re-think who I was, many of these changes have been beneficial, and my sense of self is one with which I am more at ease, than was the case before this experience.

Bury's (1982) third aspect of biographical disruption is the way in which individuals respond to their altered situation, and it is in this context that the importance of distinguishing between 'coping, strategy and style' (see chapter 2). The process of adaptation to changed circumstances in the context of emotional distress is likely to be especially problematic. Writing about the experience of depression, Karp (1996) suggests that individuals may respond by running away from it, fixing it, or incorporating into themselves. Each of these options may present particular difficulties because of the overwhelming pervasiveness of distress, the relative ineffectiveness of treatments, the stigma widely associated with mental illness, and the fact that emotional distress often 'involves the evolution of an illness consciousness often extending over many years' (Karp, 1996: 75). The very nature of some experiences of distress, particularly depression and anxiety, means that whilst stigmatized individuals may try to create positive interpretations of their situation, these experiences are 'characterised by an ongoing and mutually reinforcing double stigmatization – by self and society' (Karp: 1996: 47).

Though this is undoubtedly true, the experiences of the participants in this study do show that they have all, to some degree, adapted to their changed circumstances. It could be argued that they have all learned to *cope* with their distress, though it is perhaps difficult to imagine what alternatives they have. All have adopted *strategies* in building their lives around their circumstances, whether it be through the voluntary work carried out by Matt, the involvement with service user groups that several of them describe, or indeed the relationships which they form with providers of medical services. All of the men have also developed their own *style* of presenting themselves and their stories. Thus, Matt presents his accounts of his alcoholism by often disclaiming responsibility for his actions, and uses concepts and styles clearly learnt from his involvement with Alcoholics Anonymous, whilst Des utilises his spiritual beliefs in relating his experiences. Despite the fact that Bury's aspects of biographical distress can quite readily be mapped onto the experiences of the men in this study, there are some difficulties. In particular, for those men whose experiences of emotional distress began in childhood or adolescence, the question arises as to what degree their adaptation to their distress can be interpreted as 'disruption' to their lives, and to what degree it should be seen as continuity, an issue I will now address.

BIOGRAPHICAL CONTINUITY AND REINFORCEMENT IN EMOTIONAL DISTRESS

Though it is clear from the above that emotional distress may result in biographical disruption, we now need to examine the extent to which distress may contain

elements of 'biographical continuity' (Williams, 2000) or in fact be 'biographically reinforcing' (Carricaburu and Pierret, 1995). An important factor in determining whether emotional distress leads to disruption or continuity of an individual's biography is the timing of the onset of distress. For those narrators whose first experience of emotional distress occurred during childhood or adolescence, it is possible to see that such experience may be a formative part of their adult biographies, particularly when further episodes occur during their adult life. Thus, in chapter 5 we saw how Nick learned as an adolescent to deal with his distress by going into the 'Land of Dreamy Dreams' and how this was a major feature of his schizophrenia, and how Matt used drugs and alcohol from an early age to mask his distress. Pete and Dave both spoke of their experiences of depression and anxiety as adolescents, and how these had continued into adult life. For these men, emotional distress has been a continuing factor in their lives rather than a cause of disruption. Indeed, we saw how Nick's life has been built almost entirely around his experiences of being a mental health service user, and so it could be argued that his role as an 'expert patient' has reinforced his identity, rather than disrupting it. The same claim could be made about Matt's role as an alcoholic, and interestingly, it was his recovery from alcoholism and his engagement with Alcoholics Anonymous which could be interpreted as the major change which has taken place in his life.

In Des' narrative too, we can see how the spiritual beliefs which he identified as contributing to his psychotic experiences, are to some extent incorporated into his identity as a mental health service user. Thus, he told me how he preferred the concept of 'spiritual conflict' to describe his experiences, showing that he has, to a degree, used his experiences of emotional distress to reinforce his spiritual beliefs,

and his sense of self. In chapter 8 we also saw how part of the experience of emotional distress for men involved an element of 'failed' masculinity, but as suggested earlier, emotional distress may free men from the constraints of hegemonic forms of masculinity, and free them to live alternative forms, which may reinforce their sense of who they are, rather than disrupt it.

We saw in chapter 4 how Pete raised the issue of his sexuality and the confusion he experienced over this during his adolescence, as a possible contributory factor in the onset of his depression. However, Pete also told me how in recent years, since 'coming out', he has forged a positive sense of achievement through his work within the gay movement, creating a strong identity for himself as a politically active gay man. Thus, it could be said that the very same issue of his sexuality is identified by him as both a cause for his emotional distress, and also as the main factor in reinforcing his sense of who he is. It is possible to see in all of the narratives, aspects of the stories whereby the individuals interpret events in their lives as both the cause of their distress and of confirmation of the sort of person they are. This comes over clearly in Colin's account, as he relates a succession of 'failures', to the ultimate 'failure' of becoming a mental health service user, no longer able to work, and reliant on benefits. What we are not able to comment upon, of course, is the extent to which the stories any of the contributors tell of their lives before their experience of emotional distress, are influenced by those very experiences. Thus, emotional distress and life as a mental health service user, may be instrumental in forging the stories of their lives before, both in the choice of the stories told, and in the ways in which they are told.

BIOGRAPHICAL DISRUPTION AS EMOTIONAL DISTRESS

In a reversal of Bury's (1982) concept, it has been pointed out that 'biographical disruption as a cause of chronic illness has been less well documented, despite its implicit presence within the illness narratives literature' (Williams, 2000: 52). This, in turn, raises other significant questions as to the role of biographical disruption in emotional distress.

Several of the participants identified events which took place in their childhood and adolescence, as contributory factors to their emotional distress. For example, Pete alluded to being sexually abused as a small child, Matt described in detail the part he played, or he thought he had played in his father's death, and Nick described abuse taking place in a 'dysfunctional family'. All of these events are potentially traumatic, and as such may be viewed as biographically disruptive. Even where no such obviously traumatic events were reported, Dave's relationship with his mother, and Colin and John's accounts of being solitary children are put forward by them as factors which may have contributed to their distress. These too could be interpreted as biographically disruptive events in that they may have been constraining factors in their choices in life, and as such may have altered their potential biographical trajectory. We also saw in chapter 4 how stressful events in adulthood were raised as explanations for the onset of distress, whether it be the end of a relationship and a way of life for Colin, the inability to maintain a relationship for Dave, or the loneliness described by John. Thus, for many of the men, biographical disruption was seen as a causal factor in the onset their emotional distress.

In the case of chronic (physical) illness, there may also be other contributory factors to the onset of the illness, but it is likely to be the effects of the illness as such which leads to a disrupted biography. In the case of emotional distress however, the distinction between the contributory factors and the expression of the emotional distress is less clear. For Matt, for example, the accident which he thought led to his father's death, took place when he was about 12, but the alcoholism which he attributes in part to this event, occurred several years later. In Pete's account too, the sexual abuse he suffered occurred several years before he was diagnosed with depression. What is unclear is at what point the emotional distress begins, from the time of any precipitating event, or when signs become visible. In my own experience, I understand the end of my marriage to be a precipitating factor in the onset of my depression, but the signs of the depression would not have been visible to the outside world for two years, at which time these signs led to diagnosis and treatment. Thus, it is not always easy to order the precise timings of disruptive events and emotional distress. Evidence that no clear association can be made between disruptive events and emotional distress is provided by the fact that many individuals experience the same disruptive events in their lives, without ever receiving a diagnosis of a mental illness. What remains unclear is whether these individuals experience distress, but manage or contain it so that no such diagnosis is made, or whether some individuals are more susceptible to emotional distress than others (see the model provided by Brown, 2002 as a way of addressing this).

CONCLUDING COMMENTS

The forgoing discussion on the relevance of biographical disruption to the experiences of emotional distress leads to the conclusion that, insofar as due consideration is given to the context and timing of the onset of distress, then the concept may indeed be a valuable tool in sociological analysis of these experiences. It could be argued further, that in view of the nature of emotional distress, as a set of experiences which challenge the very sense of self and identity in ways which chronic physical illness conditions do not necessarily do to the same extent, then biographical disruption may have more relevance in analysing these experiences. In addition to the ways in which one's whole way of thinking and behaving may be altered by the onset of distress, the effects of treatments, and the stigma which many in society still associate with being a mental health service user, may contribute further to the process of biographical disruption.

What is also clear from the narratives which form the basis for this study, is that the relationship between emotional distress and biographical disruption is not a straightforward, one-directional causal relationship. This point has also been raised in the chronic illness literature (See chapter 2) and it seems clear that emotional distress may often act in ways which may be seen as 'biographically reinforcing', or in fact to facilitate the repairing of already fragmented biographies. It may in some contexts also represent biographical continuity, particularly for those individuals whose experiences begin at early age, and as we have seen, emotional distress may in many cases, be interpreted as one of the outcomes of biographically disruptive events.

In carrying out this analysis of the various ways that emotional distress both emerges from, and impacts on the lives of individuals, it is intended to demonstrate that

medical models which seek to treat the individual are unlikely to be successful, as the lives of individuals are embedded in the culture and the society in which they are lived. This illustrates the need for a focus on management of symptoms rather than 'cure', and interventions which work toward enabling individuals to reconstruct their lives in ways which are meaningful to them. Further consideration of policy implications of the findings of this study will be addressed in the final chapter.

CHAPTER 10

CONCLUSIONS AND FINAL REFLECTIONS

INTRODUCTION

What conclusions then can be drawn from the men's life histories, and the various issues which have been raised in this thesis? The previous chapter focused on the debates around biographical disruption, and the ways in which these might be appropriate to a study of emotional distress, and in this final chapter I will address some of the other sociological issues which have emerged from the study. The implications for mental health policy and practice will then be considered and finally, the chapter will end with some personal reflections on carrying out the research.

SOCIOLOGICAL ISSUES

One of the key themes of this study has been the issue of biographical disruption in the experiences of individuals who suffer emotional distress. This has been dealt with previously, but what wider implications arise from concepts and themes which have been applied in the sociological studies of chronic illness for the study of emotional distress? Some of the connections between these two areas are clear, with perhaps the most important factor being that of medical interventions. A significant factor in the lives of many of the men who participated in the project was the effect of medical treatments, including prescribed drugs and sometimes prolonged spells in hospital. Just as those experiencing chronic illness may have to learn to negotiate their way

through medical services, and learn to manage their condition and its treatments, these issues are often the same for mental health patients. Thus, though the label illness may be unhelpful in defining the various forms in which emotional distress presents itself, the experience of being a mental health service user is clearly that of an 'illness experience'. The sociological studies of chronic illness, particularly those that focus on medical interventions are therefore, likely to provide useful concepts and perspectives for the study of emotional distress.

The second common factor between the two areas is the issue of chronicity, and it was this very factor which produced the sociological interest in chronic illness, as the previous models, which were based on acute conditions, were seen to be inappropriate in analysing experiences of chronic illness. Many of the expressions of emotional distress also have chronic implications, whether it is because of the lifelong label which results from a diagnosis of schizophrenia, or the reduced expectations of oneself and others, which may result from experiencing depression and/or anxiety. Thus, the focus on research in both fields requires a focus on the management of conditions and treatment regimens, in order to gain an insight into the social implications of chronic illness or emotional distress.

This focus on long-term management in turn highlights the importance of setting the experiences in the context of the lives of the individuals concerned. The experiences of both chronic illness and emotional distress can only be fully assessed and understood, if the ways in which they emerge from, and impact on the lives of individuals are fully considered, and the important point here of course, is that it is how the individuals themselves understand and give meaning to their experiences.

Thus, research which employs life-history narratives can play an important role in the study of both chronic illness and emotional distress. Using this form of data raises the issue of 'biography' as a sociological concept, as when individuals seek ways of giving meanings to their experiences, it is in the context of their biographies that they do so. Biographies extend beyond the issue of events which occur in one's life, and include the concepts of self and identity, and also go beyond the individual and include historical, cultural and social factors, as our biographies emerge within these contexts. Thus, they are fundamental to applying a context to the explanations and meanings which we seek for our experiences. As we saw from the narratives, explanations and meanings are often difficult to find in the experiences of emotional distress, though many of the men were clearly searching for causal explanations for their experiences. However, in the field of mental health, such models are at best partial in the explanations they provide, as causes are a complex combination of past and present events, learned behaviours and responses, social expectations and norms, and individual physiology and psychic make-up. Thus, in order to gain an understanding of the connexions between life-histories and emotional distress, 'meaningful' connexions may be more relevant than 'causal' connexions (Jaspers, 1974). Such an approach may prove useful in research which seeks to examine the lives of those experiencing chronic illness, as well as of those who experience emotional distress.

Biographies then, are important in sociological research, particularly where they are threatened. Thus the debates about biographical disruption and reinforcement can seen to remain relevant to the study of chronic illness, but also to have perhaps even greater significance in the study of emotional distress. Narratives also are shown to

be important in this regard, as it is through our narratives that we give meaning to our experiences, and provide the means by which we reconstruct our biographies. In addition to casting light on the lives of the narrators, studies which focus on those whose biographies may seem to be threatened or challenged, illuminate the ways in which biographies are constructed and maintained more widely in society. The most effective way by which we gain an understanding of the 'normal', is by studying those experiences which may deviate from the norm.

Strongly linked to the notion of biography is the issue of gender. The ways in which we understand ourselves and our experiences, and the very way in which we engage with the world are all mediated by gender, and so our biographies can be understood as 'gendered biographies'. As all the narratives were provide by men, in chapter 8 the experiences were interpreted through the perspective of masculinity, with a focus on how the construction of hegemonic masculinity may have impacted on the experience of emotional distress. The constraints that society places on men in expressing certain emotions, and the expectation that men should display traits of independence, strength and self-reliance, may lead to them masking their emotional distress, so that it emerges in other forms. We saw in particular how alcohol and drug abuse were just such forms, and so the gender of individuals is an important factor in the way in which emotional distress may become visible to others. In addition, masculine identity may also be threatened as a result emotional distress, and so the experiences of the men in the study were very much mediated through their gender. Indeed, though it did not form a significant element of my analysis, the very ways in which we construct our narratives are gendered. The sociological implication of this is that gender should form an important perspective in any social research, but in areas

where gender constructs may be seen to be threatened, such a focus is of added importance. In the study of emotional distress, for example, a study which compares men's and women's experiences in this area, could provide a useful insight into the various ways in which gender contributes to the different forms of emotional distress which become visible, and to the different ways in which men and women experience mental health services, and this would clearly have policy and practice implications.

The final sociological issue to be considered is that of embodiment as a factor in social life. Again this links in with the issue of biography, as it is our embodied selves which create, and are created by our biographies. The relevance of this to the study of emotional distress is clear, as this experience is considered to be a problem of the mind. Gender constructs become relevant once again here, as men have been seen by society to be rational, in contrast to women who have been constructed as emotional. What we saw emerging from the narratives though, was that those experiences categorised as 'mental illness' were in fact wholly embodied ones, and very often were experienced and described in physical, bodily ways. Emotions were also clearly to the fore in the experiences of the men in the study, and it is the form in which they may be expressed, or their non-expression that may reinforce the myth that men are unemotional. This suggests the need for sociological research to address the embodied nature of social experience and a focus on emotions and emotional expression is a key element of this. In research in the field of 'mental health' the case for such a focus is clear, in order that medical models which categorise such experiences as psychic may be challenged, and more appropriate and less disempowering models may be developed.

MENTAL HEALTH POLICY IMPLICATIONS

It could be argued that a study which is based on the accounts of eight individuals does not lend itself to the formulation of policy recommendations. However, my own experiences both as a service user and through my association with a local branch of MIND over a number of years, in addition to published literature which includes accounts of the experiences of service users, allows a consideration of the issues which need to be addressed in future mental health policy.

One of the issues which is of particular concern to user groups, and was highlighted in several narratives, was that of sectioning. It is undoubtedly the case that in some circumstances forcibly removing an individual from society may be necessary to protect themselves and others from their actions. However, the first line of intervention in these circumstances is often the police, and for someone experiencing psychosis, to be locked in a cell with no explanation of what is happening, can only exacerbate the distress of the individual. It is perhaps necessary that it is the police who initially apprehend an individual whose behaviour is causing concern, but from the many accounts I have heard of this process, more sensitivity needs to be applied. This involves the need for more training of some police officers, and perhaps, a more co-ordinated approach with other agencies, especially social workers and medical professionals.

Leading directly on to this is the issue of forced treatment. In no other branch of medicine can treatment be forced on to those who do not want to be treated. This is justified of course by the claims that first, someone who is experiencing emotional

distress may not be in a position to make rational decisions about their own needs; and second, that forced treatment is given to protect an individual from harm. However, someone with cancer has the right to refuse treatment, though medical opinion may suggest that to do so puts them at risk. The move towards community care, and a reduction in hospital treatments has brought this issue to the fore in recent times, as 'depot' injections may be forcibly administered to those living in the community, as well as to those hospitalised, clearly raising issues of human rights. Forced treatment is not just confined to psychotic individuals, and are often administered to those in the 'manic' phase of bipolar affective disorder, and to those experiencing depression, where risk of self-harm or suicide is thought to exist. Even where a section is not applied, and an individual submits to voluntary hospitalisation and treatment, the degree to which this is voluntary is disputable. When I was admitted to hospital, as a voluntary patient, I expressed a desire not to be prescribed anti-depressants, and was told that though this was my choice, I could not expect any support or treatment if I did not comply with medical recommendations. In a state of fear and confusion, this was a very real threat, and I reluctantly agreed to take anti-depressants and sleeping tablets. Though not denying the very real difficulties involved in these decisions, more account needs to be taken of the wishes of service users, where necessary through the use of advocacy.

Another aspect of medical intervention in cases of emotional distress which arose from the presentation of the narratives, was the degree of 'fuzziness' which exists between medical diagnostic categories. In addition to any problems which this may create in terms of treatment and recovery, the application of a particular diagnostic label to an individual may have a severe impact on the sense of self and the identity of

that individual, and may lead to severely restricted opportunities for living a fulfilled life, in short to 'biographical disruption'. Thus, it could be argued that a less rigid categorisation of the experiences of an individual should be applied, one that recognises that both the 'form' and the 'content' of the experiences need to be considered in gaining an understanding of the needs of the individual. This, in turn, should allow for an understanding that whatever form the expression takes, the underlying feature is that of distress, and it is the distress which needs to be 'treated', rather than the expression of it.

One of the themes which emerged from the narratives was the mixed views which were held about the role of hospitals in the treatment of emotional distress. The same person can often be highly critical about the ways in which they were dealt with in hospital, and immediately praise the role that the time in hospital played in their recovery. My own experiences confirm this ambivalence about the time I spent in a psychiatric hospital, containing as they do, memories of fear, anger, safety and pleasure. These responses were echoed by the participants to the study, who often talked affectionately about the care with which they were treated by both staff and fellow patients; the importance of the time they spent removed from the stresses of their lives, the real sense of 'asylum'; and the understandings they gained of their experiences through being part of a community of fellow sufferers. A part of the positive experience of being in hospital is undoubtedly the relinquishing of responsibility for both oneself and others. However, this can be a double edged sword, as being treated as though one is not able to make any decisions about oneself can also be extremely disempowering, and hamper long term recovery. This is manifested in the policy of encouraging patients to go to bed early, often with the use of

pharmaceutical assistance, as a means of managing the ward on a reduced staffing level at night. The other issue which is commonly raised as an example of the lack of respect shown to patients is the experience of the ward round. Unlike in a general hospital, the consultant will often only visit a ward once a week, and as it is the consultant who makes decisions concerning medication, access to other services, and discharge, in addition to being in charge of developing a care plan. Far from being an occasion when the patient has the opportunity to have an in depth discussion with the consultant, and to air their concerns and ask the questions which have arisen during the week however, the ward round can be a terrifying experience. The patient is collected by a nurse, and taken into room and seated in front of a panel of up to seven or eight people. One of these is the consultant psychiatrist, and the patient may recognise some of the others, but as some of the narratives suggested, and my own experience confirms, little or no attempt is made to introduce these individuals to the patient. Thus, not only does this make asking questions and raising concerns extremely difficult for someone who may already be anxious and confused, it demonstrates a lack of respect and a denial of the politeness by which social interaction is made valuable. Though this is only applicable to service users in hospital, it serves to reaffirm that the mental health service user, because of their distress, is no longer due such social niceties, again potentially resulting in invalidating experiences.

The conclusion which can be made from the above comments with regard to mental health policy, is that there needs to be a review of the process of medical (and non-medical) intervention which better balances the needs of, and respect for the service user, against the financial constraints and the needs of society in managing the ever

increasing incidence of emotional distress in society. It is evident that improvements have been made in this direction in recent years, with patient charters and the increased involvement of user groups in policy decision making, and in the provision of some services. The suggestions which emerged from some of the narratives about the targeting of psychiatric hospitals by drug dealers are plainly of concern. One of the major benefits of being in a psychiatric hospital, has been identified by some of the participants in this study, is that they provide a safe haven from the outside world. There is some evidence that this element of safety may be threatened.

Finally, what the life history narrative approach to understanding emotional distress tells us, is that the experience of emotional distress is inextricably bound up with the lives of those who have these experiences. Thus, medical and other explanations and responses to these experiences need to fully take this into consideration in order to be effective. The medical profession has been criticised for the power and influence it has in western societies, and a call for medicine to understand and 'treat' the lives of individuals would seem to be suggesting an extension of this power beyond our bodies, into our lives. However, it can be argued that much of the management of the consequences of emotional distress could be taken away from the control of the medical profession. There are some examples of this taking place, with some service user groups being financed, through social services, to provide support in integrating service users into the community. This is a welcome move, but the medical professionals retain a large degree of control over the ways in which services are provided, and to whom they are provided. Other pockets of non-medical intervention such as volunteer befriending have been seen to be successful, and this has been carried out in conjunction with creating 'fresh-start experiences' (Harris et al., 1999).

This recognises that returning to the life situations in which their emotional distress emerged, may not necessarily solve the problem, and the case for an extension of such interventions would seem to be a strong one.

FINAL REFLECTIONS

One of my motivations for carrying out this research was that I believed it was important to hear the voices of those in society who have generally been silenced by their experiences. All of the men who participated in the research have at some time been in receipt of mental health intervention, and their stories demonstrate how their experiences become categorised as medical diagnoses, and treated as pathological deviations from expected forms of behaviour. In encouraging them to relate their experiences of emotional distress to the context of their lives, it allowed them to choose what the most relevant aspects of their biographies were, and to include their own meanings of the experiences they describe. This gives us an insight into the ways in which their lives integrate (or very often, not integrate) into the social world around them, and the biographical approach provides us with glimpses of their lives, both leading up to, and after their experiences of distress.

Carrying out research in any area of social life can be both challenging and rewarding and this project has certainly provided both of these elements, resulting in an experience which at times has been painful, but ultimately has been rewarding. It has at times proved difficult to balance the academic pressures and constraints with the desire to act on behalf of those who participated in the study, and to fulfil the

obligations I feel to the wider mental health community. I must acknowledge though, that the support and encouragement I have received from the men whose narratives are the basis for this thesis, has been the most enriching and humbling of experiences. To allow me into their lives, and to spend the time telling me their stories, makes me feel extremely privileged, and although I raised, as a methodological issue, the distress that I felt listening to their stories, it should be recognised that telling the stories caused them considerable distress at times. Yet all of them took on the task willingly, and the comradeship extended to me by these men, has been the most rewarding aspect of the project.

APPENDIX A: Information Supplied to Participants

RESEARCH PROJECT ON MEN'S EXPERIENCES OF EMOTIONAL DISTRESS – YOUR QUESTIONS ANSWERED

What is the research about? I am interested in finding out more about how men understand and explain their experiences of emotional distress. I am particularly interested in how you understand these experiences in relation to other experiences in your life, and how you think they have affected your life up to now, and in the future.

What are the benefits of the research? I consider that there are two main benefits which may come from the project. Firstly, it gives you an opportunity to have a voice, to have your views heard about your own experiences. Secondly, I believe that as more information is gathered about emotional distress, then public attitudes can be challenged, and care and rehabilitation policies can be improved.

What will I be asked to do? You will be asked to speak to me for about an hour, telling me about your life and how it has been affected by your experiences of emotional distress. I will record your story with a small tape recorder so that I can study what you have told me. I may, during your story, ask questions in order to make sure I understand what you are telling me, but it will be up to you what aspects of your life you tell me about, and what aspects you leave out.

What rights do I have? Before you tell me your story, I will ask you to sign a form, giving your consent to take part in the project and this consent may be withdrawn by you at any time during the project. Your anonymity will be protected by changing your name in any published or unpublished account of your story, so that anyone reading these accounts will not be able to identify you as the contributor, and no information revealed in your account will be passed on to anyone else without your permission. I am committed to providing a voice for men who have experienced emotional distress, however I realise that some aspects of your story may be difficult for you. I would urge you to use your right to withdraw from the project if you feel that your participation may have negative effects on you.

How will you use the story I tell you? I will be talking to 8 to 10 men about their experiences, and will be comparing their stories looking for common themes, and for possible reasons for the way emotional distress may be experienced differently by different men. My findings will be used in a thesis, and this will be for academic purposes only, but may also be produced in different forms for publication in academic journals, and possibly in a book. A summary of my findings will also be produced in a shorter form, and this will be available to you and the other contributors.

Please feel free to ask me any other questions you may have about the research project.

**APPENDIX B: Research Question and Consent Form
Handed to Participants**

**RESEARCH PROJECT ON MEN’S EXPERIENCES OF
EMOTIONAL DISTRESS – INTERVIEW QUESTION**

I would like you to tell me, in your own words, about your experiences of emotional distress. I am particularly interested in how you think these experiences related to other things in your life, and what effects, if any, your experiences of emotional distress have had on your life, and in what ways your life since those experiences may have been different.

Please feel free to ask for clarification on any of the above.

Consent Form

I confirm that I understand the nature of the research project, that I have had my rights explained to me, and I agree to participate in the research.

Name:

Signature:

Date:

APPENDIX C: Information for Participants

RESEARCH PROJECT ON MEN'S EXPERIENCES OF EMOTIONAL DISTRESS – WHO AM I?

My name is Alan Bradley, and I am a PhD research student in the sociology department at the University of Warwick.

My interest in men's mental health issues stems from my own experiences, as in 1996/7 I spent several months in St. Michael's psychiatric hospital in Warwick, diagnosed with depression. Since that time I have completed a BA in sociology at Warwick University and an MA in medical sociology, and am now researching in the area of men's mental health for my PhD.

In addition to my academic work, I have been actively involved in Mid-Warwickshire MIND, and am currently an executive committee member.

Contact details

By post – Sociology Department, University of Warwick, Coventry, CV4 7AL.

By email – A.Bradley@warwick.ac.uk

By telephone – 01926 330282

APPENDIX D: Notes on the Participants

COLIN. (Age: 62) Though Colin describes using alcohol to a significant degree during various periods of his life, he first experienced depression to the extent that medical intervention was sought, in his early fifties. He has been taking prescribed antidepressants since that time, though he has avoided being hospitalised.

DARREN. (Age: 43) Darren reports having experienced depression and anxiety throughout his life, and has at various times taken prescribed antidepressants, and has received counselling.

DES. (Age 23) Des experienced psychosis for the first time in his late teens, and has been sectioned on several occasions. He has been diagnosed with schizophrenia, and has been an active member of a local MIND association.

JIM. (Age: 36) Jim's mother has had a diagnosis of Bipolar Affective Disorder since childhood, and although Jim reported that he had no problems during his adolescence, he had a psychotic experience in his late teens, after his first year at university. He completed his degree, but has since had several other psychotic episodes, which have resulted in him being sectioned on several occasions, and has been diagnosed as having Bipolar Affective Disorder, and has taken Lithium for more than ten years.

JOHN. (Age: 36) John reports no involvement with psychiatric services until he was in his early thirties. He then experienced a psychotic episode, and was treated as a voluntary patient in a psychiatric hospital. He has since had two further episodes of psychosis, and has been diagnosed with schizophrenia.

MATT. (Age: 55) Matt describes abusing alcohol from the time of his mid-teens, and describes himself as an alcoholic and drug user for much of his adult life. He used Alcoholics Anonymous in order to recover, and after one period of relapse, has now not used drugs or alcohol for several years. He also has a diagnosis of Bipolar Affective Disorder, and does voluntary work for MIND.

NICK. (Age: 45) Nick first received psychiatric treatment when he was twelve and has spent much of his adolescent and adult life in various psychiatric hospitals. He has a diagnosis of schizophrenia, though he describes himself as being relatively free from symptoms for the past two years, though he is still heavily medicated.

PETE. (Age: 26) Pete experienced severe depression during his teens, and on two occasions attempted to take his own life. He has not spent time in a psychiatric hospital, though he has received counselling and been prescribed with various antidepressants. He reports still experiencing minor bouts of depression from time to time.

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