Narratives of Troubled Journeys

Personality disorder and the medicalisation of moral dilemmas

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Submitted for the Degree of

Doctor of Philosophy

Faculty of Social Sciences

University of Bradford

2017

Abstract

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Keywords: Personality Disorder, Recovery, Dialogue, Narrative, Mental Health, Moral order, Trauma

This thesis examines the interaction of the medical and moral in the historical evolution of "personality disorder" starting with the relationship between Prichard's (1835) diagnosis of "Moral Insanity" and an anti-modern religious text (Hancock, 1824) describing disorder of the moral faculty. Moral insanity is traced through to *Psychopathic Personalities* and the military's Medical 203 to *Personality Disorder* in DSM I (1952) through to DSM 5 (2013). The extent to which DSM medicalises everyday moral categories is examined by building on the works of writers theorising moral orders and moral selves, such as Harré (1993), Bakhtin (1981, 1984, 1986) and Taylor (1989). This thesis moves from macro-level concerns to the micro-level using dialogical narrative methodology (Sullivan, 2012) alongside Bakhtin's conceptual tools to examine how medical and personal narratives of "Personality Disorder" interact in lived experience by analysing a triangulation of my psychiatric clinical notes, contemporary diary entries and an autobiographical account. An analysis is undertaken of several diverse autobiographical accounts of *'successful'* recovery from mental health crisis already available in the public sphere. Consideration was given to how concepts developed throughout this study might be used in future work, concepts such as "*dialogical search for a new narrativ*e", the dialogical ethics of "*habitual excess and insufficiency*" and "*authoritative narrators"*. This thesis's originality is in linking DSM 5's diagnosis of personality disorder to anti-modern moral discourses on disorder of the moral faculty, and in revealing complex genre relationships between literal/medical and literary/moral understandings of emotional and mental crisis and recovery.

Acknowledgements

I am very grateful to my supervisors Professor Ian Burkitt, Dr Paul Sullivan and Dr Tammi Walker for their expert guidance, generosity of time and patience as they have encouraged me to persevere and not give up over the years. Thanks also to my family, my son Tom, daughter Katie, and especially to my wife Elizabeth for her support and patience. I would also like to thank my Mum and Dad, John and Pauline, for staying hopeful and not giving up on me whilst I was having my *very troubled journey* through life.

This thesis is dedicated to the memory of my grandad, Neil Stuart Middleton (5/07/1919 - 30/12/2014) - a truly remarkable and much loved man, who valued education.

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Introduction

Whilst managing a personality disorder service in 2007 I became aware of a wide variety of conflicting 'voices' reacting to patient's challenging *habitual ways of thinking, feeling and/or acting*. I reflected on my experiences as someone who had also received a diagnosis of "Personality Disorder" in the 1990's, and thus considered writing this thesis from the position of an "expert by experience" of severe mental distress in addition to someone who has managed mental health services. The recent growth in influence of 'expert by experience' voices on mental health discourses is discussed in chapter 1, and further in chapter 3. I had read the diagnostic descriptions of personality disorder in the DSM IV-TR (2000) and become aware that many of them referred to moral issues or dilemmas, such as lack of forgiveness or too much anger, and this led me to the literature on morality once I had started my PhD.

In particular I was drawn to the work of Charles Taylor on the fundamentally moral nature of human life and also to the work of Rom Harré, for whom the study of human life and psychology is inescapably a moral project. As an undergraduate student I had become aware of the work of Michel Foucault and his historical studies of madness, especially his critical approach to psychiatry that attempts to show how understandings of, and various treatments for, what came to be known as insanity, are social and historical constructs. This along with my critical reading of the DSM led me to frame the project within the wider epistemological critique of the Western 'medical model' in respect of mental health, and to take a more humanistic approach to those who face troubled

journeys through life. Thus this study is primarily a theoretically driven piece of work, with the empirical analysis undertaken in chapters 5 and 6 developing later as a way to balance the macro-level historical and social concerns addressed in chapters 2 and 3 with a micro-level narrative analysis. Here I identified a gap in the literature in terms of a critical and moral framework being used to understand the experiences of individuals who have troubled journeys through life, and also to understand some of the many and varied routes to recovery. I use the phrase 'troubled journeys' as a way to investigate how those who find themselves in crisis, or whose lives and relationships become problematical for prolonged periods of time, might attract a mental health diagnosis of disorder, such as personality disorder or something similar, but without making the assumption to begin with that the core of the problem is medically located 'in' the patient as an 'illness'.

Thus reflecting on how habits can be problematised in more than one way motivated me to undertake this study. This curiosity about different medical and moral understandings within people's narratives developed into my key research questions, which are:

1. What is the historical evolution of medical and moral categories of personality disorder? I address this directly in chapter two.

Following on from chapter two, chapter three asks,

2. How do the moral and medical categories of personality disorder currently interact?

This macro-level exploration highlighted a gap in the academic literature around the moral take on micro-level individual narratives of ‘mental health’ crisis and recovery, which led me to undertake an empirical study with two further research questions in mind, which are;

3. How do the medical and the personal narratives of "Personality Disorder" interact in lived experience? I address this directly through chapter five.

Curiosity about the relationship between the moral and medical was then broadened in the final research question to ask,

4. What narratives aid recovery in troubled journeys involving mental health crisis?, with an interest in contrasting how medical and non-medical genres might be used in recovery narratives.

Chapter Overviews:

In chapter 1 the philosophical and academic framework underlying this enquiry is outlined as I begin to explore moral/medical differences around disorder by reviewing contemporary critical literature on morality and Personality Disorder. Theoretical approaches that will allow me to investigate these questions further are also discussed. The interlinked ontological and epistemological positions I am taking are explained and justified clearly, by building on the works of established writers who have theorised moral orders

and moral selves, such as; Erving Goffman (1990), Kenneth Gergen (2009), Rom Harré (1993), Mikhail Bakhtin (1981, 1984, 1986, 1990, 1993), Charles Taylor (1989) and Alasdair MacIntyre (1981). This involved considering subjectivity to be *positioned* (Harré, 1993) dynamically within powerful discursive practices and local moral orders.

Chapter 2 takes the emerging themes of chapter 1 and looks through a macro historical lens in order to gain a perspective through a significant time-frame from the early 19th century to the early 21st century, in part because it became apparent that critiques of DSM (e.g. Szasz, 1970) tend not to focus attention on texts published prior to the 20th century. This chapter examines the medical literature that originally brought morality into the modern definition of madness, namely Prichard's (1835) *Treatise on Insanity* which introduced the novel diagnosis of "Moral Insanity". Through this examination the extent to which the DSM assumes certain everyday moral categories, which it then medicalises, is investigated to its historical roots within early 19th century space-time. From the emergence in the 19th century of the notion of moral insanity the complex routes are traced through "*Psychopathic Personalities"* in the 1920's, and through the military's Medical 203 (1946/2000) to "*Personality Disorder*" in DSM I (1952). Further iterations of Personality Disorder definitions are traced, including the significant success of the neo-Kraepelinian movement in influencing DSM III (1980).

Chapter 3 then turns to the current context to explore in more detail the extent to which the DSM 5 (2013) medicalises everyday moral categories. This

chapter explores the notion that the expanding DSM project may be increasing disorder in society, and reviews feminist, poststructuralist and phenomenological critiques of DSM. The DSM categorical approach to mental disorder is put into context as one of a variety of possible approaches available, including dimensional models of holistic normal human variation. Social functioning, as a key component of a Personality Disorder diagnosis, is examined as unavoidably interlinked with moral values, such as an efficient and productive work ethic. Current critiques of DSM 5 are considered, such as Livesley (2012) and the research Livesley draws on (Kellert, Longino and Waters, 2006, Widiger, 1993) to critique political power relations influencing DSM 5. Alternative conceptualisations are also considered, such as viewing personal moral habits as a set of skills with potential for excess and insufficiency, with all human being having the capacity for combinations of skills and excess/insufficiency. Experiential validity is also considered through examples of '*expert by experience'* perspectives. Finally Foucault's concept of *the practice of a foreign knowledge* is brought into the discussion as potentially useful when thinking about changes to subjectivity which may alter habits of excess/insufficiency and skills. Thus chapters 2 and 3 *dialogises* DSM 5's diagnosis of Personality Disorder by demonstrating it is historically and socially dependent on its *other*, namely non-medical moral discourses.

Chapters 2 and 3 go further than current critiques of DSM in arguing that pathological personality traits used to diagnose personality disorder are predominantly moral habits of *excess and insufficiency* formed within everyday genres of *local moral frameworks,* re-worked into a medical/scientific

professional genre as symptoms of mental illness/disorder. This historical examination showed there were gaps in the academic literature, in that not enough research has been undertaken on the *personal take on morality* in relation to experiences of mental health crisis and recovery, and I address this directly though my analysis chapters 5 and 6.

Chapter 4 then turns from these macro-level historical and social concerns to consider micro-level individual narratives of lived experiences by describing a systematic dialogical narrative methodology, which will be used to investigate the final two key research questions through the subsequent analysis chapters 5 and 6. A theoretical justification for narrative methodology is outlined followed by a discussion of current examples of narrative and autobiography research, which focus on mental health crisis and recovery. Ethical dilemmas for this study's data collection are then addressed, followed a description of steps I took for my data analysis. The systematic methodological approach used for my data analysis is described involving five steps, which are;

Step 1: Reading and Re-Reading all the transcripts/accounts;

Step 2: Looking for and selecting key moments;

Step 3: Identifying the major genres;

Step 4: Looking for the material features of narration (formal, informal, diegetic, intra-diegetic), chronotopic genre shifts, use of metaphor.

Step 5: Evaluation and validation of interpretations through dialogue with supervisors

This dialogical narrative methodology draws on the work of Sullivan (2012), Mishler (1995), Reissman (1993) and Bakhtin's (1981) *Dialogism*. The purpose of taking a dialogical narrative approach is in part to value micro-level individual stories and illustrate that alternative ways of understanding 'madness' are valid.

Chapter 5 uses a top-down analysis (Sullivan, 2012) to analyse how medical and moral genres play out in the lived experience of someone diagnosed with a Personality Disorder in order to answer the research question, 'how do the medical and the personal narratives of "Personality Disorder" interact in lived experience?'. I use my own data for this, comprised of my medical notes and diary entries from the early 1990s contrasted with an autobiographical account written during the course of the PhD research. This analysis focuses on my own journey through a period of troubled life experience. A dialogical narrative analysis us undertaken in relation to the subjective experience of having 'a very troubled journey' through life. The three data sets analysed are;

- Contemporary Diary entries [Text D] 1993 - 1994 (Appendix I)
- An autobiographical account [Text A] 2012 (Appendix II)
- Clinical psychiatric notes [Text C] 1993 - 2000 (Appendix III)

Attention is drawn to the different genres within which the self-self-other relationship is constructed. The analysis explores how differing subjectivities emerge within complex genre interactions involving shifting chronotopes, hybridised dilemmatic identity and changing authorial power via narration. Extradiegetic (outside-in) narratives *re-accentuating* intradiegetic (inside-out)

utterances are analysed using Sullivan's (2012) dialogical method for analysing commentaries on subjectivity. This includes exploring the emotional orientation of the author to their hero and consideration of how chronotopic genre shifts allow different subjectivities to emerge. This chapter identifies the major literal/medical genres, such as medical dramas involving DSM diagnosis, and literary/non-medical genres encountered, such as philosophical, religious and self-help, bringing them into a dialogue with each other by comparing the chronotopic genre shifts and other material features of narration to analyse the different subjectivities that are enabled to emerge.

Chapter 6 takes these findings forward to focus on recovery chronotopes, by analysing several diverse autobiographical accounts of *'successful'* recovery already available in the public sphere on The Scottish Recovery Network (2018) in order to answer the last research question: 'what narratives aid recovery in troubled journeys that involve some kind of mental health crisis?' Recovery narratives analysed were broadened from focussing only on someone receiving a formal diagnosis of personality disorder to people self-identifying they had recovered from a serious mental health crisis which they may or may not choose to describe in medicalised ways. The chapter is organised into two halves; Part 1 focusses on recovery narratives that resist medical genres and Part 2 focusses on recovery narratives where mental health genres are partly internally persuasive. This chapter broadens the analysis to look at other stories of how people have made sense of having their own 'very troubled journey' through life. I analysed this data to understand how people drew on both mental health genres and genres outside of mental health

discourses when making sense of their own troubled journeys. ‘Key moments’ (Sullivan, 2012) were selected for analysis in terms of content reflecting a chronotopic genre shift moving into recovery and descriptions involving significant discourses (such as medical, trauma-informed, religious, psychotherapeutic, philosophical, self-help, etc.).

Chapter seven then discusses conclusions from the whole study and considers some pragmatic themes such as how the key findings might be applied to benefit people currently experiencing a very troubled journey through life and how an ethical narrative dialogue might help staff and services attempting to help this group of people, who are often disempowered and marginalised from mainstream society and services.

Chapter 1:

The philosophical and academic framework for this enquiry

1.1 Literature review of existing critical work

The context of this work draws on the concept that people are 'positioned' within discursive moral orders where some patterns of behaviour, emotions and thoughts are socially valued whilst others attract negative moral judgements within the local social context. This concept of 'positioning' was developed (Davies and Harré (1990), Harré (1993)) within linguistically orientated social-psychological analysis as a way to overcome some of limitations of the concept of 'role' (as too static/formal) and allow consideration of the more the dynamic nature of selfhood positioned within local moral orders, where discursive practices exert varying powers to 'position' people and generate subjectivity. Discursive moral orders appear active around diagnostic practises for "Personality Disorder" from the very start of people's journeys into psychiatric services. Current interest in Personality Disorder being a concern of moral order can be seen reviewing the academic literature.

For example, Shaw and Proctor from a feminist perspective (2005) examine how a diagnosis of Borderline Personality Disorder (BPD) pathologises women's experience of surviving sexual abuse. They highlight BPD as a gendered diagnosis with 75% of those diagnosed being women, with 70% to 80% of those diagnosed reporting experiences of childhood sexual abuse. They argue the label of BPD is a diagnostic distraction from the aetiological

significance of traumatic childhood sexual abuse in psychological distress. They view high rates of sexual violence towards women diagnosed with BPD within a moral framework of sexual violence being an “unacceptable” reality, which they would like to see changed. They challenge the established psychiatric power structure to see psychological distress of survivors in the context of wider gender power relations in society. They agree with Wilkins and Warner’s (2001) argument that habits pathologised as symptoms of BPD are better understood as habitual relational reactions to traumas and understandable adaptations developed to cope with oppression. They argue BPD diagnosis serves a dual role of pathologising women’s response to traumatic sexual violence and distracting from the aetiological reality of morally unacceptable traumatic sexual violence.

Critically reframing the pathologising diagnosis of Borderline Personality Disorder within a moral discourse of *sexual violence as an unfair social injustice* brings to light the importance of four interlinked themes, namely, the role of;

1. Power-relationships (both interpersonally and within wider society)
2. The formation of *habits* of thought, emotion and action as understandable reactions to cope with abusive oppression
3. The experience of trauma and abuse
4. The moral context in which both traumatic abuse and different reactions to it are understood

From a feminist Bakhtinian point of view Hodge and Bryant (2017) also examine the damaging role of pathologising medical discourses in under-playing the aetiological significance of childhood sexual abuse. Interviewing seven women with lived experience of trauma and eating disorder they found a common *narrative* theme emerged of *masking of the emotion of shame*, an emotion inextricably linked to local moral orders, value-systems and self-evaluations. The women felt disempowered combined with the need to reshape their bodies to mask their shame. Their study demonstrates how listening to the narratives of marginalised women with lived experience can disrupt authoritative discourses that describe sexual abuse as permanently damaging the personality. Drawing on Warner (2009) they critique authoritative self-harm discourses for erasing its social production through pathologising self-harm as a symptom of an underlying personality disorder. They argue there is a need to develop ways to uncover unarticulated experiences of trauma, sense-making and responses/resistances outside of powerfully pathologising medical model narratives such as The Diagnostic and Statistical Manual (DSM) (2000, 2013). Thus the theme of *power-relations* on this subject needs to consider the relative power of different discourses such as DSM as well as alternative discourses people may draw on to make sense of their troubled journey through life.

Hodge and Bryant (2017) argue medicalising misery and suffering constructs it as individual pathology and erases its social and moral status as a *response to social injustice*. Reflexively drawing on Lash (2003) they consider the possibilities and limitations of their vision as researchers as always influenced

by their ethics, their privileged and/or marginalised situatedness and their images of the world. This current thesis also approaches the subject of the medicalisation of moral issues associated with personality disorder, but from a different situatedness of power relations by examining the experience of a male diagnosed with BPD who is a survivor of sexual abuse by a woman. Although each individual 'small story' of someone's experience is different the hope is that these themes of power-relations, habits, trauma and moral context will prove a fruitful analytic lens.

DSM diagnostic practices have also been critiqued from a different perspective as *genre-systems*, for example Burkenkotter (2001) critiques DSM IV-TR (2000) as an institutional genre system or *professional genre* that works by mediating individual communication and institutional structural properties through a process of *rhetorical recontextualisation*. This approach sees the context of any micro level unit of analysis as a genre-mediated multidimensional activity system. She showed how the initial mental health assessment by a therapist creates multi-voicedness and inner-contradictions as a conflict is generated between the therapist wanting to listen to individual narratives of distress as a healer/consultant as at the same time she is looking through the DSM genre to fit people into its grid of nosology for bureaucratic and economic purposes in order to be seen as a professional cost-efficient producer within the mental health institutional context. For Burkenkotter DSM acts as a meta-genre organising several other professional genres (psychiatry, psychology, finance departments, psychotherapy, academic research, etc.) Thus the mental health assessment is a micro-level site of multiple genre-

systems at play, but DSM is the most powerful organising meta-genre because its categories are ultimately organisationally systemically linked to financial payment. She argues the process of diagnosing the client using the DSM meta-genre with its coded grid of categories meets the needs of institutional and economic bureaucracies but at the cost of reducing the person's identity into the clinical picture of their disorder. She argues genre theory, drawing on Bakhtin (1981, 1986), is a useful lens to study the influence of DSM on patients and mental health practices as it allows a micro-macro level shifting of perspective between micro-level narratives of distress and reactive professional activity embedded within macro-level traditions of organisations, institutions and texts organised through powerful historically conditioned genres.

Crowe (2000) used critical discourse analysis to explore the theoretical assumptions underpinning DSM-IV's categories of disorder by examining how the construction of disorders also implicitly constructs 'normality'. He found what clinicians consider 'normal' is based on their culturally bound beliefs, ethics and values 'veiled in scientific objectivity'. He found the DSM text to be an *authoritative discourse,* basing definitions of disorder on its authors' unarticulated assumptions about what counts as normal in terms of *social values* around *productivity, rationality, moderation* and *unity*. He argues the authoritative image of normality embedded within the DSM's diagnostic definitions pathologises people's understandable reactions to difficult life events. Crowe argues mental health professionals' beliefs and values are significant factors in the diagnosis of disorders because clinicians are given

the authority to exercise ‘clinical judgement’ in diagnostic practice. Such clinical judgement is in turn informed by the dominant discourse of DSM. Thus he challenges the key assumption underlying DSM that disorders occur in the individual through faulty individual functioning. He argues this ignores the discursive, social and cultural context in which distressing experiences are taking place and highlights failures of DSM to acknowledge assumed social and institutional values underlying diagnostic definitions in relation to lack of moderation, unproductivity and irrationality. Thus he argues professionals are exercising moral judgements when they claim clinical judgements supported by the authoritative discourse of DSM, which is itself masking moral judgements within its clinical definitions of disorder. However, Crowe (2000) doesn’t explore Personality Disorder’s iterations in previous editions of DSM or its historical predecessors, considering how social change has impacted on its development, and I will examine this question directly in chapter 2.

Through a Bakhtinian lens we can see the genre of DSM has developed through different iterations (DSM I, DSM II, DSM III, DSM IV, DSM IV-TR and DSM 5 (2013)) and been influenced by non-medical discourses in the wider culture. Although always presenting itself as scientifically objective it has been shown that social changes in the political and moral cultural context influences the development of which disorders it legitimises or discredits through its authoritative discourse. For example, Kutchins and Kirk (1997, p. 55-99) demonstrate how the diagnosis of “homosexually” as a mental disorder in DSM was only eliminated after an organised protest campaign targeting the American Psychiatric Association (APA) annual conventions between 1970-

1974. Similarly the removal of Masochistic Personality Disorder (MPD) from DSM-III-R followed a sustained feminist campaign between 1985 -1994, which included arguing MPD criteria were understandable reactions to male violence rather than personal pathology (Kutchins and Kirk (1997, p. 126-175)). The moral, political and social context influences the creation and inclusion of new categories in DSM as well as their elimination, for example, an organised political campaign by Vietnam veterans targeting the APA to add a new diagnostic category of Post-Traumatic Stress Disorder (PTSD) to DSM-III was successful, where they believed a categorical diagnosis would both validate their suffering from trauma and give access to health care (Kutchins and Kirk (1997, p. 100-125)). These social campaigns influencing DSM disorders support the argument that the moral context and social power-relations within which trauma and habitual reactions to it are conceptualised are significant themes worth considering in this thesis.

Additionally a number of studies of mental health professional practice found they routinely make negative moral judgements about patients diagnosed with Borderline Personality Disorder (BPD), such as judging them to be 'manipulative' and 'bad not mad' (e.g. Ross et al (2009), Black et al (2011)). In an attitudinal study of mental health professionals Bodner et al. (2015) found the highest rates of negative attitudes towards people diagnosed with BPD was amongst nurses and psychiatrists when compared to social workers and psychologists. Making sense of medics' moral judgements towards their patients the authors say they agree with Sansone and Sansone (2013) that, "...the attitudes nurses present simply reflect a very human reaction to the

complex and pathological behaviours of these patients." (Bodner et al. 2015, p. 9). These studies find in practice professional negative moral judgements always circulate around patients diagnosed with BPD within the local moral orders of both the outpatient clinic and the inpatient ward. These findings support the value of exploring *the local moral context* and power-relationships within which people experiencing a troubled life-journey interact with professionals.

Crowe (2000) argues moral judgements masquerade as professional clinical judgements in the space opened up by DSM's failure to be clear where the lines lie between 'normal' habits and pathological habitual excess and insufficiency. Potter (2011) explores this issue further to demonstrate how both the context and the subject's situatedness within unequal power relations will affect whether a pathologised habit associated with DSM disorder will be viewed as a vice or a virtue. She argues personality disorders are moral and not medical, and uses the personality trait of *defiance against authority* as an example where the nosology of psychiatry is unclear around where they draw the line between normal and pathological defiance. She highlights that social norms around gender and ethnicity are not taken into account by psychiatry when assessing personality traits as excessively pathological or normal. She argues unjust and unequal oppressive power relationships between social groups can mean being defiant against authority is a virtue resisting oppression but this virtue of the oppressed may be pathologised by the powerful and medicalised through a powerful authoritative discourse such as DSM-IV (2000). She argues an individual's relative position of power within

the social structure will affect whether their defiance is seen as a reasonable response to oppression or pathological excess. Potter claims habitual personality traits which are pathologised by authoritative medical discourses can actually be moral virtues, such as defiance. In addition the lines are unclear about where the expression of such traits becomes excessive because the relative position of the defiant or defied person judging the situation will be affected by their relative privilege or oppression in terms of gender, ethnicity, occupation, disability, etc. In a society intersected with social injustice the oppressor may see habitual defiance as pathological whilst the oppressed see it as a vital moral virtue. By viewing DSM's medicalised pathological traits through a moral lens of virtue and vice Potter challenges DSM's claim to scientific objectivity in its formation of nosological lists of symptoms of disorders.

In addition to studies showing symptoms used to *diagnose* personality disorder are moral not medical, other studies examine *treatment* options and argue successful *treatment* of these difficulties is moral treatment masquerading as medical treatment. For example, Charland (2006) argues Personality Disorders are moral rather than medical conditions. He analysed the language used in Personality Disorder diagnostic definitions in DSM-IV (2000) to show the criteria uses moral terminology, calling this critique an *argument from identification*. He supports this analysis through an *argument from treatment* where he claims successful outcomes from treatment of Borderline Personality Disorder (BPD), such as through Dialectical Behavioural Therapy (DBT) involve a change in the moral character of the client. However, Horne (2014)

strongly refutes Charland's moral claim by looking at the evidence around treatment outcomes for Dialectical Behavioural Treatment (DBT) for patients with BPD. In his analysis Horne concedes that the treatment goals for DBT are in fact moral and successful treatment does in fact involve improvement in moral behaviour. However, he perseveres in holding that personality disorders are medical conditions and not moral by arguing that despite the moral nature of the goals and outcomes of DBT the treatment is a "clinical" treatment of cognitive and "non-moral emotional deficits" which once treated allow the expression of an intact moral character. Horne distinguishes between moral character and moral behaviour. He argues *moral character* relates to underlying personality traits involving values, beliefs and desires which may or may not produce *moral behaviour*. Thus he argues,

> "Successful treatment of BPD, then, requires moral behaviour change, but not necessarily moral character change" (Horne, 2014)

Horne argues that although DBT treatment and outcomes are moral this does not necessarily mean the causes of BPD are moral. Horne's explanation of BPD, drawing on Linehan (1993) is that non-moral emotional dysfunction in an individual is the cause of emotional overload which then leads to immoral behaviour. However Horne appears to concede much in arguing against Personality Disorder being a moral concern by admitting its treatment and outcomes are moral in nature, and fails to explain the cause of the underlying non-moral emotional dysfunction which he positions in the individual as the cause of immoral behaviour symptomatic of Personality Disorder. He fails to analyse the local moral context in which some habitual traits are problematised morally, instead he assumes an implicit universal agreement on "moral

behaviour" and does not define what he understands by "an intact moral character" that can express itself after treatment. Given the very high rates of reported experiences of childhood sexual abuse amongst those diagnosed with Borderline Personality disorder he also fails to address this aetiological issue or consider the role power-relationships may play in DBT treatment producing moral behaviour change. He also fails to address the feminist concern raised that problematic habits may be understandable reactions to trauma developed in order to cope with oppression. This critique is relevant for my empirical study in chapters 5 and 6 as this specifically uses narrative dialogical methods (outlined in chapter 4) to consider the range of major genres (including medical) within which habitual reactions to traumas are made sense of by individual narrators of successful recovery stories.

From a different perspective analysing the moral philosophy of institutional practices Matravers (2011) argues the authors of DSM-5 are always embedded in moral dilemmas as their definitions of disorder determine which people with what types of mental distress receive treatment. This could include harm from 'false positives' – people receiving potentially harmful treatment that they do not need, and 'false negatives' – people in mental distress not covered by DSM-5 who need help to get better but which will not be paid for by systems of care driven by DSM's authorised categories. Thus Matravers argues, in addition to DSM 5's authors' moral responsibilities, current and potential patients in mental distress have a moral claim on the textual content of DSM-5's diagnostic definitions because it directly affects their life chances and treatment options. An example of this could be war veterans successfully

campaigning for treatment as a social justice right by arguing for Post-Traumatic Stress Disorder to be added to DSM.

Thus from different theoretical perspectives there are multiple concerns raised in the academic literature around DSM as an authoritative discourse medicalising moral issues through its definitions of mental disorder. Morality has been shown to be an issue not only in the pathologising of personality traits defining the diagnostic threshold, but moral issues also emerge around personality disorder in its *aetiology* (e.g. reactions to high levels of childhood sexual abuse), *treatment* (Charland, 2006), *treatment outcomes* (e.g. Horne, 2014), overtly in *professional practice* (e.g. Bodner et al., 2015) and communicated covertly through '*clinical judgement'* (e.g. Crowe, 2000). This thesis will develop these themes that run through these differing arguments, which are the significance of the moral context and power relationships within which trauma and habits reacting to trauma are conceptualised within.

Building on these findings the focus of this study is the radical questioning of how some very troubled people in society who meet the diagnostic threshold for "Personality Disorder" are conceptualised and treated within psychiatric discursive practices and an exploration of what alternative understandings may be available to aid recovery from mental health crisis.

1.2 The theoretical approaches underpinning this thesis

This chapter now outlines the broader philosophical and academic framework underpinning and guiding this enquiry, drawing and building on a number of established thinkers, including the work of the social psychologist Rom Harré (1993), the philosopher and theorist Mikhail Bakhtin (1981, 1984, 1986), the moral philosophers Charles Taylor (1989) and Alasdair MacIntyre (1981) as well as the academic works of Erving Goffman (1990) and Kenneth Gergen (2009).

Reflecting on Wilkins and Warner's (2001) argument that habits pathologised as symptoms of personality disorder are better understood as habitual relational reactions to traumas, often developed to cope with oppression, shows how habits can be conceptualised in more than one way. However, how any habit is assessed will depend on the local moral order it is thought about within. I take a Bakhtinian dialogical theoretical lens to the concept of *habits*. Thus in this thesis when I use the term "*habit*" I am defining it as any repeatable *habitual way of thinking, feeling and/or acting* that can be thought about at the same time in more than one discourse (such as a medical or moral discourse). To be clear, I am not defining habits as moral or medical but by defining it simply as any *habitual way of thinking, feeling and/or acting* it allows this thesis to analyse how any habit is simultaneously seen as a symptom of disorder or thought about in a variety of different ways within different discourses, such as morally as a virtue or a vice, or as a 'skill' in a discourse around 'competency'.

The philosopher and theorist Mikhail Bakhtin (1981) usefully conceptualises the experience of these multiple positioned voices as ‘polyphony’. I noticed these differently positioned voices within, and in-between, mental health professionals as they drew on several different narrative discourses (popular, professional, moral, medical, etc.) alternatively resonating and conflicting with each other. Bakhtin (1981) conceptualises such multiple conflicting narrative discourses as *heteroglossia*. Using a Bakhtinian conceptual lens there is a polyphony of voices around *personality disorder* which provides clues to the conflicting context of the social heteroglossia in contemporary culture. That heteroglossia has a social history that can be traced out, not only to help understand the present but also to anticipate possible future directions of the dialogical practices that continuously form and re-form around people who attract the diagnosis personality disorder. However the discourses drawn upon to make sense of people experiencing a very troubled life-journey have disproportionate amounts of power in relation to each other and the subject so the theme of power-relations between genres can be introduced through this Bakhtinian lens. Hodge and Bryant (2017) use a Bakhtinian feminist lens to highlight the difficulty of giving a voice to people with lived experience of trying to mask the feeling shame in reaction to trauma outside of the powerful dominant genre of DSM. Whilst managing a personality disorder service my curiosity about these conflicting genres and multiple voices took me on a journey into this current study.

Human beings tend to form both helpful and unhelpful habits. Many *habitual ways of thinking, feeling and/or acting* (for example; violence, being reliable,

lack of self-control, etc.) are usually either positively or negatively valued as *moral* issues within everyday narrative discourses. Thus an effective human science should be able to integrate the fact that human beings are *moral beings* into its theories of being human in a social world. When viewed within psychiatric discourses these human *habitual ways of thinking, feeling and/or acting* become objects of medical science, reformed and re-conceptualised as "*mental health issues"*. For example, Hodge and Bryant (2017) noted women reporting habitual feelings of guilt *and shame.* Shame and guilt are moral problems because it relates to thoughts and feelings provoked when people believe they hold moral responsibility for something they have done '*wrong*' within their believed in local moral order.

Over the last two centuries habitual moral feelings, like *guilt*, around human habits have been worked into the diagnostic criteria for a variety of psychiatric disorders through the social/historical practices of psychiatry. Guilt and shame are now embedding within authoritative medical mental health texts such as *The Diagnostic and Statistical* Manual: DSM-5 (2013). Thus common *habitual ways of thinking, feeling and/or acting* can be seen simultaneously within both popular moral discourses and professional medical discourses.

This way human habits are viewed as moral and medical has not come about by accident but has developed over time within certain social spaces through a very particular social history of the relationships between discourses and their powerful practices. This social history of the dialogue between discourses

and the narratives contained within them is open to examination, but not by using positivist modernist techniques for looking. To do so would be to use the ways of looking peculiar to one participant in the polyphonic dialogue (i.e. modern positivist methods) which makes it difficult to see the wider dialogue of discourses within the heteroglossia. Burkenkotter (2001) articulates how genre theory drawing on Bakhtin can be a way to undertake a critical examination of DSM by seeing it as a meta-genre organising other medical genres. This DSM meta-genre can then be seen alongside other non-medical genres and their effect on the 'micro-level' individual stories of distress can be critically compared.

As human beings we are social subjects whose *habitual ways of thinking, feeling and/or acting* are either held in high social esteem (such as working hard or being honest) whilst other habits are estimated negatively and problematised (such as lying or getting drunk). Although moral and medical discourses differ in conceptualising these habits as 'morally wrong' or pathologising them as 'symptoms of a disorder' both discourses have in common the process of problematising some *habitual ways of thinking, feeling and/or acting* whilst valuing others. Whilst changing through historical time discourses on the human subject tend to practice this dual process of both problematising a group of *habitual ways of being* in the world as excessive or insufficient whilst at the same time valuing different habits. For example, mental health professionals are trained and encouraged to be "non-judgemental" whilst simultaneously making "clinical judgements" assessing if

patient are habitually impulsive, excessively guilty, intoxicated or overly mistrusting of others?

All human beings have these *habitual ways of thinking, feeling and/or acting.* Some of these habits, in certain social contexts and at particular times in history, help people to function socially and 'get on' in their world. Functioning socially may involve performing roles in society and achieving tasks like shopping, maintaining employment, securing accommodation, finding a partner, etc. Whilst some habits like listening and working hard may help people function socially, other habits are problematised within discourses because they cause people to *not function well* in a particular society.

These two key features are related in the DSM diagnostic definition of personality disorder in that:

1. The development of problematical long standing habits of thought, emotion and/or behaviour is linked to
2. Not functioning well socially.

However the social and historical context influences how all *habitual ways of thinking, feeling and/or acting* are viewed. The social context defines which habits attract attention and mediates the social reaction, such as whether people become subjects of the criminal justice system or the psychiatric system, put in the workhouse or sent on a rehabilitation course, etc. It is only the difference in time of our reading position that make some words seem reasonable or unreasonable, words like 'moral insanity' or 'personality

disorder'. Kutchins and Kirk (1997) demonstrated how the historical social context mediates what counts as mental disorder by showing how it was only after a political campaign in the 1970's that homosexuality was removed from the DSM.

Discourses on the mad subject develop from observations of those who happened to be already contained and observable within *mental health services* (in the 21st century) or within *mad houses* (in the 18th century). Current discursive practices and narratives around 'personality disorder' have developed historically from discourses on the mad subject formed from observations of those residing in 'mad houses'. All the inmates of mad houses were human beings, so there was always the risk that common problematic human habits might be observed and ascribed to madness rather than to simply being human.

My curiosity about how personality disorder developed historically led me to reflect on my personal experiences. Prior to working delivering mental health services I had personal experience of severe and enduring mental distress, during the 1980's and 1990's, and personally used mental health services. In the 1990's I was given various diagnoses including anxiety, psychotic depression, obsessive compulsive disorder (OCD), bi-polar affective disorder, substance misuse disorder and borderline personality disorder (BPD). Alongside these diagnosis came various discursive practices ('treatments') such as hospitalisation, psychotherapy, psychopharmacology (anti-

psychotics, anti-depressants and mood stabilisers) and occupational therapy. Eventually I *got better* through a set of practices I found outside of the range of mental-health discursive practices on offer in Britain in the 1990's. Thus both my professional experiences delivering mental health services and personal experiences being diagnosed with mental health disorders motivated my interest in undertaking this study.

What might be called *'very troubled'* people habitually develop a biographical trajectory within every society. People who function better socially also develop social trajectories which form their biographical stories. Attempts are usually made by powerful social institutions to subject those not functioning socially to various narratives and discursive practices such as; imprisonment, banishment, torture, therapy, refrigeration, physical surgery, psychopharmacology, submersion, electrocution and/or hospitalisation. These practices are embedded within socially accepted narratives which justify them, such as; "criminals must be rehabilitated", "the mad must be treated", "the sick must be quarantined", etc. As history shows us, any practice can be made to sound reasonable by the powerful practitioners of it. It is only the different perspective enabled by changes in social space and time which allows it to be seen as *unreasonable*, which is an important point because *Reason* rules the *modern* world. Whether someone not functioning socially is electrocuted, operated on (lobotomised), plunged into icy water, euthanised, drugged or dialogued with will depend on what is currently considered reasonable and valued by those with relatively more power in society. What is considered reasonable will depend on the subject's location and co-ordinates in (historical)

time and (social) space within the perpetually circulating powerfully productive social orders. For example, when I came under the authority of psychiatric practices I could have been 'treated' with a lobotomy if it was the 1950's but I instead I was prescribed anti-psychotics (haloperidol, chlorpromazine) because of my time/space location living *in England in the 1990's*.

Although every social grouping and age has its *obviously troubled* members who do not function well in relation to that society's norms and expectations it is only in relatively recent times that modern medicine and psychology have claimed *almost* monopolistic authority to do paid work on those considered to be a 'thorn in the side' of the social body, that is, society's more troubled and troubling members.

For the purpose of this study I reframed and re-named "Personality Disorder" as someone experiencing a "very troubled journey" in life because society is made up of numerous competing discursive practices and only some people during their biographical trajectory become subject to the powerful narrative discursive practices of psychiatry. Thus the phrase '*very troubled journ*ey' attempts to validate the serious, life limiting and life-threatening, chronic distress of people who attract the label Personality Disorder without minimising or denying that distress. The phrase attempts to acknowledge that their experiences are at the more extreme end of the range of experiences of being human in a social world without using a diagnostic label. People living biographical social trajectories attracting the label personality disorder experience, and cause, serious distress to those people who are in

relationships with them. Their journeys through life often involve stays in institutions (such as the hospital, prison, the workhouse, etc.) In addition to physical morbidity, people attracting this diagnosis also experience high rates of premature death, both accidentally during chaotic and self-destructive lifestyles and sometimes deliberately through suicide. The Consensus Statement for People with Complex Mental health Difficulties who are diagnosed with a Personality Disorder (Allister et al., 2018) reviewed data which shows on average men diagnosed with Personality Disorder die 18 years younger than other men, and women with the diagnosis die 19 years earlier than other women.

The biographical trajectory of someone experiencing *a very troubled journey* through life will be affected both by their habitual ways of thinking, feeling and acting as well as the wider social response to them by powerful institutions (such as being diagnosed with a disorder, experiencing stigma, or being sectioned into a psychiatric hospital). The novel use of the phrase 'very troubled journeys' attempts to avoid unreflectively adopting the clinical language of psychiatry, the use of which, like so many modern mainstream discourses, limits what is *thinkable* by implying mental-health discursive practices are the only authoritative way to make sense of, and therefore, escape from, these extreme experiences of being chronically mentally distressed in relation to their social world. The concept of 'very troubled journeys' also allows space for significant social events, such as trauma and abuse, to be integrated into the sense-making about why someone's

biographical trajectory is difficult without pathologising problems exclusively within the individual.

Thus the subject of this study has been outlined as the very troubled subject whose biographical trajectory could attract a diagnosis of “personality disorder”. A key question being asked of that subject are; what *habits of thought, feeling and/or actions* are being problematised through which discourses and are these habits usefully understood as reactions to trauma? Consideration will be given as to whether local moral orders are influencing the way in which habits are problematised. The role of power-relationships will be considered when analysing whether moral habits are being medicalised by the discursive practices of psychiatry. This thesis will also explore what alternative genres are available to subjects for ‘making sense’ of their habits, and what effects different discursive practices have on people and those in relationship with them who have troubled biographical trajectories.

However, to ask these question of that subject within the human sciences is challenging because it does not sit easily within the traditions of discourses like medical science or the relatively limited thinkable-space permitted by the powerful regulating authorities of mainstream psychology. Given the relatively narrow discursive space opened up and then regulated by the dominant monological discourses of psychiatry and psychology the question arises as to where this study can position itself within current discursive practices in order to take a critical perspective on the subject? Fortunately there are already

established positions within the human sciences from where these critical questions can be asked and answers begun to be worked out.

1.3 Moral Selves and Moral Orders

Rom Harré, in his book Social Being (1993), proposes a framework for understanding ways of being human in four dimensions; a relationship with our selves, a relationship with others, a relationship with the physical natural world and physical body, and people's relationship with something "super-natural" (such as a relationship with a personal God or alternative spiritual beliefs). Harré argues as spirituality is very important to the majority of human beings on the planet a credible non-discriminatory human science needs to be able to consider relationships in this dimension as well. For Harré human psychology is best understood as developing within a social network of discourses and related practices. He argues the central task of social psychology could be defined as "the work of making the tacit, practical knowledge of a community explicit by representing it discursively." (1993, p.14). Human identity is formed and reformed in relation to these networks of social relations within which the individual is thinking, feeling and acting, as;

> "The self is a location, not a substance or an attribute. The sense of self is the sense of being located at a point in space, of having a perspective in time, and of having a variety of positions in local moral orders." (p.4) and ultimately, "…human beings become persons by acquiring a sense of self" (p. 4).

From this perspective *power-relations* are important to consider because the relationships where people are positioned within any social network are unequal in a number of respects. People are located on several axes of power relationships (ethnicity, age, gender, class, etc.) simultaneously. If power is thought about in relative and relational ways resistance to its effects is always possible. Harré argues human social groups tend to be hierarchical and therefore human relationships need to resolve issues of power relations, such as who is relatively dominant and who is relatively submissive. However, power is not just prohibitive but is also productive. Social networks are made up of these differing power relations which positively and negatively affect people's identity. In addition to the expression of interpersonal power relations, Harré argues people are capable of receiving and exerting power in relation to nature, the supernatural and in relationship to themselves.

Harré argues that the discipline of psychology ought to study how we acquire, maintain and practice the discursive and practical *skills* required to be effectively in each area of his four dimensional framework. This conceptual lens will be relevant because lack of skills leading to ineffective social functioning is a central concept in diagnosing a personality disorder within a health narrative. The repetitive nature of developing skills means they can be thought of as a *habit*, a habit that is valued socially. As habits and social functioning are central theme being considered in this thesis, the way Harré conceptualises some habits as morally valued skills which enable social functioning will prove analytically useful. Harré says,

> “These skills must be learned from others and they can be employed more or less expertly. If to be a person consists in having and using such skills, people are artefacts. We are the product of all sorts of processes and procedures of people making. These processes and procedures are also the exercise of skills and so can be done well or ill. We can apply them to ourselves.” (Harré, 1993, p.2)

Humans have general capacities to develop both helpful and unhelpful habits of thought, emotion and behaviour. As Harré puts it in relation to helpful habits or skills,

> “All human beings have certain generic capacities to acquire skills, which, though they differ in their specific forms from tribe to tribe, are nevertheless of the same general kind.” (Harré, 1993, p. 3)

This study will consider how both unhelpful and helpful (or *skilful*) habits develop from a social psychological point of view by drawing on Harré’s idea of ‘local moral orders’. This analytical approach accepts that human beings develop as *moral* beings, whilst acknowledging we *differ greatly* as to which habits are valued as skills or devalued and problematised.

People can practice habits that they consider morally problematic. This affect the relationship they have with themselves and can lead to feelings of guilt. This issue is particularly pertinent to personality disorder studies as people attracting the diagnosis are acting in ways that tend to be judged by wider

society as not fitting into social norms and expectations (for example, harming themselves, not in employment, frequent arguments in public or social withdrawal from the world). A vicious circle can develop where the awareness of public moral judgments on habitual behaviour can drive feelings of guilt and shame which cyclically then lead to more problematic habits. Local moral orders defining the limits of habitual excess and insufficiency may play a significant part in maintaining or escaping vicious and virtuous habitual circles in relation to social functioning. Harré's argues human beings in groups form moral frameworks and local moral orders of the valued and devalued, including the promotion of role model biographies, hence,

> "Lives are lived according to the local patterns of exemplary biographies, creating moral careers, ups and downs, in reputation in the eyes of others." (p. 32).

Thus moral frameworks are created and maintained socially within which people act and hold a sense of themselves and others. However there are numerous conflicting moral orders in contemporary society, and people can always choose not to conform to the local moral order:

> "Human beings can distance themselves from any of the rule systems that underpin their culture, but only if they are prepared to pay the social and practical costs." (Harré, p. 32)

The habitual excess and insufficiencies attracting a diagnosis of personality disorder do appear to exert this “social and practical cost” on people, even if they have formed, as Warner (2009) argues, in reaction to social injustices and oppression such as sexual abuse. As not everyone agrees with the local moral order they develop and form a sense of identity within, “Disappointment and resentment encourage some to search for other icons of alternative social orders.” (Harré, p.32) So it is possible for the disappointed to search within other discourses and communities for different local moral orders to re-orientate within, including health and illness discourses. Harré emphasises that the moral judgements of others play an important part in our social life and a powerful motivator for people in general is the respect and / or contempt that they may be held in by others as they try to achieve goals in public. People’s behaviour and achievements can be judged by others to either have failed (attracting contempt) or succeeded (attracting respect (see Harré, p. 28)). He argues people act and risk distain publically because they seek the respect or esteem of others in their group. Linked to this is the idea of public social reputation, referred to as “a public character”.

The idea that local moral orders are important is highlighted in Hodge and Bryant’s (2017) argument that medicalising socially caused habitual distress as individual pathology erases its moral status as a *response to social injustice*. Additionally Crowe’s (2000) argument supports the significance of local moral orders by showing how mental health professionals’ moral values are factors in the diagnosis of disorders through the exercise ‘clinical judgement’ in

diagnostic practice, particularly their moral judgements on where to draw a line between *moderation* and *excess*.

Ervin Goffman (1990) calls the acquiring of character, in small incremental steps, a “moral career”. Public character can be lost as well as gained. When considering whether habits are esteemed and encouraged or problematised and discouraged this study will make use of Goffman’s concepts of public character and moral careers in addition to Harré’s concept of local moral orders. I will consider the local moral orders the authors of DSM draw upon as a professional class when developing their authoritative texts.

This study will build on Rom Harré’s position, citing Goffman’s work (1990), by focusing on the practice of discursive skills which people use to relate with others in joint activities to create the ‘dramas of character’ of their everyday life (Goffman, 1990, p.24-25). People build both skilful and unhelpful habits as they engage in joint problem solving and so create these ‘dramas of character’. Conflict and cooperation are common types of social activity associated with problem solving as many problems necessitate negotiating and working with others towards mutually acceptable solutions in the pursuit of shared and agreed goals.

The question of creating, re-forming and maintaining identity is of central importance to this study because human beings are more than the set of skills and problematic habits they have developed. People hold ongoing core beliefs about themselves and others in relation to being part of wider groups.

Belonging to a group can be called social functioning as it is achieved by performing a role in the dynamic life of the group, such as in a family, community group or an employing organisation.

1.4 Ontology and Epistemology

Every discourse on the human subject is shaped by its authors' beliefs about ontology and epistemology: 'Ontology' refers to the basic assumptions being made about what it is to be a human being, whilst 'epistemology' refers to the fundamental ways in which truth claims are being produced and accepted within a discourse (Smith, 2007). The human sciences and some discursive practices outside of the human sciences take as the object of their knowledge "human beings". Thus human beings hold a double position simultaneously being both the producers of and the subject of discourses on 'being a human'. This is problematical because *we are what we are also observing* (human beings) which unavoidably affects our observations in ways that examining a non-human subject (like a rock) would not.

The human sciences often silently imply, whilst not making explicit, their underlying assumptions about what it is to be human and what capacities they assume humans have (called ontological assumptions). Within human sciences such as psychology, psychiatry and psychoanalysis there are lots of different conflicting and competing ontologies. Confusion often breaks out because these ontological assumptions are not made plain to the reader. As

Rom Harré points out, many differing ontologies compete within academic psychology:

> "As editor of an encyclopaedia of psychology I have been very much aware of the multiplicity of ontologies that are alive amongst practitioners, long after their weaknesses have been exposed." (Harré, p. 13).

Therefore this study will question the implicit underlying ontological assumptions within any given discursive practice and attempt to bring to light unarticulated ontology. This study's ontological assumptions include believing human beings are moral beings capable of forming habits of thought, emotion and/or behaviour and that whether these habits are valued as skills or problematised and pathologised will depend on the local moral order an individual is situated within. Ontologically people tend to orientate towards a future ideal self which can motivate them to practice both problematic and skilful habits. People are in relationship with others who are in a similar ontological position, and so people in groups may help or hinder each other on their quests to solve problems and achieve social goals. Although the pursuit of social goals partly involves the exercise of will-power, Bakhtin usefully points out that 'our will' travels through *zones* where it is modified by being subject to the power of 'other's will' (Bakhtin, 1986).

This study will also ask questions about the epistemological assumptions of discursive practices on the human subject. That is to ask what the grounds

and processes are on which a discourse claims to produce the “truth” about its subject. Epistemology is important because a truth claim is related to the authority a discourse claims to promote and justify its practices. A common modern truth claim is “scientific research evidences this is the most effective treatment”, for example, Rosen et al (2007) use this format to argue Assertive Community Treatment (ACT) is an effective approach in psychiatric treatment of severe mental illness. However more broadly in the history of psychiatry such statements could make surgical solutions, such as lobotomies, sound very reasonable ‘evidence based’ solutions to serious mental health problems without the epistemology of the truth production being rigorously investigated.

Epistemological questions consider how any “knowledge” of the human subject has been acquired and constructed. What are the grounds for believing a particular discourse is true? Our social identity is temporal and spacial and so the coordinates our location affects what we are likely to believe as true and, in turn, these issues raise historically contingent epistemological and ontological considerations. As Kutchins and Kirk (1997) found, it was not the dispassionate internal epistemological workings of DSM’s ‘scientific’ approach to discovering disorders that removed homosexuality from DSM but an external political campaign by those who believed it was not true. The campaign attracted press coverage in the media which risked the public social reputation of the APA and the psychiatric establishment, which may suggest Goffman’s concepts of the rise and fall of public social reputation and moral

careers may be applicable to organisations and institutions such as the psychiatric establishment as well as to individuals.

Part of the task of social psychology is to uncover ontological and epistemological illusions and by so doing reveal the unstable ground some influential authoritative discourses, such as DSM, have been built on. Although histories of the concept of personality disorder exist (e.g. Livesley and Larstone, Ch. 1, 2018) there appear to be gaps in the academic literature around a detailed historical tracing of the concept which consistently consider the moral context, including the moral journeys of individuals and the non-medical moral context of the early 19th century. This study will seek to trace back the historical contingency of discursive practices relating to subjects who experience very troubled journeys through life by examining the ontology and epistemology of authoritative discourses.

Our identities develop in the dialogue of different regimes of narrative discursive practices. My chapter 2 will place discourses on personality disorder within a historical process of development and in so doing reveal how historically contingent some assumptions are about people whose mix of skills and problematic habits does not enable them to function well within a particular society. To historicise something assumed not to have a history can be one way to effectively question its authority over the subject. Discursive practices of power producing humans will not be examined in isolation. Consideration will be given to the variety of containers and maintainers of these discursive

practices, such as professional regulatory organisations. From this overall context my empirical study in chapters 5 and 6 will use dialogical narrative methods (chapter 4) to analyse micro-level small scale individual narratives of successful recovery stories.

This enquiry would assume that there is no “free subject”, living in a vacuum away from language, power relations, other people and their physical body. That is to say there is no social identity free from being subject to particular discourses and practices of the self. To have an identity with a subjective position is literally to subject oneself to (and within) a narrative discourse, or more often to be subject to *a hybrid combination of several competing discourses*. Narrative discursive practices are powerfully productive of subjectivity. The primary vehicle for becoming the subject of a discourse is by **believing** it. People can only free themselves from the subjectivity of a discourse by stopping believing in it. However, people cannot believe in nothing. People need to become the subject of an alternative discourse and practice in order to free themselves from a kind of subjectivity that they do not like. Kuhn (1962) refers to this as particular kinds of scientific epistemology will not be given up in a vacuum – they need an alternative paradigm to believe in prior to abandoning attachments to a particular epistemology. To free ourselves from what we currently think we need to dialogue with our *other*.

Thus reviewing the academic literature and linking emerging themes to the analytical approaches of Harré, Goffman and Bakhtin, it would seem reasonable to undertake this study exploring how the habits of those

experiencing very troubled life-journeys may be linked to social factors, such as reacting to trauma, and how the moral context and power-relations of different discourses influence these experiences. After setting the scene for the interplay of morality and psychiatric science in chapters 2 and 3, I will look at how these issues emerge in small stories, albeit in a different form, namely an individual account of someone diagnosed with personality disorder and other individual "small story" narrative accounts of recovery from mental health crisis. This would include an examining the crucial relationship between forming (and reforming) habits and how these relate levels of social functioning. I plan to examine through narrative analysis my own account of being diagnosed with personality disorder and supplement the data set to be analysed with contemporary diary entries from the 1990's and my psychiatric medical notes obtained under the data protection act.

Expert by experience social activism has gained significant momentum in recent years influencing the current debates around the diagnosis of "Personality Disorder". There are a diverse range of views within the experts by experience social activists, from those campaigning for the disorder to be abolished, those wanting it renamed to reflect personality difficulties associated with complex trauma and those wanting to keep the label but improve the quality of mental health services offered. Their influence is evidenced by the publication of *The Consensus Statement for People with Complex Mental health Difficulties who are diagnosed with a Personality Disorder* (Allister, et. al., 2018). This is a consensus statement agreed between experts by experience and mental health professionals. Whilst acknowledging

a range of views exist, and that access to services is currently dependant on getting the label, their agreed consensus statement included that people diagnosed are likely to have experienced system failures in addition to past trauma and “The label of Personality Disorder is controversial and needs to change” (p. 4). I am a member (in a professional capacity and not as an *expert by experience*) of the Personality Disorder Strategic group for the mental health trust in the North East of England (NTW). Further evidence of expert by experience campaigning influencing current debates was that the group meeting on 14/02/2018 discussed (and agreed) whether to change its name to be more inclusive, in the light of concerns raised about the label, to “The Personality Difficulties associated with Complex Trauma (PACT) strategic group”.

From a philosophical perspective MacIntyre (1981) argues that the human being in society cannot be understood without consideration of the morality of social issues. He argues in favor of local communities having shared moral values where members engage in practices towards shared valued goals. He sees the need for local communities to defend themselves against the big institutions of the Enlightenment, such as capitalism, which he sees as lacking any meaningful historically routed moral framework (MacIntyre, 1981). Another philosopher, Charles Taylor views ways of being human as inescapably embodied within moral narrated worlds. As moral beings we have *strong evaluations* (moral views) of what are *fair and just* ways to be treated and to treat others (Taylor, 1989). The high rates of *moral judgements* by medical professional towards people diagnosed with personality disorder found in

studies would support this assertion that despite a professional role human beings are moral beings who habitually make strong evaluations of each other (e.g. Sansone and Sansone (2013), Bodner et al. (2015)).

For Bakhtin, a number of conflicting narrative discourses exist in society called ‘heteroglossia’. Psychiatry is a modern example of a monological discourse that tries to silence the polyphony of alternative discourses around it, the less powerful voices that can offer different interpretations and meanings. *Dialogization* is a process where awareness is raised of the competing discourses available in society for defining meaning. This process shows monological discourses, such as psychiatry, to be relative, contingent and lacking in the ‘absolute’ authority it claims over human beings. This process makes *resistance* to monological discourses easier through practicing some alternative discursive practices from the polyphony of discourses surrounding a monological discourse. Micro-level resistances are always possible, such as individual journaling in a diary their experience of being in a psychiatric hospital which may be different from the professional justification for placing them there. Bakhtin’s dialogue is relevant to personality disorder as it is predominantly conceptualised within the monological medical model genre (DSM 5, 2013). Micro-level resistances to medical discourses through alternative genres may be expressed in individual narrative accounts as people may draw on a polyphony of genres to make sense of extreme life experiences.

Bakhtin describes a dialogical world where final meaning is never reached but multiple readings and interpretations increase and are therefore epistemologically meaning is ultimately always *"unfinalisable"*. Discursive practices like medical-science (e.g. DSM 5) that produced general categories such as "personality disorder" to fit people into would be seen dialogically as an "authoritative discourse". That means a privileged, powerful discourse that does not allow any play with its wider frame, which holds great power over its subjects. Authoritative discourses are contrasted by Bakhtin to 'internally persuasive discourse' where we retell a text in our own accent and make subtle changes. Becoming "conscious" for Bakhtin is a constant struggle between these two: authoritative and internally persuasive discourses. We free ourselves from, or assimilate into ourselves *authoritative discourses* into internally persuasive ones by believing or disbelieving them as we find credible, trustworthy, believable stories to orientate ourselves within (Bakhtin, 1981, p. 424).

The sense of time/space we are in can be unconscious and then be brought to our attention through some processes. Our social identity has co-ordinates in time and space (social history) from which we dialogue with others (who have their own co-ordinates of existence) and the relationship between these co-ordinates can be analysed, as long as we hold in mind that both coordinates are moving relative to each other through space and time through their biographical trajectories. We analyse the trajectory of someone's time/space coordinates from our own trajectory.

Considering the representations of time and space in a narrative accounts is helpful because ways of perceiving the world have both general elements (such as a common plot (for example, *a quest to escape to a better place*)) and elements unique to a person's location in time/space (e.g. wanting to escape from a psychiatric hospital in the 1990's, or from a prisoner of war camp in the 1940's). The teasing out of this general / specific relationship of emplotted time/space through narrative methods allows for insight. This study will make use of such Bakhtinian analytic concepts at both the macro-level (the relationship of mental-health genres to other genres) and at the micro-level when analysing the emplotted narratives individuals orientate within in order to get better from severe mental distress.

The dialogue can be analysed between the actual chronology of events and their distortion into a typical plot or genre (e.g. an adventure novel of everyday life, a scientist discovering a truth). For example Burkenkotter (2001) drew on Bakhtinian analytic concepts to examine the DSM text as a professional genre that reprocesses individual narratives into a coded nosology of disorder. The distortion of actual sequence of events into an emplotted story is for the purpose of communicating something of value to others, such as a diagnostic moment within a health narrative. This can illuminate social forces at work because the desire to tell the story (and to 'read' the story in a particular way) within pre-existing conventional plots or genres is socially and historically conditioned. Too much uniqueness in a story and the narrative risks not being understood, but too much conventional plot risks sounding formulaic and "made up". Thus in narrative accounts there is always "...a constant dialogue

between uniqueness and generality" (ibid, p. 146). Literary devices like plot and metaphor allow narrative meaning to be communicated and the genre, or relatively stable and general set of expectations, shapes what can be said and understood.

Conclusion

This introductory chapter has outlined the philosophical and academic framework for this enquiry. Ontologically I am taking up a position against positivism, amongst the moral philosophers MacIntyre and Taylor and the social psychologist Rom Harré, by considering human social beings to be moral beings that attribute strong evaluations to the habits of thinking, feeling and behaving formed in relation to each other in society. From a macro perspective a dialogical analysis will be undertaken of the key text that introduced difficulties in interpersonal relationships and regulating emotions into the medical literature defining madness, namely Prichard's (1835) *Treatise on Insanity* which expanded the definition of madness significantly by introducing the novel diagnosis of "Moral Insanity". Chapter 2 addresses the research question 'what is the historical evolution of medical and moral categories of personality disorder?' Chapter 3 then addresses the research question 'how do the moral and medical categories of personality disorder *currently* interact?' and identifies any gaps in the academic literature. In chapter 4 I then turn from these macro level historical concerns to outline a dialogical narrative methodology which will be used to investigate the two key research questions that have emerge from my enquiry through chapters 2 and 3, namely;

1. How do the medical and the personal narratives of "Personality Disorder" interact in lived experience? and,

2. What narratives aid recovery in troubled journeys involving mental health crisis? - with an interest in contrasting how medical and non-medical genres might be used in recovery narratives.

From a micro-perspective of 'small stories' this thesis will undertake, in chapter 5, a narrative analysis of my own psychiatric medical notes triangulated with my contemporary diary entries from the time and an account recalling that period of time a decade later. Chapter 6 then analyses other narrative accounts from 'experts by experience' of mental health crisis and successful recovery. Key themes will be considered, which have been drawn from reviewing the academic literature, specifically *habits* of thinking, emotion and/or behavior, the role of trauma, power-relations and *the dialogical moral context* within which sense is being made of the *habits* of people experiencing very troubled life-journeys.

Chapter 2

The Historical transformation of moral habits into madness:

from Pritchard to the DSM

"***History is written by the victors***"

(Attributed to Winston Churchill, 1945)

In this quotation attributed to Winston Churchill at the end of the Second World War he was referring to who would write the future histories of that conflict. When it comes to the histories of systems of thought and their epistemic battles it would perhaps be more accurate to say, "History is written *within the epistemology* of the victors".

Introduction:

This chapter answers the research question 'what is the historical evolution of medical and moral categories of personality disorder?' by examining how, historically, everyday moral issues of excess and insufficiency became embedded within the mental health diagnostic criteria for personality disorders within the American Psychiatric Association's (APA) Diagnostic and Statistical Manual (DSM I (1952) to DSM 5 (2013)) in order to trace the origins of Personality Disorder. In contrast to other critics of the DSM, such as Szasz (1970), I am doing this via a tour through pre-DSM history. The role of morality will also be examined in the treatment of madness by examining Moral

Treatment, the reform movement and The Retreat at York as social movements around madness originating outside of medical science at the beginning of the 19th century, which were subsequently taken over by scientific medicine during their incremental monopolisation of the mad subject. The professionalization process is examined as a process for de-legitimising non-medical voices speaking on the mad subject as the medical model legitimises the emerging profession of psychiatry and symbiotically psychiatry legitimises the medical model. The history of the rise of scientific approaches to madness can be traced through medieval, renaissance, classical and modern historical time periods. Increasingly over the last 200 years madness has been seen in the *remote context* of professionalised medicine which creates its own nomenclature and new categories of madness. In this historical context Prichard's (1835) influential text, which originated the diagnosis of *Moral Insanity,* will be dialogically examined using Bakhtin's concept of *inter-illumination*, by considering its inter-textual contact with an anti-modern text (Hancock, 1824). This will demonstrate the origins of Personality Disorder lay in the diagnosis of "Moral Insanity", with its habitual moral excesses, whose origins lay outside medical science within modernity's *other* of religious and ethical discourses.

2.1 The History of the Rise of Scientific Approaches to Madness

Legitimised definitions of *madness* and what counts as *treatments* are constantly shifting within the wider power relations of relatively stable, but competing, sets of ideas at play within each transforming historical period.

Whilst I am focussing on diagnostic practices, it is worth noting that whilst diagnosis and treatments are separate practices there is a reciprocal inter-relationship between the two, as the content of any currently accepted diagnosis of disorder will affect the range of ideas around what treatments will restore order. A number of writers, such as (Porter 2002) Foucault (2006) and Scull (1991, 1993) have articulated how differing historical periods influence the complex ways in which madness is thought about and treated. Scull shows that in the middle ages the mad were mostly a domestic responsibility supported in local communities and helped by a wide variety of people including astrologers, folk medicine, clerics, medics and apothecaries (Scull, 1993). Porter claims the medieval mad were kept mainly within the family home, although often shameful to the family and occasionally restrained within the attic, cellar or outhouses (Porter, 2002). Foucault (2006) argues that since these medieval times there are broadly three historic periods in Europe which produce differing conceptualisations of madness and its relationship to *Reason*. These are; the Renaissance, the Classical Age and Modernity.

Foucault argues that up until the early 1600's in *the Renaissance* madness was predominantly thought about as a kind of *foolishness*, or lack of wisdom. Here the literary figure of the fool influenced thinking about madness. The 'mad/fool' had what Bakhtin (1981) would call a dialogical relationship with Reason in literature where they become a kind of mirror of, or reflection on, what counts as Reason (Bakhtin, 1981: 379). For Foucault, writers in this period presented the *mad/fool* as having a relationship with Reason where the person experiencing madness can have value by revealing *the truth* through

their madness. The specific details of their madness can lead someone on a journey where they eventually return to Reason;

> "……in the literature of the early 17th century its [madness's] preferred place is median, forming the core of the action rather than an ending, and is an adventure rather than the ultimate immanence. Displaced in the structures of novels and plays, it now allows both a manifestation of truth and a calm return to reason."
> (Foucault, 2006, p. 36)

Foucault argues that thinking about madness shifts from the early 17th century period to the end of the 18th century, during *the Classical Age*, to be defined less as a mirror to reflect on Reason, and more as a separate, distinct threat to reason, as *unreason*. However, in the 18th century the predominant world view remained that, "…a madman was not sick." (Foucault, 2006, p. 146).

The philosopher Descartes had argued the only thing we can know for certain is that we think, and therefore reliable knowledge is achieved only through rational activity. This philosophical position has had numerous critics (Husserl 1970: 75-84). However, despite his critics, Descartes influenced the dialogical context by increasing the social valuing of the realm of Reason which meant madness was more and more defined and devalued in opposition to the ascending Reason, as "unreason", without value. The mad became perceived as social outcasts alongside other undesirable groups thought to be a threat to the industrial growth of the well-functioning capitalist/industrial city. Those

who could not govern themselves well enough to function socially in an increasingly capitalist urban society (the idle, disabled, poor, criminals and the mad) were now seen through a particular lens as needing to be put in well governed institutions for the health of society. Consequently this period saw the growth in prisons, workhouses and asylums. Thus the mad increasingly become confined in institutions rather than a domestic responsibility.

According to Foucault around the end of the 18th century another historical shift occurs, into *Modernity,* where madness becomes increasingly the exclusive object of science and medicine and is redefined monopolistically as an illness or disease. This shift in the definition of madness was associated with a wider shift in Western societies known as the Enlightenment. Religious, spiritual and supernatural understandings reduced in influence as the power rose of scientific, secular and materialistic explanations based on a way of looking involving what could be observed physically, speculated about (hypothesised) and measured scientifically.

Descartes and Newton had influenced this shift in world views from the supernatural immaterial to the material, measurable and observable. Cartesian dualism grew in influence as the idea, originating from Descartes, that creation is divided into mind (including rational thoughts) and matter (including the physical body) became widely accepted. Descartes said the mind was connected to the body via the mid-brain pineal gland (Porter, 2002: 57-8). Consequently from a Cartesian dualism perspective *madness* was a problem originating physically, from within the body (matter), like any other physical

illness, an idea that can be traced through to contemporary discourses of bio-psychiatry (Insel, 2013). This philosophical dualism (mind/body) underpinned the broader movement of medicine separating from the Religious institutions of the Church and forming its own professional identity. Foucault argues the materialist knowledge produced by science and medicine that locates madness in the physical body, succeeds in silencing the mad and positioning them in the social space lepers used to hold in society, as potentially contagious outcasts, to be feared as a threat, and not to be tolerated within free society.

Medics began to use their scientific reason to conclude that *the mad* were to be treated as unreasoning animals. Because their madness originated in their physical body there was no value in reasoning with them, nor was there any value in giving them a voice in a dialogue. This historical period, developing from the late 18th century onwards, sees the emergence of, and rise to power, of *psychiatry* as the dominant way to think about madness. During the modern era medicine and science produce knowledge and sets of practices which created and defined the mad subject. In addition to creating a modern profession they produced scientific/technological treatments (physical, chemical, electrical, mechanical, etc.) and built social institutions such as asylums.

Foucault refers to this period of incarcerating the mad as the great confinement of Western Europe. Bakhtin would describe the way psychiatry comes to dominate our thinking about madness as a *monological discourse* (Bakhtin,

1981) because it claims monopolistic authority to author its subject of the mad person. However, Bakhtin argues alternative, less powerful, voices are always present in the polyphony of the wider culture in resistance to a monological discourse's attempt to totally define its human object to form it as its subject. In relation to the rise of psychiatry, alternative voices with the potential to resist and critique psychiatry within the wider dialogical context include service-user perspectives, philosophical, religious, and self-help discursive practices. Peter Good's work examines psychiatry through a Bakhtinian lens and observes psychiatry as a powerful monological, *unitary* language which, in defence of power over its subject, views diverse alternative language genres surrounding it as irritants who must be kept at a distance and whose power to influence must be severely limited (Good, 2001). An example of the medical model genre distancing, disempowering and delegitimising alternative discourses can be seen in the medical profession's response to Moral Treatment.

2.2 Moral Treatment of the mad: The Reform movement and The Retreat at York

At the end of the 1700's a reform movement around madness started led by Philippe Pinel in France and Samuel Tuke in England. Samuel Tuke was part of a Quaker Christian community in York which had been traumatised by the death of a young woman in the local lunatic asylum in York who had been one of their congregation (Tuke, 1813). The treatment of the mad was thought to be barbaric in the asylum and her family had been refused access to visit her shortly before her death. The Retreat and Moral Treatment is seen as a turning

point in reforming treatment of the mentally ill because it offered an alternative, more humane model of treatment than the traditional one of beating and shackling the mad (e.g. Shotter, 1993, Scull, 1993, Porter, 2002). It was also seen as significant in the moral context of the time because it was an amateur, Christian, non-medical approach which opposed the growing centripetal forces of the modern Enlightenment movement towards increasing professionalization, secularism and scientific management of social groups deemed to be problematic to society. There was interest in Moral Treatment in the early 19th century because 'judicious kindnesses' claimed to produce better results in terms of recovery than the traditional medical physical treatments such as; ice-baths, rotating, and bleeding (Tuke, 1813, p. 190 – p. 212).

The treatment involved maximising the comfort of patients and focussed on the moral habits that the staff demonstrated towards the patients, such as staff treating patients with kindness, compassion and building up the patient's self-esteem. It also involved providing them with occupational activity such as gardening and, controversially, not using corporal punishment or chains, which was the standard approach in private asylums. This combination of techniques became known as "Moral Treatment" and was central to the reform movement around madness. The perceived relatively good outcomes of Moral Treatment in terms of recovery rates (Tuke, 1813) was a challenge to medical ideas of madness as a biological/physical illness, because, if madness had a biological cause it ought not to respond at all to moral treatments of compassion, kindness and comfort and ought to respond to physical treatments, such as bleeding, operations, psychopharmacology, etc.

The relative success of Moral Treatment can be partly understood by considering it in the light of Rom Harré's (1993) concept of local moral orders. The staff deliberately used the esteem of self and others within "the family" of The Retreat to increase people's self-control. Thus, mindful of their *moral career* within the Retreat, patients come to feel valued and want to be valued as members of the community. For example, Tuke says,

> "I can truly declare, that by gentleness of manner, and kindness of treatment, I have seldom failed to obtain the confidence, and conciliate the esteem, of insane persons; and have succeeded by these means." (Tuke, 1813).

Contemporary writers on the history of madness agree it did appear to have better recovery rates in terms of rates of discharge (e.g. Scull, p. 102-108). However whereas Porter (2002), Scull (1993) and Shotter (1993) saw Moral Treatment in a relatively positive light of humanitarian reform away from brutalizing physical treatments, Foucault (2006) differs by being very critical of Moral Treatment, referring to it as, "...that gigantic moral imprisonment that became known, ironically perhaps, as Pinel and Tuke's liberation of the mad." (Foucault, 2006, p. 515).

Foucault is very critical of Moral Treatment and the claim that The Retreat was part of a positive reforming movement around treatment of the mad. He argues the fear of physical corporal punishment is merely replaced by fear of being

judged through a moral discourse in Moral Treatment. Additionally the idea of giving patients occupational activities Foucault criticises as positioning patients in a system of responsibilities around promoting the work ethic in a time of the rise of industrial capitalism. Foucault also criticises the recreation of a family structure in the community at The Retreat where pastoral paternalistic power is exercised over patients through the way they will be judged by staff in a system of rewards and punishments. For Foucault power over the mad did transform through Moral Treatment, but in a sinister and oppressive way from a treatment relationship based on violence to a treatment relationship based on discipline, involving the work ethic, fear of being judged and the 'gaze' of the staff (Foucault, 2006). Although born in the non-medical, local and amateur context of The Retreat, Foucault argues these techniques of disciplinary power were quickly adopted by medics involved in the Enlightenment project and incorporated into public asylums during the 19th century as the twin disciplinary techniques of *surveillance* and *judgement*.

A more nuanced reading of Tuke's Moral Treatment than Foucault's can be found from Bracken and Thomas's study, "Postpsychiatry" (2005):

> "…if the care of mad people had remained a moral issue, the disasters of the asylum era may well have been avoided. With the ethics of care to the fore, attention is focussed on the behaviour of the care givers and the sort of environments constructed by them. With medical logic in ascendance, these move to the background and only the disturbed behaviour of the patient is visible…We continue to believe we have

> much to learn from the tea merchants of York…Foucault is overly negative in his writings about the Tukes."
>
> (Bracken & Thomas, 2005, p. 189)

Post-psychiatrists such as Thomas and Bracken (2005) have argued that Foucault is excessively and unfairly critical of the moral treatment reformers because Moral Treatment did shift practices away from focusing on the physical body to focus on practices aimed at changing the non-physical; thinking, emotions, desires, passions and will of the mad - their character or personality traits. However, practices against the physical body of the mental health patient constantly re-emerge and resurface as treatment options throughout the history of psychiatry, right up to the present day, such as psycho-surgery, electro therapy and psycho-pharmacological treatments.

For Foucault, during the 19th century, as the modern era developed, the medical science of madness grew in power over its subjects, partly in a symbiotic relationship with the growth in asylums to incarcerate the mad. Pragmatically incarceration in asylums allowed increasing observation of the mad enabling the generation of scientific knowledge and practices on a captive audience of asylum inpatients. In addition to separating out the mad as a distinct category from other problematised populations (such as the poor, disabled, criminals etc.) modern medical science increasingly judged and divided madness into a range of sub-categories of madness, creating new diagnoses for patients to be given and organised by under the medical gaze.

Thus the genre of medical science increasingly monopolised the mad business, or the 'trade in lunacy' as it was called in the 19th century.

The reform movement eventually led to the Lunatics Act of 1845, which decreed Asylums were to be erected throughout England. The model for this was The Retreat and Moral Treatment, which was perceived to be more successful in producing recovery and less brutal than privately run 'mad-houses' (Scull, 1993: 148). However The Retreat was a small scale, amateur, local church outreach in York with high staff to patient ratios, low numbers of patients, artist rooms, galleries, music rooms and gardens. All of these were seen as unnecessary expenses when the State came to reproducing Asylums on an industrial scale to accommodate mainly poor lunatics. Instead of reproducing the experience at the Retreat, asylums were built for large numbers of patients with poor accommodation and were more like prisons, but run by professional medics (Scull, 1993: 67). Once Moral Treatment had been medicalised and began objectifying patients as mentally ill, its ability to produce recovery and cures dramatically declined and the modern experiment in producing large scale asylums led to them filling up with patients who did not get better and recover, resulting in what Bracken and Thomas called "…the disasters of the asylum era" (2005, p. 189).

The increasing numbers of private and state asylums put the medics who managed them in a powerful position to define and monopolise the growing economic market for dealing with the mad. Turner (1995) argues professional groups such as psychiatry developed in such a context where the medics who

managed asylums claimed specialist technical knowledge over their subject, the ‘mad’. The claim to specialist technical knowledge built the social status of these medics and was used in *the professionalization process* to exclude non-medics from having authority to speak on the subject. Through this professionalization process psychiatry was born as a professional body where the medical model genre legitimises psychiatrists and reciprocally psychiatrists legitimise the medical model (Turner, 1995).

However, in terms of monopolising the mad business an obvious difficulty to overcome was the perceived success of Moral Treatment as it had been developed and delivered by non-medics as a common sense application of judicious kindness and building self-esteem. To monopolise madness as an economic business medics needed to eliminate the non-medical competition and build public confidence and trust in them as professionals, to such a point where the general public would consider it *common sense* to think that only psychiatrists ought to deal with madness, because everyone else, including relatives and friends, lacked the skills to do so (Scull, 1993: p 186).

However at the start of the 19th century many influential public figures and politicians had concluded medicine had little to offer in the treatment of the mad (Scull, 1993: 194-6). Having initially dismissed Moral Treatment as amateur, the medical profession changed its strategy to claim authority and monopoly over administering and regulating the techniques of moral treatment amongst a wider range of medical physical treatments for madness (Scull, 1993: 260). The medical profession then influenced changes in legislation to

say medics had to be in charge of every asylum and in addition each asylum had now to be offering 'medical treatments' (Scull, 1993: p. 229-231). Thus the professional power of psychiatrists over their patients grew stronger as they increased their production of specialist technical knowledge, including novel nosologies.

As the problem of madness became thought about as *physical* or *moral disorder* the goal of treatment became restoring physical and moral order to the patient. This raises a question about definition, about whether this would be a *modern* moral order, defined by medics and ruled by reason. For example, Robert Castel (in Cohen and Scull, 1983) quotes Dr. Girard, a leading mid 19th century expert on madness declaring,

> "The most salient feature of madness being physical and moral disorder....the most uniform therapeutic tendency must be the re-establishment of order in the exercise of the functions and in that of the faculties." (p.253).

Having reviewed the literature Robert Castel argues that the moral treatment movement in its discursive practices had set itself a clear goal, to restructure personality to cure mental illness. Their stated aim was, "...to annul the disorder of mental illness through a restructuring of the personality of the insane." (in Cohen and Scull, 1983: p. 254).

By 1862 Mr. Delasiauve writing of moral treatment methods says,

> "If you wish to reduce the number of lunatics, to supply them if need be with arms against their blind instincts, pay attention to the formation of their morals, the tempering of their characters." (Quoted by Castel, in Cohen and Scull, 1983: 255).

Thus by the second half of the 19th century the social context had shifted to a general acceptance that identifying and treating people's madness on behalf of the State was the legitimate business of medical science, and the goal of treatments became the restructuring of personality into a new moral order where reason would rule over disorders of excess and insufficiency. Reflecting the *modern* times this assumed *reason* to be very powerful.

Bakhtin's concept of understanding something "in a remote context" is useful here (Bakhtin, Ch. 6, 1986) as the experiences of patients considered mad are re-contextualised by medics claiming expertise in an increasingly *remote context* of professional medical technical terminology, where medics are perceived to be in possession of knowledge of disorders the patient is not expected to understand, and consequently ill equipped to resist. The growth of a specialist nomenclature of madness outside the patient's language genre of ordinary life would increase the dialogical imbalance of power relations between professional and patient, when discussing their difficulties.

Evidence exists (e.g. Digby, 1985) that by the 1850's medical science had reversed its initial opposition to Moral Treatment and began to claim it as its

own, stating now only professional medics, not amateurs, could administer this "moral treatment". For example, the first edition of the *Asylum Journal*, stated, "The moral system of treatment can only be properly carried out by the continuous assistance of a physician." (*Asylum Journal, 1853,* quoted in Digby, 1985, p. 113). Modern medical science's reversing its initial rejection of Moral Treatment in order to claim monopolistic medical power and rights to practice it appears to support Good's (2001) Bakhtinian assertion that monological discourses will defend power over its subject by distancing and disempowering alternative language genres surrounding it. As the medical science of madness became increasingly concerned throughout the 19th century with the restructuring of the personality it began to focus on moral issues in terms of treatment, in addition to its clinical tradition of physical treatments. However, as Bracken and Thomas (2005) noted, medics turned Moral Treatment's gaze away from including the ethics of the behaviour *of staff,* towards exclusively observing the patient. Moral concerns not only influenced discourses on possible treatments, but, as we shall examine in the next section, morality also became integrated into diagnostic practices.

2.3 The construction of Moral Insanity from moral habits of excess and insufficiency

The historical context of the early 19th century was of emerging *modernity* where positivistic science was growing in power and establishing itself as the dominant genre claiming authority to organise and order society and its citizens (Docherty, 1993). It is in this dialogical moral context that madness

was becoming re-defined by medical science as a disorder, illness and disease of the *Reasoning faculty*. An individual who firmly held beliefs which the majority thought unreasonable (such as they were made out of glass) were no longer defined in a pre-modern genre, such as foolish, but as a distinct disease/disorder that could be medically diagnosed and treated. Psychiatry as a branch of medicine steadily grew in power over the 19th and 20th centuries to monopolise the mad business, into what Bakhtin (1981) would call a *monological* discourse.

To make these general points more tangible and to clarify where these were influential in forming assumptions around diagnosis there are some examples worth reflecting on and discussing in more depth. An early influential modern scientific text on Madness is James Prichard's "Treatise on Insanity and Other Disorders Affecting the Mind" (1835). In this he draws on ideas of how the Moral Faculty functions in excess and insufficiency outlined in Thomas Hancock's "Essay on Instinct" (1824). Hancock and Prichard had been friends at medical school in Edinburgh as undergraduates training to be Doctors together. They had also attended the same Church community of Christian Quakers in Edinburgh. However, in the 19th century advancement in the medical profession was restricted if you were a member of the Quaker Christian denomination as Quakers were viewed with suspicion as too radical by the establishment, because they were involved in anti-establishment social reform movements, such as the anti-slavery movement. In this dialogical moral context James Prichard converted to the Church of England, which as the established church had no restrictions on professional advancement, whilst

Hancock remained a Quaker, but did practice as a General Practitioner (GP) in Edinburgh.

Hancock's published "Essay on Instinct" (1824) is *not about madness* at all, but an argument against the group of writers he refers to as "the moderns" who were promoting the modern Enlightenment project. His book is a warning about the dangers to individuals if society takes an epistemological shift into a positivistic modernity. The central tenant of his argument is that scientists and medics, like himself as a General Practitioner, are human beings and as such have natural desires for power, wealth, self-esteem and the esteem of their peers which will unavoidably influence their Reasoning powers. He says modern positivistic science is effective at observing non-human objects (like trees and rocks) but an ineffective epistemology for looking at other humans because scientists are human beings looking at other humans through their scientific lens and so will be influenced by their own desires for esteem, power and wealth (their moral emotions and affections (social relations)) in what they observe and hypothesise about (Hancock, 1824). So there is evidence (e.g. Hancock, 1824) of early dissenters to the modern project of creating a medical nosology of personality traits, partly born out of a concern that medics will have their own challenges around moral excess and insufficiency whilst looking through their modern medical lens.

To advance his argument Hancock describes a faculty theory of how humans beings are organised internally and socially in terms of the self-system being interconnected discrete areas of; instinctual desires, moral emotions, relations

with others, conscience and reasoning ability. Hancock describes human ontology operating through different “Faculties”, separating the Reasoning Faculty from the Moral Faculty and the Will. He argues that ‘*the moderns’* are in error as they desire to put the Reasoning Faculty in charge of the Moral Faculty and create a *modern* new ordering of both society and the human subject. He argues scientist and medics producing knowledge about human beings will inevitably be biased by their natural desires for excess of money, power and esteem from peers and so in the pursuit of progress through science they will create “*moral disorder”.* He argues some actions modern scientists promote as *reasonable* may not be moral, because humans have the creative capacity to find reasonable arguments for any actions they desire, even if it harms others. More recently Thomas Szasz has also developed this argument through his critique of the rise of pharmacracy (rule by medicine and the doctors) and the therapeutic state (Szasz, 1994). In 1824 Hancock argued the new moral ordering of the self the moderns want to impose is not a healthy moral “order” but actually *disorder ruled by Reason*, a criticism that finds resonances with Taylor’s (1989) argument that modern positivism is a reworking of ancient Greek narrative from Stoicism of ‘self-mastery through Reason’.

Hancock’s core argument is that non-medical *moral disorder* occurs when there is a lack of self-control to govern our natural desires (for power, sex, wealth, self-esteem, etc.) within morally moderate levels. Hancock argues the Moral Faculty, where ontologically he locates people’s moral emotions, social

relations and conscience (moral sense), has significantly more power than the weak Reasoning Faculty to self-regulate and control powerful natural desires.

Hancock uses an explicitly Christian epistemology for his anti-modern argument, looking through a moral / religious lens he quotes scriptural passages from the Bible in support of his argument and also quotes secular poetry to support his claims to truth. He sees himself as a medic and scientist and values scientific observation but argues against the emerging modern version of science. He uses scientific observation of animals to support his thesis, observing animals, such as crows, are able to reason but are not able to be moral. He says the *modern* scientific Enlightenment movement desires to put scientific Reason in sole charge of the self-system of Faculties, which will cause people to develop cold-hearted, calculating, selfish and emotionally numb or emotionally excessive habits of character as they try to rule themselves and society solely through modern science and the Reasoning Faculty (Hancock, 1824).

For Hancock the Moral Faculty needs to be in authority over the Faculty of Reason. This explains his concern that '*the moderns'* will reverse the natural ontological order of the self-system, thus increasing *moral disorders* of excess. He says the modern project cannot succeed in progressing humans and society through Reason because the human ontological order involves moral, emotional, relational, social, pleasure-desiring beings, and humans are not solely rational/reasoning beings. For Hancock the capacity to be moral and

make ethical judgements distinguishes social humans from animals, and not our capacity to reason, as even crows can reason.

This anti-modern argument is significant for this study because in 1835 James Prichard wrote “Treatise on Insanity and Other Disorders Affecting the Mind” which accepts and adopts the basic human ontology outlined by Hancock and problematises in the same way its moral excesses and insufficiencies as indicative of *disorder*. He praises Hancock’s philosophical insights into how human beings are organised ontologically, but makes no reference to the anti-modern nature of Hancock’s publication, perhaps because Prichard is writing a modern medical scientific book on *disorders of the mind* and so he is part of the modern scientific movement Hancock is warning against. Prichard adopts the basic ontology of Hancock and assumes it is correct, with the Moral Faculty, Reasoning Faculty and the Will constituting the main interrelated components of the self-system for being human. Prichard then describes the ways in which the Moral Faculty becomes disordered in the same way as Hancock does – as *lack of self-control* producing moral habits of excess and insufficiency of moral emotions and interpersonal relationships. Thus through his 1835 publication Prichard dialogically transports the Moral Faculty, and its functioning of order and disorder, from an anti-modern moral/religious discourse into a scientific/medical discourse, thus transforming *moral disorder of excess and insufficiency* of poor *self-control* into a scientific category of *Moral Insanity* of medical disorder/disease.

2.4 Prichard creates “Moral Insanity” using the medical model genre

In contrast to Hancock’s (1824) explicit Christian epistemology, Prichard (1835) is a medic who claims to only use the modern positivist scientific epistemology of outward observation, hypothesis and reasonable reflection. Prichard takes Hancock’s conception of order and disorder in the Moral Faculty in relation to people’s *lack of self-control* over natural desires leading to excess or insufficiency and re-contextualises it within a medical model genre of madness mimicking how physical illnesses are seen as a discrete syndrome of symptoms with underlying cause. He says it is already accepted amongst medics that when the Reasoning Faculty becomes disordered people believe in something untrue (a delusion) and madness can be diagnosed. Prichard builds on and expands this argument by claiming to have observed and discovered an entirely new ‘type’ of disorder of madness where the Reasoning Faculty is unaffected but the Moral Faculty has become disordered. The medical model genre of madness borrows concepts from physical medicine where *disorder* and *disease* become interchangeable concepts. Thus Prichard argues habitual moral excess of emotion and interpersonal relations due to lack of self-control are symptoms of “Moral Insanity”. In order to diagnose the disorder medics should look out for habitual moral excess in patients as symptomatic indicators of the syndrome of Moral Insanity. For example, he observes;

> “Not infrequently persons affected by this sort of disease [Moral Insanity] become drunkards; they have an uncontrollable desire for intoxicating liquors. They are occasionally “brought under control” by

> confinement in a lunatic asylum, but they demand their release, and once free...at the first opportunity resort to their former excess, though perfectly aware of the consequences that await them." (Prichard, 1835: p. 19)

Prichard argues Moral Insanity can be identified by observing habits of moral excess which affect the healthy orderly functioning of the system of Faculties by creating a *pathological disorder*. In defining Moral Insanity Prichard criticises "the German writer's" on Madness, exemplified by Heinroth, who argue, "..moral depravity is the essential cause of madness." (Prichard, p. 236).

The main difficulty for Prichard, writing as a modern scientist, is Heinroth, like Hancock, writes from within a Christian epistemology and says the mad who have problems with self-control over moral issues, like anger and violence, need to confess and repent (turn away) from their excess ('sin'). This approach does not fit with a modern scientific epistemology so Prichard distances himself by criticising Heinroth's use of "dogma", but says Heinroth still has some useful ideas (Prichard, p. 236).

Prichard *assumed* his readers would accept the ontology of the self, with three Faculties of Reason, Will and Morality, which he uses in his text (Prichard, 1835), without arguing evidence to justify his ontological assumptions. He does not argue he has discovered this particular ontological ordering the Self using scientific epistemology, instead he refers briefly to other writers, such as

Hancock (1824), and praises their philosophy for the authority to assume this ontology is correct and usable as a basis for developing definitions of Madness (Prichard, 1835: p. 189). Prichard does not address the fact that Hancock's ontological arguments for the ordered and disordered workings of the Moral Faculty are based on a Christian epistemology and are articulated in a publication which argues against adopting modern scientific positivism in relation to governing human beings (Hancock, 1824). Thus modernity reflected on its other and absorbed moral disorder into its medical/science discourse. This raises a question about whose moral order will treatment work to establish if medics are defining the diagnosis of moral disorder? This is particularly interesting if medial science is borrowing definitions of moral excess from anti-modern writers such as Hancock who problematises issues like un-forgiveness, guilt and pride (excess self-esteem) from a Christian ontology and epistemology.

Prichard (1835) argues that medical writers on madness before him have defined madness too narrowly. He criticises Locke for defining insanity only in the form of a false conviction or erroneous notion. He also criticises Cullen for excessively *narrowing* the definition of madness to unreasonable thoughts and false beliefs (Prichard: p.iii) because he has observed a kind of madness where, "..the disorder is manifested principally or alone, in the state of the feelings, temper or habits." (Prichard, 1835, p. iv)

Prichard argues Pinel is the modern medical writer on madness who has come closest to observing this distinct category of madness when observing

“madness without delirium”. However, he criticises Pinel for illustrating this type of madness too narrowly with examples of “fits of anger” and “rage” as the true disorder affects the full range of moral emotions, including fear, self-esteem and guilt, as well as social relationships (affections), all located within the Moral Faculty. Prichard says he will define the mental disease of Moral Insanity for the first time in history and in doing so he will be the first modern scientist to define the pathological manifestations of this moral disorder fully. He decides to create a general category of Moral Insanity rather than sub-dividing into varieties as he say “In fact, the varieties of Moral Insanity are perhaps as numerous as the modifications of feeling or passion in the human mind.” (p. 17). Prichard claims to have discovered Moral Insanity through his scientific observations, defining it as;

> “In cases of this description the moral and active principles of the mind are strangely perverted and depraved; the power of self-government is lost or greatly impaired; and the individual is found to be incapable, not of talking or reasoning on any subject proposed to him, for this he will often do with great shrewdness and volubility, but of conducting himself with decency and propriety in the business of life.” (Prichard, 1835, p. 4)

Prichard outlines the key symptoms for medics to observe in order to diagnose Moral Insanity as insufficient or excessive habits in; interpersonal power-relations (p. 14), social attachments (‘moral affections’) (p.15), moral emotions (such as sadness, fear, anger and excitement (p.18)) and self-esteem (p. 17).

As we shall examine further in the next chapter, insufficiencies and excesses in these key areas of moral insanity are defined as pathological personality traits in the 21st century and are specifically included in the DSM-5 (2013) diagnostic criteria for personality disorder.

Prichard highlights an obvious diagnostic problem for medics will be where to draw the line between *normal* and *excessive* moral habits. Although he thinks it 'perhaps impossible' to determine where this line lies (p.18) it may be obvious to a medic if they are expressed "...beyond the limit that belongs to natural character." (p.19). The dilemma of defining the line between acceptable habitual moderation and excess can still be observed in contemporary personality disorder literature (e.g. Livesley & Larstone, 2018, Potter, 2011).

In terms of aetiology Prichard (1835) says habitual excess and insufficiencies may develop through a gradual 'increase of peculiarities', or may be in reaction to some specific traumatic incident, such as being deeply affected by some "reversal of fortune" (p.12) or the loss of a relative (p.13). Prichard concludes the prognosis for moral insanity is worse than for other forms of madness, and recovery "can scarcely be expected" when connected with a strong natural disposition, but if it is caused in reaction to an external cause, then if the negative influence is removed then a gradual recovery is possible. Prichard says that whilst reversing adverse circumstances can produce recovery in some cases of moral insanity, to produce such a reversal of circumstances "…the art of medicine affords very inadequate resources." (p.26).

Thus Prichard created the new category of Moral Insanity in 1835 expanding the nosology of madness by reframing the Moral Faculty from a religious/moral discursive genre into the hybrid meta-genres of positivist science and the medical model which grow to monopolise discursive practices around the mad subject. It is useful to conceptualise this process through a Bakhtinian lens where the dialogical context was a tension between the growing centripetal forces of modernity forming a monological discourse of positivist science and centrifugal forces opposing its formation. Hancock's (1824) anti-modern text can be seen as representative of centrifugal forces, whilst Prichard's (1835) text is representative of the modern centripetal forces gathering momentum. When Bakhtin wrote some brief notes *Towards a Methodology for the Human Sciences* (in Bakhtin, 1986) he describes the problem of *understanding in a remote context*. Using this conceptual lens we can see the dialogical interaction between Hancock's and Prichard's texts enabled the ontological framework and orderly/disorderly functioning of the Moral Faculty to be transported into the *relatively remote context of understanding o*f the medical model genre in order to construct a new disease/disorder of moral insanity. Thus Prichard's treatise in 1835 expanded the medical gaze to insist that attention should be paid to possible disorders of excess and insufficiency of self-control in the moral faculty, foreshadowing the description of Personality Disorder in DSM I (1952) though to DSM 5 (2013).

2.5 The 20th century's routes of DSM's Personality Disorder develop from Moral Insanity

2.5.1 The 1920's - Psychopathic Personalities

Both Berrios (1993) and Livesley (Livesley & Larstone, Ch 1, 2018) identify Kurt Schneider (1923/1950) as the writer who influenced the transformation of Prichard's 19th century disorder of Moral Insanity in the 1920's into the concept of "*psychopathic personalities*" in the 20th century, through his publication of "Psychopathic Personalities" (Schneider, 1923/1950). However, before Schneider the idea of *psychopathy of the personality* can be found as early as 1845 in the writings of Baron Feuchterslaben. He popularised the concept of psychopathy and psychopathic as an interchangeable ways for medics to describe any mental disorder in the 19th century. Specifically Feuchterslaben (1845) talks of the psychopathies of the personality as disharmony or disease in the harmonious relations of feeling, reason and will in the personality of the patient, stating;

> "Everything, therefore, which helps to form, to determine and to restrict the personality of man, is to be considered only as a cause of the psychopathies, and the change taking place in the midst of his (empirical not metaphysical) personality itself, is to be considered as psychopathy." (Feuchterslaben, 1845, p. 243).

Late in the 19th century, during the 1890's, Julius Koch proposed renaming Moral Insanity as Psychopathic Inferiority defined as a weakness in the moral faculty, arguing psychopathic habitual criminals should be treated less harshly than mentally healthy criminals due to diminished responsibility (Berrios,

1993). Schneider (1923/1950) argued Koch's attempt to redefine Moral Insanity as Psychopathic Inferiority was misinterpreted as too moral in its definitions. He says Koch was not intending to be moralistic, but he thought some of Koch's illustrative phrases categorising character types may be seen as moral judgements, such as; over-scrupulous, tactless, lounger and gossiper, highly-strung, vain and dandified, trouble-maker, bad lot, obstinate, and the 'fanatic for justice' (Schneider, 1923/1950, p. 20-21). Instead Schneider proposed his description of "Psychopathic Personality" as a more 'scientific' description of disorders of the personality as a distinct category to the mental health nosology. Schneider criticises the 'old concept of moral insanity' (Schneider, 1923/1950, p.130) for being too generous in covering too broad a range different types of psychopathic personalities within one concept (Prichard had said there were simply too many to sub-classify), whereas his new concept will have sufficient sub-categorisations to differentiate different 'types'. He argued whilst there are extreme abnormal variations from the healthy average functioning personality there is a clinically significant sub-group which can be distinguished where extremes of personality *cause the person to suffer* or *the community around them to suffer*, this sub-group he called *psychopathic personalities*. He defined ten ideal types of psychopathic personality as; attention-seeking, explosive, affectionless, weak-willed, asthenic, depressive, hyperthymic, insecure, fanatical and labile.

Scientifically, not morally, he argued abnormal and psychopathic personality are statistical deviations from the average normal personality in current society. Dialogically distancing moral insanity from morality to be conceptualised more scientifically Schneider stresses,

> “The variation may be expressed as an excess or deficiency of certain personal qualities and whether this is judged good or bad is immaterial to the issue…Our own definition of psychopathic personality remains a clinical one and non-moral…we wish the topic as a whole to be entirely removed from the sphere of moral judgement.” (Schneider, 1923/1950, p. 3-4).

Schneider defines psychopathic personality but argues this should not be seen an “illness”, even when used in psychiatry as a metaphor. He questions whether a failure to meet the moderate requirements of society can be called an illness (p. 8). He shares with Pelmann (1893) an anxiety that if psychopathic personalities become defined as an illness then this would risk every “rascal” in court being labelled as morally insane, and eventually no sane person in court will be seen as “a sane rascal.” This concern can still be seen in current debates about mental health, diminished moral responsibility and crime (e.g. King & May, 2018). In 1923 Schneider warns of the potential misuse of “psychopathic personality”, stating there is a danger of harm if they are used as “diagnostic categories” and not merely as “types” (as he intends) because,

> “The human personality cannot be labelled diagnostically as we label mental or physical symptoms.” (Schneider, 1923/1950, p. 51).

However subsequent psychiatric nosologies, such as DSM I (1952) (discussed below) broadly use his definitions of psychopathic personality whilst choosing

to simply ignore his warning not to use them as diagnostic labels of illness/disorder, perhaps as Schneider predicts, due to entrenched clinical tradition. He warns some psychiatrists may abuse these types as ‘labels’ to diagnose people and then withdraw, without looking to the work of psychotherapeutic influence to moderate the excesses and insufficiencies of personality types (Schneider, 1923/1950, p. 56). On the other hand he says psychotherapists often overlook un-psychological factors like the innate hereditary biological disposition behind some personality characteristics and are mistaken in looking for explanations solely in terms of early childhood conflicts. He says the aetiology of excess and insufficiency is partly biological, but partly in early childhood conflicts and also modified by social contextual factors.

Examples of excess and insufficiency within Schneider’s definitions of psychopathic personality include; over-confidence, overestimated self-esteem, inadequate self-esteem, over-optimistic, overly-pessimistic, alcoholism, insecure feelings, overly anxious, overly high moral standards, harsh self-judgements, over-compensatory activity to hide inferior feelings, guilt, excessive shame, insufficient shame, insufficient remorse or conscience, lack of compassion, overly-combative fanatics (his illustrative example being, “Leaders of the early feminist movement in England..” (p. 101)), weak-willed, too easily led, overly labile mood changes, short-tempered explosive personalities, defiance and bitterness (p. 69-144). He stresses these habits are to be thought about by professionals *scientifically*, and not in moral terms.

2.5.2 The 1930's and 1940's

The wider dialogical context of the 1930's and 1940's experienced a power struggle between bio-psychiatry emphasising the genre of the medical model and a categorical approach (assuming biological aetiology) and the rise of psycho-analytic psychosocial/psychosexual explanatory discourses around 'normal' and 'deviant' sexual development. Freud's theories of conflicted psychosexual childhood stages of development influenced ideas in psychoanalytic discourses as the idea developed (through writers such as Reik) that relatively stable personality patterns or character types may develop from each psycho-sexual conflicted state, such as obsessive/compulsive character types (e.g. Reik, 1932/1959). It was in this competitive context that DSM I (1952) was created.

2.5.3 The 1940's and 1950's - DSM I (1952)

By the end of World War II in 1945 psychiatry had been heavily influenced by exposure to the general population in contrast to the pre-war context of mainly seeing patients in insane asylums. This was due to military psychiatrist's involvement in the recruitment, discharging and treating of both combatants and veterans, which increased their awareness of adverse reactions to trauma. During World War II US army psychiatrists had developed its own psychiatric nomenclature to guide their practice and published guidance called "Medical 203 - War Department Technical Bulletin" (1946/2000). This text drew on the historical context of existing mental health literature and applied it to recruiting and discharging civilian populations into military personal.

Medical 203 divided psychiatric states into categories of mental disorder, sub-classified into “reaction types” due to the influence of psychodynamic discourses. Medical 203’s general categories of disorders included; simple personality reaction, psycho-neurotic disorders, somatisation reactions, character and behaviour disorders, immaturity reactions, disorders of intelligence, psychotic disorders, paranoid disorders, affective disorders and organic psychosis.

Medical 203’s **Character and Behaviour disorders** are described as pathological developmental defects/trends in the *personality structure*, sub-classified as disorders of *pathological personality types,* acknowledged in the text as often being synonymous with the earlier definitions of *psychopathic personality types.* These disorders are defined as; schizoid, paranoid, cyclothymic, inadequate, anti-social, asocial and sexual deviate (transvestitism, homosexuality, fetishism, sadism, etc.). There is an additional sub-classification of addiction (to alcohol or drugs). The nosology of individual *pathological personality types* is changed from Schneider’s original list, but the reader is often informed the new “…term is synonymous with the former diagnosis of psychopathic personality…” (Medical 203, 1946/2000, p. 929/930). The *genre of excess and insufficiency* is maintained and the symptomatic character/personality traits of concern remain largely the same, such as; insufficient sociability, suspiciousness, envy, jealousy, stubbornness, sadness, elation, poor judgement, inadaptability, social incompatibility, disregard for social codes and *amoral* habits/trends.

Medical 203's general disorder of **Immaturity Reactions** are also described as replacements for the former diagnosis of *psychopathic personality types*, and are sub-classified as; Emotional Instability reaction, Passive-Aggressive reaction, Passive-Dependency reaction, Aggressive reaction and Immaturity with symptomatic habit reaction. Symptoms include strong and poorly controlled guilt, anxiety and aggression, inefficiency, procrastination, resentment and temper tantrums.

After the war ended, the American Psychiatric Association (APA) published its psychiatric nosology, the Diagnostic and Statistical Manual, DSM I (APA, 1952). DSM I's stated aim was to address the deteriorating confusion around psychiatric nomenclature (p. Vii). DSM-I's nosology drew heavily on the US Army's Medical 203 document including descriptions of the disorders of pathological personality types. DSM I claimed its members (of the APA) had demanded more information on diagnosing personality disorders (p. Vii). DSM I adopted the general concept of "disorder" of personality pathology. However it substituted the word "disorder" for the word "type" to re-describe Medical 203's *pathological personality types* as diagnosable "Personality Disorders". Although now called Personality Disorders, it largely used the list of individual problematic personality traits that medical 203 claimed medics should be looking out for. Although an apparent subtle substitution of "disorder" for "type" of personality pathology, arguably reasonable as Medical 203 already had placed personality pathology in a general category of mental disorder, the historical effect is profound in ignoring

Schneider's original intention and warning that personality "…cannot be labelled diagnostically" (Schneider, 1923/1950, p. 51).

In the post war context DSM I was influenced by psychoanalytical discourses in explaining the excess and insufficiencies of personality as *reactions*. Personality Disorder emerges from ideas around excess and insufficiency linked to *psychopathic personality types*, but is deployed as a diagnosable *mental disorder*, rather than a non-diagnostic *type* on a dimensional spectrum linked to normal personality. Thus in the 1950's Personality Disorder emerges in DSM I to include symptoms of poor self-control leading to habitual excesses and insufficiency (APA, 1952). However, departing from a strict medical model genre, DSM I explains excessive habits of personality in psychoanalytic terms as defensive *reactions* protecting the ego.

DSM I described Personality Disorders as developmental pathological defects/trends in the personality structure and exaggerated personality/character patterns. Frequently it clarifies that the new term is superseding but synonymous with a type of *psychopathic personality* (p. 36-38). DSM I groups Personality Disorders into three clusters and a "Personality trait disturbance, *other*" category allowing for any excessive personality trait not covered elsewhere, to permit a 'greater latitude in diagnosis' for Personality Disorders. DSM I's first group of Personality Disorders is described as resistant to any restructuring of the personality through therapy, these are; **Inadequate** (with traits such as; lack of emotional stamina, social incompatibility, poor judgement), **Schizoid** (with traits of;

avoidance of social relations, inability to express aggression, eccentricity), **Cyclothymic** (with traits of persistent euphoria or depression) and **Paranoid** (with traits of; envy, extreme jealousy, suspiciousness, stubbornness, exquisite sensitivity in interpersonal relationships). DSM I's second cluster of Personality Disorders include; **Emotionally Unstable** (including traits of; fluctuating emotional attitudes, *strong and poorly controlled* guilt, anxiety and hostility), **Passive-Aggressive** (traits may include; pathological resentment, over-dependency, indecisiveness, inefficiency, passive obstructionism, procrastination, irritability, temper tantrums) and **Compulsive** (with traits of; excessive adherence to standards of conscience, inordinate capacity for work, lacking normal capacity to relax, over-conscientiousness).

DSM I's third cluster is called *sociopathic personality disturbance* who, "…are ill primarily in terms of society and of conformity to the prevailing cultural milieu…" (p. 38). This grouping is sub-categorised into; **Antisocial reaction** (including; callousness, irresponsibility, hedonistic, rationalising anti-social acts), **Dyssocial reaction** (including disregard for usual social codes due to living life in an 'abnormal moral environment' and adherence to values/codes of criminal or *other* social groups), **Sexual Deviation** (including homosexuality, fetishism, transvestism, sadism) and **Addiction** (**to Alcohol** or **to Drugs**). Schneider referred to the 'old term' of *moral insanity* being incorporated within his new term of psychopathic personality (Schneider, 1923/1950, p. 130). In a similar discursive move, DSM I explicitly acknowledges that Personality Disorder is a new term synonymous with, but now superseding *psychopathic personality types*, incorporating its concern with personality patterns of excess

and insufficiency (of conscientiousness, emotionality, social dependency, etc.). Thus Moral Insanity can be linked to Psychopathic Personality and then Personality Disorder through this series of superseding discursive manoeuvres.

2.5.4 DSM II (1968)

Towards the end of the 1960's DSM II (APA, 1968) was published. This reduced the 12 categories of Personality Disorder to 10 as they decided to separate **Addiction** (to *Alcohol* or *Drugs*) and **Sexual Deviation** from their original list and give them their own codes as distinct disorders. Relatively minor changes were made to the descriptions of the remaining Personality Disorders; **Dyssocial** is dropped in favour of keeping **Anti-Social**, **Compulsive** is re-named **Obsessive-Compulsive**, **Emotionally Unstable** is renamed **Hysterical** with the addition of the habits of being seductive, attention seeking, vain, and self-centred, **Paranoid** is kept but adds a trait apportioning moral responsibility of '*blaming others'*, **Cyclothymic, Schizoid**, **Passive-aggressive** and **Inadequate** are all kept (DSM II, 1968). In addition two of Schneider's original list of *types* of *psychopathic personality* are introduced as new Personality Disorders, namely; **Explosive** (for those with outbursts of rage) and **Asthenic** (for those *over-sensitive* to stress and unable to enjoy life).

2.5.5 DSM III (1980) - The neo-Kraepelinian influence

The dialogical context in which DSM III was produced was one where the authority of the APA and the medical model of psychiatry was being challenged

from a number of different directions including the anti-psychiatry movement (e.g. Szasz, 1970, 2009), psychoanalysis (e.g. Collier, 1977) and sociology (e.g. labelling theory (see Scheff, 1974)). A dialogical analytic lens would see these challenges as centrifugal forces challenging the centripetal forces of medical science claiming monological authority over the mad subject. In a dialogical reaction to these challenges a group of prominent psychiatrists formed the neo-Kraepelinian movement asserting the legitimate authority of psychiatry and the medical model over the mad subject including mental disorders as discrete syndromes with predominantly a biological aetiology. This movement heavily influenced the text of DSM III, removing the psychoanalytical explanations of personality disorder, and the descriptions of disorders as "reactions", which had been present in DSM I, whilst retaining the authoritative claim to a categorical (not dimensional) medical diagnosis as distinct psychopathic Personality Disorders. DSM III introduced a new model of five Axes, with each axis potentially influencing the others. It placed major clinical syndromes (such as depression and schizophrenia) in Axis I, Personality Disorders in Axis II, physical problems in Axis III, psychosocial stressors in Axis IV and Axis V estimated the patient's level of adaptive social functioning.

DSM III kept **Schizoid, Paranoid, Antisocial** and **Passive-aggressive** Personality Disorder largely unchanged. **Obsessive-Compulsive** is returned to its original **Compulsive,** and **Hysterical** becomes **Histrionic. Cyclothymic, Inadequate, Explosive** and **Asthenic** are dropped and five new categories were added; **Narcissistic, Borderline, Schizotypal,**

Dependent and **Avoidant**. Although introducing some new sub-categories DSM often re-introduces older psychopathic traits which had appeared in Medical 203 into these new disorders, such as emotional instability (in **Borderline**) or passive dependency (in **Dependent**). The option was retained for *other, mixed or atypical Personality Disorder* to allow professionals diagnostic latitude to diagnose Personality Disorder in their clinical judgements (Coolidge and Segal, 1998).

The text was revised in 1987 (DSM III-R, 1987), keeping the eleven categories but proposing two new ones for further study, **Sadistic** and **Self-Defeating**. **Compulsive** reverted back (again) to DSM I's original **Obsessive Compulsive**. DSM IV was published in 1994. As described in chapter one, a feminist campaign succeeded in preventing **Self-Defeating** Personality Disorder entering the official nomenclature and **Sadistic** was also dropped. The rest were retained apart from Passive-Aggressive which was put into the appendix, which has left 10 consistent categories relatively unchanged and authorised for use in clinical practice for over 30 years, from DSM III (1980) through to DSM 5 (2013). The controversial decision by the APA to reject its own scientific working group's recommendations for evidence-based change and retain identical DSM IV-TR (2000) diagnostic definitions for Personality Disorder in DSM 5 in 2013 will be explored in more depth in the next chapter.

Thus Moral Insanity developed within medical scientific discourse to keep its symptoms of moral excess and insufficiency by developing through

psychopathic personality (Schneider, 1923/1950) and Medical 203 into *Personality Disorder* in DSM I (1952) through to DSM 5 (2013). This helps to explain why most of the excessive moral habitual traits which make up Prichard's definition of Moral Insanity in 1835, such as lack of self-control and intoxication (in DSM 5's Borderline Personality Disorder) or too high self-esteem (in DSM 5's Narcissistic Personality Disorder) are in current use in the definitions of Personality Disorder provided by The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5, 2013). The next chapter will examine in more depth the dialogical political context of the early 21st century in which DSM 5 (2013) was produced.

Once a monological modern episteme establishes its power over its subject it adapts and amends its knowledge over that subject within its own epistemological rules. It was Prichard's establishment of *Moral Insanity* in 1835 as a legitimate category within modern medical scientific discourse (Augstein, 1996) which allowed it to develop with relatively minor changes through Schneider's psychopathic personalities into DSM's *Personality Disorder* currently used in the 21st century (see Tyrer, 2015). In the history of systems of thought one text leads to another within the limitations of the epistemology. Once a diagnostic category is established funding by powerful mental health institutions tends to be offered for research around these categories which creates more knowledge justifying the category. A variety of attempts at treatments of the illness/disorder of Moral Insanity were developed or dropped and relatively minor changes to the definition have been made over the 180 years since Prichard's 1835 definition. What is of interest to note concerning

the inter-linkage of the moral and the medical is that Prichard originally developed the concept of Moral Insanity and its workings *from* outside of the modern scientific epistemology within the dialogical moral context of the rise of the epistemology of positivist modernity and the medical model genre and those who opposed it. For the truth of this knowledge was not simply produced as Prichard claims, by the scientific method of 'outward observation' and 'speculation' but in a dialogical relationship with modern medical science's *other(s)* in opposition to it, such as Hancock (1824).

This historical dialogical context explains how everyday moral issues became absorbed into medical disorders as practices on the mad subject became organised by the meta-genres of modernity's medical model and positivist science. However as will be explored in the next chapter, the medical model has experienced a narrative failure to come up with the basic generic expectations of its narrative, such as evidence for discrete categories of personality disorder (as opposed to a dimensional models), clear unitary aetiological causes of the disorder/syndrome, or an effective medical treatment which cures and heals, which are the minimal plot elements to reasonably expect from a modern scientific medical narrative genre.

Conclusion

This chapter has addressed my first research question investigating the historical evolution of medical and moral categories of personality disorder by examining historically how everyday moral dilemmas became embedded within psychiatric diagnostic criteria within DSM. This has traced Prichard's

Moral Insanity into ideas around Psychopathic Personality types, through Medical 203 and the emergence of Personality Disorder in DSM I and on through its further iterations. Comparing the texts in detail has allowed the consistent theme to emerge of *habitual moral excess and insufficiency*. It has examined how the creation of the hybrid moral-medical nosology occurred within a wider historical context of an epistemic shift into modernity. Prichard (1835) established the Moral Faculty, with its potential for disorder of excessive moral habits, to be legitimately part of defining the mad subject, partly by praising Hancock's (1824) philosophy and borrowing his Christian ontology where excessive habits lead to non-medical *disorder of the Moral Faculty*. Hancock had problematised habitual moral excess as disorder within a religious / moral discourse where habits such as resentment, pride and unforgiveness were, for him, problematic due to Christian ideas, justified by drawing on biblical quotations. Prichard then looked at habitual insufficiencies and excesses within the Moral Faculty with a modern medical/scientific lens and saw Moral Insanity/Disorder within patients in asylums in the early 19th century. The dialogue around moral disorder between anti-modern and pro-modern scientific discourses led to an adoption of habits such as pride, resentment and unforgiveness into the medical science of madness creating a hybrid moral-medical nosology. Examples of *habitual moral excess and insufficiency,* such as lack of self-control and excessive self-esteem (pride), have been traced in this chapter through to DSM 5's (2013) diagnostic criteria for Personality Disorder.

After Prichard (1835), future modern discursive developments occurred within the relatively narrow epistemic range of perspectives known as scientific modernity with *disorders of moral excess and insufficiency* being changed in name from Moral Insanity to Psychopathic Personality (with additional sub-classifications) and then into Personality Disorders. Epistemologically modern medical science claims to have clinically observed the symptoms of certain disorders of the mind by outward observation and speculation (hypothesis) about “mad” patents. As it developed, medical science in the second half of the 19th century viewed their mad subjects through the lens established by early modern writers on madness, such as Prichard (1835), and made the relatively minor adjustments available through the relatively limited range of truth producing techniques available within a *modern* epistemology (observation and hypothesis).

Thus this chapter has established that attention should be paid to *habitual moral excess and insufficiency* because these lie at the heart of the historical roots of DSM’s Personality Disorder criteria. Showing these problematised habits originated outside of the medical model genre (e.g. Hancock, 1824) demonstrates that such habits can travel between different narrative understandings. This opens up the possibility of analysing how *habitual moral excess and insufficiency* is made sense of within differing (and hybridised) narratives within contemporary auto-biographical accounts from people experiencing mental health crisis. Having examined the historical context of the emergence of Personality Disorder the next chapter addresses my second research question, ‘how do the moral and medical categories of personality

disorder *currently* interact?', drawing on contemporary critiques of DSM and Personality Disorder. In light of the themes emerging from the historical examination, particular attention will be paid to how *habitual excess and insufficiencies* are conceptualised within deferent genres. Such an approach resonates with a post-psychiatry position which argues legitimate space ought to be opened up and valued for a variety of non-medical perspectives on madness alongside traditional psychiatry by valuing a variety of voices such as; service user/survivor, philosophical, self-help, faith and spiritual perspectives on madness (e.g. Bracken and Thomas, 2005).

Chapter 3

Contemporary critical perspectives on the DSM and personality disorder

The aim of this chapter is to answer the question 'how the moral and medical categories of personality disorder *currently* interact?' The diagnostic and Statistical Manual of Mental Disorders is published by the American Psychiatric Association (APA), a professional organisation formed to promote the interests of its membership of over 36,000 psychiatrists. The APA's mission statement says it exists to "serve the professional needs of its members" and to "represent the profession of psychiatry" (APA website, 2016). In 2013 the APA published its fifth edition of its handbook of diagnosis, DSM-5 (2013).

DSM-5's content has been highly contested and critiqued from a wide spectrum of viewpoints; from within academia (e.g. Hornstein, 2013), from practitioners (e.g. Livesley, 2012), from service user groups (see Allister et al., 2018) and the media within the wider public sphere (e.g. Pickersgill, 2014). DSM's authoritative categorical approach to mental and emotional distress is understandably contested because *diagnosis* exerts multi-dimensional power over its subjects. The legitimisation of diagnosis in DSM-5 is used to justify specific institutional practices and its categorisations affect the economic vested interests of specific groups, such as; mental health professionals, the psycho-pharmaceutical industry, the medical insurance industry and institutional research agendas. Diagnosis also effects people as diagnosed

patients, in terms of; their social identities, stigma, benefit entitlements and treatment entitlement options. Diagnosis also constructs a boundary between what counts as normal and pathological, influencing the ways in which people think about themselves and others.

Prescribed treatments and clinical guidance intending to heal and cure are authorised in connection to specific diagnosis. To be treated and cured from a mental disorder involves being transformed into a "*mentally ordered"* individual who no longer meets the diagnostic threshold for a DSM-5 disorder. A variety of practices are *authorised* to restore order; physical treatments, such as chemical (e.g. anti-depressants, anti-psychotics, mood stabilisers, chemical castration), electrical (e.g. ECT), surgical (e.g. lobotomy), hospitalisation, verbal treatments (e.g. Talking Therapies; Cognitive Behavioural Therapy, Systemic Family Therapy, etc.) and visual treatments (e.g. EDMR for post-traumatic stress disorder) and occupational therapy.

3.1 DSM increasing disorder in society?

A considerable degree of DSM-5 criticism has come from within the mental health industry itself, for example an influential critic is Allen Frances. He is significant because of his authoritative speaking position as the psychiatrist who chaired the APA workforce which produced the previous edition to DSM-5, namely DSM-IV (1994). He criticises DSM-5 for excessively expanding diagnostic definitions to unnecessarily increase the medicalisation of 'normal' human experiences. Though not focussing on morality specifically, in part he

is concerned future DSM iterations will medicalise normal moral dilemmas of excess, such as turning temper tantrums into “temper dysregulation disorder” (Frances, 2013a, p. 149) or intermittent over-eating into “binge-eating disorder” (Frances, 2013a, p. 142). Frances argues DSM-5’s increasing medicalisation is not science based but serves a number of powerful interested parties including the pharmaceutical industry (Frances, 2013a, Ch. 3). He argues DSM-5 increases the pharmaceuticalisation of society that increases the profits of the pharmaceutical industry by shrinking the definitions of “normal” human experiences.

However Frances is not anti-diagnosis or anti-psychiatry but argues instead for a more conservative use of less, more tightly defined psychiatric diagnosis, applied more cautiously over longer time frames in gradual diagnostic steps, starting with the least harmful diagnosis. He argues this would allow scarce resources to be concentrated on a smaller number of people who experience the most severe and enduring emotional and mental distress rather spreading limited resources towards the “worried well” (Frances, 2013b). I would agree with Frances’s broad argument that DSM is unnecessarily expanding reach into ‘normal’ everyday issues, a criticism that could have been levelled at Prichard (1835). In particular, I would agree with Frances’s main argument - the influence of the pharmaceutical industry on psychiatric expansion – as this has supporting evidence elsewhere (see Whitaker, 2010, 2017). However I disagree with Frances in that the smaller group of diagnosis he wishes to retain as legitimate within the medical model include the Personality Disorders, which

I argue are better conceptualised dialogically within a wider range of genres other than a neo-Kraepelinian medical model narrative.

Expansion of DSM's diagnostic reach into normality is particularly questionable as the diagnostic categories it has already created, established and claims as true/real have longstanding criticisms in terms of their lack of scientific validity (e.g. Livesley, 2012). An example of these challenges to DSM-5 being a credible valid diagnostic toolkit fit for use in mental health is in a blog post in 2013 from Thomas Insel, the Director of the National Institute for Mental Health (NIMH), who wrote;

> "The weakness [of DSM-5] is its lack of validity. Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure." (Insel, April 29th, 2013)

Although questions have been raised for decades around DSM's validity, Insel's publically voiced doubts entered the public sphere attracting the attention of journalists asking if there was a crisis of confidence in psychiatric authority (e.g. Stevenson, 2013). Attention from the media was due to Insel's powerful *authoritative speaking position* as the director of the National Institute for Mental Health. Insel and NIMH had responded to academia's long held doubts about DSM's diagnostic validity by launching a project called the Research Domain Criteria (RDoC), a bio-science project with the aim of

changing psychiatric diagnosis by using more biologically based technology (such as genetics, cognitive science, and brain imaging) to create a new classification system to rival and replace DSM-5's categories. Indeed Insel makes it clear that one of the assumptions NIMH are making in their RDoC programme is: "Mental disorders are biological disorders involving brain circuits that implicate specific domains of cognition, emotion, or behaviour" (Insel, April 29th, 2013).

This shows APA and NIMH are rival powerful institutional players competing for the finite business, authority and power that can be exercised over the mental health subject, with APA claims in DSM-5 competing with NIMH's biologically based RDoC programme. Insel's blog weakened the credibility of DSM-5, bringing longstanding concerns about validity to mainstream media attention, however APA and NIMH have a shared interest in maintaining public confidence in professional institutional practices in mental health, so they came together after DSM's credibility had been weakened by NIMH, to make a joint public statement of mutual support for each other's institutions (see Pickersgill, 2014). In addition to exemplifying serious doubts about the validity of DSM's diagnostic categories, such institutional power struggles sensitises us to the need to pay attention to individual micro-level accounts of people with lived experience and not just macro-level conflicts. Micro-level analysis is one way to broaden the range of perspectives worth considering to resist solely focussing on these important, but relatively narrow macro-level powerful institutional disputes. I will address this micro-level of analysis in chapters 5 and 6, whilst holding in mind that these wider macro-level discursive battles

will influence and attempt to regulate the available ways in which individual experience can be thought about.

3.2 Feminist, poststructuralist and phenomenological critiques of DSM

From a different viewpoint feminist critiques of DSM have been sustained for over 40 years. A recent example is Cosgrove (2013) arguing psychiatry, as expressed in DSM-5, needs an epistemic shift from its medical reductionism into a holistic, gender informed, social, political and legal model. She argues DSM-5 is not “objective” science, highlighting the financial influence the pharmaceutical industry holds on individual APA members of DSM task forces. This creates a conflict of interest for those who powerfully create diagnostic categories for psychiatric practice (Cosgrove, 2013). This criticism was developed into a more substantial critique of DSM-5 lacking credibility because the APA has been corrupted through its relationship with the pharmaceutical industry (Whitaker & Cosgrove, 2015). This shows the institution of psychiatry has become corrupted by the *economies of influence* of the psychiatric *profession’s member interests* of APA (behaving as a guild) and the substantial income from the *pharmaceutical industry*. A small and growing number of psychiatrist and mental health professionals are now finding a voice for criticising current psychiatric practice, including its relationship with the pharmaceutical industry by organising around Robert Whitaker’s website madinamaerica.com.

Many poststructuralist arguments also critique DSM, for example, Guilfoyle (2013) argues DSM-diagnosed people are trapped in a subject position by the power/knowledge practices of psychiatry. People become recruited into this way of thinking about themselves (e.g. self-identifying as “borderline personality disorder”) becoming complicit in their own subjectification. Guilfoyle argues this lack of resistance to DSM labels may be partly explained by diagnosis giving some temporary subjective relief from anxiety, feelings of containment of uncertainties and the hope of “treatment” for ill health. He uses poststructuralist thinkers such as Foucault to argue people are always unfinalisable and power is relative, so people always have the potential to resist the current constraining and controlling power of DSM. Using narrative therapy concepts developed by White (2000) he problematises DSM knowledge practices by arguing diagnosis damages the diagnosed by closing down their access to alternative narratives within which they could reimagine themselves (Guilfoyle, 2013). This is relevant to the analysis in chapters 5 and 6 as consideration will be given to the extent to which people find DSM diagnosis helpful or unhelpful in making sense of emotional distress and the extent to which people access alternative narratives to the medical model to help them get better.

Another range of criticisms of DSM-5 comes from the phenomenological perspective, an example of which is Hornstein (2013). She critiques DSM-5 using subjective lived experience through people’s autobiographical accounts of experiencing severe mental and emotional distress. Based on her research into over 1000 autobiographical accounts, she argues DSM-5 categories are,

> "…so far away from lived experience as to have little clinical use" with categories "…that turn out to have little relation to anyone's actual experience." (Hornstein, 2013, p. 31).

This would resonate with Bakhtin's concept of *understanding in a remote context*, raising the question that if the context has become so relatively remote as to not be useful, then maybe the dialogical context needs to change? This theme will be explored in the analysis in chapters five and six by considering how relevant and relatively close/far people find diagnostic explanations are from their everyday lived experience.

3.3 DSM's categorical approach to mental disorder

DSM-5 (2013) defines 20 broad categories of Mental Disorder as pathological mental illnesses/diseases, exercising a dividing practice which separates the mentally ordered from the disordered, with the disordered further divided through sub-categorisation. To varying degrees professional practitioners recognise that categories are a convenient way for the industry to divide up its business, however the boundaries between constructed categories are not neatly maintained within real individual patient's lived lives (Frances, 2013, b). Personality Disorder is one of these 20 broad diagnostic categories which DSM-5 divides into 10 distinct sub-categories (DSM-5, p. 645), namely;

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder

- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder
- Dependant Personality Disorder
- Obsessive-Compulsive Personality Disorder, and
- Other Specified and Unspecified Personality Disorder (DSM V, p.645)

3.4 DSM and Social Functioning

DSM-5 (2013) describes **the general diagnostic criteria** for personality disorder (p. 645-6) as the existence of **pathological personality traits** that negatively affect the individual's ability to **function socially**, which can be traced back to Schneider's (1923/1950) concept of pathological personalities causing *suffering either to self or society*. Several studies of social institutions (such as prisons and psychiatric hospitals) find over two thirds of their population meet the diagnostic threshold for personality disorder irrespective of the actual diagnosis (Livesley, 2003). Thus the estimated 15% (DSM-5, p. 646) of the population who meet the diagnostic threshold for personality disorder are not evenly distributed throughout society but are disproportionately located outside of mainstream, employed society within what could be called the socially excluded under-class, located predominantly within populations who are poor, homeless and unemployed, revolving in and

out of social institutions such as prisons, homeless hostels, addiction services and hospitals. In contrast psychiatrists are located within relatively privileged speaking positions economically and culturally within the local moral orders of the middle classes.

DSM examples of Social Functioning are; gaining and maintaining paid employment, forming and maintaining friendships and/or an intimate relationship, performing adequately in family or social roles and the ability to maintain accommodation and honouring financial responsibilities. Thus DSM-5 defined *pathological personality traits* need to be causing relationship breakdowns, repeated dismissal from employment, prolonged unemployment, repeated homelessness and/or problems of offending leading to prison, in order to meet the diagnostic threshold for Personality Disorder.

Whatever position the reader takes in relation to the psychiatric category of personality disorder it is apparent that large amounts of tax revenue is spent by governments trying to control and/or transform this socially excluded minority into socially functioning personalities (e.g. spending on criminal justice rehabilitation, psychiatric services, employment services, homeless services, supported accommodation, substance misuse services, etc.). Whilst diagnostically significant, what counts as “social functioning” is historically and socially contingent, constantly changing as social expectations change throughout the 20th and 21st century. Therefore the personality disorder diagnosis relies on the concept of social functioning which is not an objective

static criteria but one varying over time as society changes (e.g. rates of and types of employment available, skills required, etc.). This raises questions about the extent to which people value social functioning (or lack of it) in their narrative accounts of recovery, which will be considered in the following analysis chapters.

3.5 Pathological Personality Traits

Once a mental health professional identifies a link between **pathological personality traits** and **impaired social functioning** (or **clinically significant distress**) a "personality disorder" can be diagnosed as they have been given *authority* by the mental health institutions, professional governing bodies (APA) and published texts (DSM-5) to practice this type of knowledge on their patients. Thus the semantic lens through which someone searches for a personality disorder is constructed by the DSM-5 text which guides the professional to assess pathological personality traits during the dialogue between professional and the patient undergoing a mental health assessment. The professional lens the subject is viewed through varies historically through each iteration of DSM, with more attention being paid to *inefficiency* and *procrastination* in the 1950's (in DSM I) whilst in the DSM II (1968) era clinicians were looking, amongst other traits, *for over-sensitivity to stress* and *outbursts of rage*. In reality the dialogue between professional and patient is always a unique encounter between two unfinalised subjective personalities, where both the psychiatrist and the patient always express a range of

personality traits in order to have a meaningful dialogue (anxious listening, annoyance, guilt, evaluative judgements on both sides, etc.).

Personality traits are defined as habitual ways, or patterns, of thinking (cognition), emotion (affectivity) and acting (behavioural). To count as pathological traits these **habits of thinking, emotion and action** need to be;

> "…stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood." (DSM-5, 2013, p. 645).

The mental health professional is told **not** to diagnose personality disorder if;

- The enduring pattern of personality traits is better explained by the direct effect of a drug, or
- If the traits are better explained by another mental disorder (like "Schizophrenia"), or
- If the traits are better explained by another medical condition (e.g. problems have only developed after a head trauma).

Thus Personality Disorder refers to pathological personality traits that have developed during someone's biographical journey traceable back to early adulthood or childhood. These traits are enduring, relatively inflexible habits of thinking, emotion and action. Each sub-category of Personality Disorder diagnosis depends on the particular cluster combination of personality traits judged by the psychiatrist to be impeding the patient's social functioning.

DSM-5 text *authors* Personality Disorder in two distinct senses; linguistically it constructs and defines how personality disorder, pathological personality traits and social functioning are defined for professional practice, and it gives *legitimising authority* to the professional who is trained in and believes in DSM's semantic categorical lens to diagnose and treat people who meet the above criteria as having a *Personality Disorder.* The process of legitimising authority linguistically constructing and *authoring* diagnosis will be picked up in the analysis in chapter 5.

DSM-5 (2013) defines seventy-nine pathological *personality traits* symptomatic of a *personality disorder*, examples of which include;

1. Lack of remorse
2. Persistently bears grudges, i.e. is unforgiving of insults, injuries or slights
3. Failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest
4. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
5. Reckless disregard for the safety of self or others
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations
7. Views self as socially inept, personally unappealing, or inferior to others

8. Has a grandiose sense of self-importance (e.g. exaggerates achievements and talents, expects to be recognised as superior without commensurate achievements)
9. Is interpersonally exploitative, i.e. takes advantage of others to achieve his or her own ends
10. Is often envious of others or believes others are envious of him or her
11. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation or devaluation
12. Inappropriate intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)

The previous chapter showed these habitual excesses and insufficiencies of poor self-control, such as frequent physical fights, irresponsibility, law-breaking and overvaluing (pride/arrogance) or devaluing self and others, were described in moral terms in Prichard's Moral Insanity (1835) and in a more medical/scientific genre in Schneider's Psychopathic Personalities (1923/1950). This thesis is exploring the idea that these traits gain their meaning from the local moral context defining what counts as *excess and insufficiency* and are not exclusively medical symptoms of discrete disorders. For example, from DSM-5's list, *remorse* requires a local moral framework as a prerequisite, within which guilt can be felt for perceived wrongdoing, and *forgiveness*/*unforgiveness* also need a moral framework in order to perceive wrongs done.

3.6 Livesley's critique of political power relations influencing DSM 5's Personality Disorder

Livesley (2012) outlines that scientific research has shown over decades that people do not fit neatly into DSM's ten personality disorder discrete categories, but instead people exhibit unique clusters of personality traits which appear within different categories. Additionally scientific research consistently shows that people exhibit personality traits on a *dimensional* range of severity, so traits like impulsivity are not either absent or present but rather there is a continuous range of trait expression as all people demonstrate *degrees of trait expression*. Livesley (2012) is a significant critic because of his authoritative speaking position as employed by the APA as part of the DSM-5 task force reviewing the research literature and evidence to re-define the diagnosis of Personality Disorder. The task force presented evidence that the current definitions of Personality Disorder were not supported by the scientific evidence, proposing a new dimensional approach rather than DSM's categorical model.

Despite their own task force presenting evidence that the DSM-IV descriptions were not valid, the APA decided to reject their recommendations, assigning them to a later section of the DSM-5 text on 'emerging ideas', and simply reprinted the old, now discredited (by its own taskforce), definitions of Personality Disorder from DSM-IV-TR (2000) in the new DSM-5 (2013) claiming they were valid for clinical use. Livesley explains this remarkable

decision as the APA choosing clinical *tradition* and interests of its member's over scientific evidence:

> "Thus, by conceptualising personality disorders as discrete types, the DSM-5 proposal adopts a model that according to a publication by the Work Group is untenable. Faced with whether to follow the clinical tradition and represent personality disorders with categorical / typal diagnoses or accept empirical evidence advanced with its own work group, the DSM-5 does not appear to hesitate – clinical tradition outweighs evidence, even evidence adduced by members of its own Work Group." (Livesley, 2012, p. 90)

The DSM-5 working group recommended some of the categories of personality disorder were discontinued, such as Narcissistic Personality Disorder, because the evidence simply was not there that this was a real credible diagnosis. Political pressure was then put on the working group to include certain personality disorder diagnosis because there were vested commercial and reputational interests invested in continuing a category despite the scientific evidence, for example, for Narcissistic Personality Disorder:

> "The issue here is not whether narcissistic personality disorder should or should not be included but rather that the decision to include it was based on politics, not science. The lack of evidence for the types

selected and susceptibility to political influence gives lie to any claim that the DSM-5 is evidence-based." (Livesley, 2012. p.90)

Thus the dialogical context contains criticisms of current DSM-5 Personality Disorder definitions as invalid, not evidenced based, untenable and politically influenced. Significantly criticisms are coming not only from outside, but from within the APA's own task force members, who are internationally recognised experts chosen by the APA themselves (e.g. Livesley, 2012).

Livesley is critical of DSM 5 and the medical model. He joined the APA DSM 5 working party to redefine Personality Disorder in line with scientific findings, but resigned and published some of his experiences of the political power struggles that go on behind the scenes when the APA create its DSM diagnostic categories (Livesley, 2012). He proposes developing an alternative conceptual model for 'a new science of personality disorder' based on evolutionary adaptations of the personality conceptualising *personality disorder* on a continuum with healthy functioning 'normal' personality (Livesley & Larstone, Ch 1, 2018). Whilst he has contributed much to the field of developing better services for this client group, I would view him as a relatively conservative critic of DSM 5 embedded within academic institutions, when viewed within the wider dialogical context of the heteroglossia of competing discourses around habitual excesses and insufficiencies of personality. Specifically Livesley promotes keeping the diagnosis of "Personality Disorder"

whereas I do not think this is sufficiently appreciative of patient disagreement (e.g. Allister et al., 2018).

Whilst I would agree with Livesley's preference for a *dimensional* model rather than a *categorical* model, I would differ in terms of what epistemology is appropriate for studying personality, as in this study I argue an ethical dialogical epistemology, based on Bakhtin (1986), better fits a dialogue around moral excess and insufficiency of personality. This study argues where the lines lie for excess and insufficiency will depend on the local genres and moral orders subjects are positioned within, and I will examine these lines in the later analysis chapters 5 and 6. By contrast Livesley takes a more traditional positivistic epistemological stance in his quest for "a new science" of Personality Disorder and does not see the excess and insufficiencies as moral issues but objective clinical ones (see Livesley & Larstone, Ch 1, 2018). However Livesley does draw on the work of Kellert, Longino and Waters (2006) to argue a philosophical pluralism of multiple approaches and models is needed for studying personality pathology. I would go further in arguing the personal and autobiographical needs to be considered more seriously and be given more weight within a systems-based approach such as Livesley's.

Livesley relies on the reviews of the literature by Widiger (1993) to evidence the research failure to find personality structures in line with DSM diagnosis. Whilst I would take this as evidence to argue for the abandoning of the personality disorder diagnosis entirely, Livesley proposes replacing DSM

categories with a dimensional four factor personality trait model *covering social avoidance, dissocial traits, emotional regulation and compulsivity* (Livesley & Clarkin, 2015). Whilst an improvement on DSM's categorical model, I do not think it necessary to clearly divide "personality disorder/psychopathology" from "normal personality". In contrast Livesley argues the need to retain, but better define, *personality disorder* in new classifications based on better science, in response to his criticism of DSM 5's attempt. I do agree that people do have habitual problems of excess and insufficiency affecting their social functioning, but would be in favour of opening up a dialogical understanding of these to an infinitely expanding number of possible narrative explanations, including, but not restricted to, those offered by psychiatry and psychology and the local speech genres of the people affected. I do not think it necessary to describe excess and insufficiency as *personality pathology or disorder* as Livesley does, but would suggest using everyday language from the genre of the person's life (such as 'unhelpful habits') alongside strengths based valuing of skills, which affect someone's life-story, journey or narrative. I also differ with Livesley in arguing these habits are moral or ethical problems deriving from differing local moral orders. I believe an ethical dialogical approach opens up new ways to reflect on ethical problems of excess and insufficiency without necessarily being morally judgemental in an absolute or positivist sense. Part of the appeal of the medical model is it appears to offer a relief from moral anxiety as the subject enters a narrative where they are a relatively passive patient, mentally ill or disordered with the offer of medical treatment and cure.

My concern is that if habitual excess and insufficiency is connected to ethics and people's local moral orders then we need an epistemology that allows an ethical dialogue about these dilemmas, and a medical model narrative may not be best placed to facilitate such a dialogue. I would suggest a dialogical approach could enable a helpful reflective dialogue about habitual excess and insufficiencies to occur without necessarily drawing on the medical lens of disorder. Such an approach could consider the range of discursive genres subjectivities in a dialogue are orientating within.

I would also take a more systemic view than Livesley who largely views the pathology within the individual. As I will examine in my analysis in chapters 5 and 6, I would put more emphasis on the context in which these habits are expressed by seeing any problematisation of excess and insufficiency as a dialogue between someone and their social world. Such a dialogical lens allows the social context of staff/institutions to equally be seen as a possible location in space/time where pathology is being expressed. For example Schneider (1923/1950) felt he could see excessive defiance in the psychopathic personalities of early feminist leaders in England, whereas an analysis focussed on the personal opens up space to consider the feminist's view, where feminist leaders may have seen their defiance as *a virtue* campaigning for social justice/change. Livesley does not give enough consideration to context of pathology, with his writing predominantly locating pathology in the individual personality and not in contextualised moments of ethical dialogue.

3.7 Personal moral habits as a set of skills, with capacity for excess and insufficiency

I am adopting a different theoretical underpinning from Livesley in viewing moral habits through a dialogical lens which considers the skills, excess and insufficiency of *both* professional and 'patient' within the wider context of differing discourses and institutions. DSM-5's medicalisation of the moral through its diagnostic definition of Personality Disorder can be critiqued using Rom Harré's social psychological concepts. Harré (1993) argued that to credibly reflect lived life a psychological theory needs to acknowledge that humans are *moral beings*. Harré argues that human beings live life within local, social patterns of value including institutions such as education, work environments, family life, etc. Within these "local moral orders" the course of our life is constantly being morally judged (*evaluated*) by others, and we too reciprocally judge others, and ourselves, in moral terms. Harré argues that social-psychologically we always hold multiple views of both how we see/judge/evaluate ourselves and how other people morally judge and evaluate the way we live our life, including its biographical trajectory.

Harré argues our lived life is judged against the local moral values of what is believed to be *good* and *bad* ways to live, and these habitual ways of living attract social honour/respect or contempt/shame. Harré's work developed Goffman's concept of a moral career, arguing that *local moral frameworks* are essential to understanding the psychology of human beings within their social context. A psychological theory that did not incorporate moral thinking would

be of little use, as it would not reflect lived lives. Thus to be relevant and useful psychology and psychiatry needs to be able to reflect on how local moral orders affect the way people habitually think, feel and act, such as how the local moral order affects someone's emotion of guilt or anger about a particular action.

People morally judge/evaluate the success and failure of their own and other people's lives in the everyday tasks and problem-solving of ordinary life. We are always evaluating and being evaluated on how well we perform these ordinary challenges of life, such as; speaking publically in a group, getting and maintaining employment, passing an exam, finding accommodation, socialising successfully, avoiding debt, finding an intimate partner, etc. Achieving these common social goals could be equated with DSM-5's description of "social functioning". Failure to function socially caused by personality traits is the defining characteristic of personality disorder as a health problem. Harré argues that failing to function socially and displaying certain habitual character traits or actions (e.g. lying, fighting) attract moral judgments from others.

For Harré (1993) people attribute *public social reputation* in the form of respect and contempt based on how they judge others performing these tasks and reciprocally people can feel respect and humiliation as their "*moral careers*" go up and down in the eyes of others. The public social reputation is attributed to relatively stable characteristics demonstrated by people which Harré calls their

character. For example, someone may be judged morally by others as being “a good listener”, a “habitual drunk”, “resentful, holding a grudge” or “very helpful” by their colleagues at work, based on their habitual character trait interactions with others.

When people are not functioning socially in the 21st century they may be referred for a DSM-5 (2013) informed mental health assessment. From this analytical lens the habits of thinking feeling and acting that mental health professionals are called on by DSM-5 to judge in their patients as personality traits, such as insufficient forgiveness, when making a personality disorder diagnosis, are the same moral habits of character Rom Harré (1993) discusses being practiced during moral careers.

These personality traits have originally been formed in the local moral orders of someone’s social world. For example DSM-5 asks the professional to judge the personality trait of “lack of remorse” in a patient. This implies there is an appropriate, objective, level of remorse to feel for a particular moral wrongdoing. Therefore in the dialogue between the two unfinalised personalities of professional and patient the professional is called upon to judge a moral quality in their patient and ask themselves: do they lack the appropriate level of remorse for what they have done wrong (anti-social personality disorder)? Or alternatively at the other extreme, do they experience *too much* guilt linked to being over-conscientious (obsessive-compulsive personality disorder)?

DSM-5 claims the professional can judge this objectively using a medical/scientific lens. However there is no objective position for one unfinalised personality to judge another's habits morally as this judgement is made relative to the local moral order of the psychiatrist's social world or their imagined partial understanding of the local moral order of the patient's social world which will be affected by a number of factors including class, age, ethnicity, sexuality, etc. Either way it is ***a moral judgement*** evaluating if someone has too little (*lacking*) remorse or too much (*excess*) guilt. The levels of too little, appropriate, and excessive remorse is not quantified anywhere in DMS-5, it is left to the professional's *clinical* judgement. To illustrate that DSM-5 personality traits are moral habits consider the habits of being un-forgiving, described as a pathological personality trait; "*Persistently bears grudges, i.e. is unforgiving of insults, injuries or slights*" (DSM-5, 2013, p.649)

Medically ***unforgiveness*** is claimed as a pathological symptom of a mental disorder. However to be unforgiving of harm an individual needs to believe in a local moral framework with a good/bad axis around what is socially fair and just to enable them to judge the behaviour of others towards them as morally unfair and thus feel angry at being unfairly wronged. Unforgiveness cannot be problematised outside of a believed in moral framework. For example, to feel angry at being sexually abused as a child or robbed of intellectual property rights someone needs to believe these behaviours are morally wrong (abuse, theft, etc.). If someone repeats thoughts and feelings of anger at unfair injury

for a prolonged time period they may be judged by others to have a moral problem of being resentful, unforgiving and ‘holding a grudge’.

Additionally unforgiveness is problematised morally only within those discourses that ascribe positive moral value to the *practice of forgiving others*. The local moral framework within which someone has developed unforgiveness is replaced by DSM-5’s scientific/medical lens which sees unforgiveness not as a moral dilemma but as an unhealthy pathological personality trait symptomatic of mental disorder. The professional undertaking a mental health assessment is making a *moral judgement* about the patient (e.g. are they unforgiving?) in order to come to a medical diagnosis. Moral judgements are being made in a clinical setting and being presented as an objective medical diagnosis within a health narrative.

During a mental health assessment the professional’s evaluation of the patient’s habits in estimating their own value (self-esteem) are also moral judgements as is they have to judge if the patient has too much (*excess*) self-esteem (i.e. “grandiose, self-important, arrogant”) or insufficient self-esteem (i.e. self-esteem as “unappealing, inept, inferior”) or they have an ‘appropriate’ amount of self-esteem commensurate with their achievements. The patient’s habitual estimation of other’s character (other-esteem / public-esteem) are also *moral evaluations* as the professional judges if the patient habitually over-estimates others (e.g. “idealises”) or under-estimates (e.g. “devalues”) other people or if they unstably fluctuate between *idealising* and *devaluing*

themselves and other people, thus attracting a diagnosis of Borderline Personality Disorder.

Seeing personality traits as moral character traits formed during the moral careers of people's biographical trajectories raises the question as to whether medicalising moral habits into medical health problems holds back people's moral development. By diagnosing personality disorder around habitual traits DSM-5 takes common problematic habits affecting everyday goals of social functioning away from people's local moral frameworks, where they formed in the everyday genres of ordinary lived life, into a remote context of a medical discourse where the power, responsibility and authority lie more with the professional to prescribe an effective treatment to heal and cure these habitual problems. People may take less moral responsibility for their character trait difficulties if they believe it is a medical problem the professional is going to treat, especially if the professional takes authority, diagnoses disorder and prescribes treatments raising expectations of a cure. This suggests an analysis is needed to draw out the skills and problematic habits that can be conceptualised differently within both medical and alternative non-medical genres, which I will attempt to do through the analysis in chapters 5 and 6.

3.8 Moral habits as skills

From the perspective of Harré's moral careers people are seen holistically as much more than a list of their problematic habits (such as a list that DSM-5 presents – see p. 106/7). For example, Harré talks about morally valued habits people develop within local moral frameworks as skills. Thus an individual can acquire positively valued skills which enable them to perform the everyday social tasks expected from their society. Thus within a moral career perspective someone could be seen to vary over their lifetime and have a mixture of problematic habits (such as unforgiveness) and valued skills (such as listening, compassion and co-operating with others). This mix of habits, both morally problematised and valued skills are always seen in the local context of the narratively driven biographical trajectory of someone's life towards the goals they are trying to achieve with others.

Taylor (1989) argues people pursue their strongly valued idea of "the good life" within their currently believed narrative within which they orientate. Resonating with Harré's views, Taylor (1989) says this is primarily a *moral* experience where an individual's narratively driven desire to pursue their "good life" is strongly value driven. The valuing of the desired good life is experienced within a believed narrative which drives and motivates people to practice habitual skills and avoid morally problematic habits in order to perform relevant social tasks.

3.9 A different kind of validity: Experiential validity and '*expert by experience'* perspectives

The voice of 'experts by experience' and 'service users' receiving mental health diagnosis and treatment being able to influence the dialogue around personality disorder has been growing in recent years. An example of this was *emergence* (2018), an organisation led by people who had received a diagnosis of personality disorder. Examples of ways in which they influenced services was co-writing and co-delivering the NHS Personality Disorder Knowledge and Understanding Framework (PD KUF) training on personality disorder alongside NHS professionals to mental health staff. Admittedly involving service users in writing and co-delivering training is unusual within statutory mental health services. Guilfoyle's (2013) analytic lens would argue this is evidence of people becoming complicit in their own subjectification, drawn into promoting a subjective position of medicalised power/knowledge. However, the involvement of experts by experience in the NHS PD KUF training raises the question as to whether Guilfoyle over estimates the power of the medical model and in doing so is he disempowering service users as lacking choice and agency? The co-delivery of PD KUF training role modelled partnership working and visibly showed staff that people with the diagnosis have strengths, skills and assets, as well as difficulties. I have co-delivered this training myself and co-deliver the forensic Personality Disorder KUF course in 2018. This is an example of shifting the power relationship between patient and professional to a more collaborative approach, compared to training only delivered by professionals. However, legitimate questions can be raised about

the extent of the service user involvement and the limits of the ideas that can be shared through this training once the course content is set and agreed.

Also, unfortunately emergence as an organisation went into liquidation due to reduced funding from the NHS which clearly demonstrates the limits to service user involvement if the funding comes primarily from statutory mental health institutions, such as the NHS. As with any financial relationship service user groups funded by mental health institutions will have to negotiate the limits to how far they can go in campaigning for change without risking their funding being cut, which is clearly an unequal power relationship funding the voice of *experts by experience*.

Another example of expert by experience voice is “The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder” (Allister et al., 2018). The Personality Disorder Consensus Group producing this text was co-chaired by Sue Sibbald, a Peer Specialist in personality disorder, and involved a number of different professional and voluntary organisations in a dialogue to produce the statement. In comparison to DSM 5, this description of personality disorder talks of “poverty” and “childhood trauma” being large aetiological factors. It is also critical of the average service offered by the NHS as not meeting the complex needs of the people it diagnoses with this disorder. Its criticism are systemic in nature rather than focussing, as DSM does, all the pathology within the individual patient. For example it states,

> “People given a diagnosis of 'personality disorder’ have been left in the wilderness for too long and it's about time the system as a whole, such as health, social care, housing, third sector and community initiatives come together to bring help and hope.” (Sue Sibbald, p.3)

However getting consensus through dialogue between different professional bodies and service users is very difficult as it means sharing power dialogically, as the statement acknowledges. The statement says the label of “Personality Disorder” is misleading and stigmatising and their desire is to get rid of the label in favour of an agreed alternative (p. 4). However they also acknowledge that in the current system the diagnosis is for some the only passport to access services. The statement advocates for a holistic and systemic understanding of the individual with personality difficulties in the context of; past trauma, sexual abuse and adversities, poverty, deprivation, social exclusion (affected by race, gender, sexuality) and past attachment and relationship history. They also point to system failures of services providing support as a contributing factor to people developing personality difficulties (p. 9), which can be compared to DSM 5 descriptions - which do not locate pathology within the wider system of service failures.

The document summarises a consensus view between service users and professionals working in the field and is written in easy to understand plain English, without the need for clinical jargon. This is an example of how opening

up a dialogue and sharing power between experts by experience and professionals can produce a more useful discourse with a systemic understanding of aetiology, prognosis and treatment options whilst highlighting the need for change and continued campaigning for this socially excluded group of people. When the dialogical context is expanded to include views critical of the current system, including service user perspectives, then those services can be held in the dialogical moral context of excess and insufficiency (system failure) as well as the patients. An example of this is the view expressed that the NHS is insufficiently meeting the complex needs of people with personality difficulties associated with complex trauma (p. 4).

3.10 The practice of a foreign knowledge

Foucault said the motivation for his work was a curiosity for *the practice of a foreign knowledge* which resulted in the knower "…staying afield of himself" (Foucault, 1990, p. 8). In his work on the history of sexuality he argued seeing the history of our ways of thinking about our self can free people from being stuck in their ways of thinking, and so enable them to think differently about themselves. Foucault's *ethics* refers to these ways in which someone can have a relationship with themselves as they form themselves as the subject of particular moral frameworks within narratives which problematises some habitual parts of the self, whilst valuing others and defining moderation and excess.

Foucault's ethics (Foucault, 1990) is relevant to this study because in order to desire to be free of habitual thoughts, emotions and actions (of excess or insufficiency) any habit needs to be morally problematised within someone's believed narratives and local moral frameworks. It is a believed narrative which creates the motivation and desire to change those parts of the self by practicing techniques-of-the-self on offer within a narrative. Exercising ethical work on the self to achieve *moderate* habits requires effort and will only makes sense within a narrative where someone is working towards becoming their ideal self (telos).

As we shall explore in depth in chapter six, the subject who is discontent with their life-trajectory and experiencing a narrative failure may maintain their subject position or search for a 'foreign knowledge' to practice and a new narrative within which to re-orientate their habits within. In the analysis chapters I am going to focus on some 'successful' journeys of *getting better* from severe emotional and mental distress in order to examine other ways in which morality can be dealt with outside of, or hybridised with, the medical model genre.

Some people try a number of different believable discourses on their journey through life (scientific, medical, philosophical, political, religious, self-help, survivor, etc.) each of which offer different valued habits (skills) and techniques-of-the-self (revenge, forgiveness, meditation, medication, mindfulness, drug-intoxication, etc.) with which to reduce habits problematised

as insufficient or excessive (resentment, compulsion, anxiety, depression, intoxication, etc.) in order to work to achieve a specific ideal 'good life' or telos.

Some narratives may simply not problematise certain habitual parts of the self. If a subject believes and re-orientates their lived life within a new narrative only those habits a specific narrative morally problematises will require ethical work through practicing techniques-of-the-self. However in addition to someone's estimation of their self, there is always other people's public moral estimation of their habits and life-trajectory. Other people, such as partners, parents, line managers, work colleagues, landlords or friends in the local moral order may problematise habits an individual does not view as morally problematical, such as intoxication or punctuality, so the issue of who is problematising specific habits within particular moral orders will need to be explored in my analysis chapters.

However, Bakhtin's dialogical perspective would argue that a polyphony of multiple narratives can be active within an individual consciousness ***at the same time***, and a dialogue is always ongoing within and around someone in-between these competing narrative explanations of our habitual ways of being (e.g. "Why am I resentful?", "How ought I handle my resentments, with forgiveness or revenge?"). Someone may feel conflicted as they oscillate between believing different competing ethical narratives within which to orientate themselves and their habits. Bakhtin would argue such oscillations, hybridisations and contradictions reflect the reality of human psychological

consciousness (for example, see Bakhtin's analysis of Dostoyevsky's novel "Notes from Underground" (Bakhtin, 1984)). As we shall demonstrate in chapters five and six, Foucault's ethics (Foucault, 1990) becomes more complex when combined with Bakhtin's dialogical concepts, such as a polyphony of dialoguing discourses within an individual, as this opens up the possibility of conflicting ethics and ethical hybridisation. For an example of hybridisation, 'meditation' as a technique-of-the-self from Buddhism has been transferred into a secular technique-of-the-self and re-described in popular mental health discourses as 'mindfulness'.

Lived life is a heteroglot of multiple perspectives without any one unifying objective singular point of view (e.g. naïve positivism). However, epistemologically dialogism is not relativism, as each individual always holds a position with their moral values in time and space from which we evaluate other articulated positions, texts and utterances. There is no objective, value free neutral viewpoint above the discursive battle for the subject to position themselves within from which to observe the battle. The effect of the medical model genre is to close down every unique autobiographical journey and every voice, every alternative narrative understanding of problematic moral habits, in order to claim the final word (e.g. a diagnosis or a prescription). In contrast a dialogical approach always opens up understanding of something problematic (a failed narrative, a moral habit, an anxiety, a psychotic experience, a low mood, etc.) into an ever expanding context of different genres creating new dialogical understandings which could re-contextualise that which was initially thought to be problematic or unarticulated emotions. An example of applying

Bakhtin's dialogical approach to mental health problems would be the "open dialogue" approach to severe psychotic experience in Western Lapland. This has produced consistently remarkably positive outcomes since they replaced the medical model approach with an open dialogue approach over thirty years ago (see Siekkula, 2006, 2012).

Conclusion:

There are well-established and wide ranging criticisms of DMS-5, both from within and outside of professional mental health institutions. That many of the criticisms come from within traditional mental health professional positions (e.g. Francis, 2013, Livesley, 2012) could be explained by centrifugal social forces possibly increasing and thus weakening the grip of centripetal monological texts such as DSM-5 over their subject. However most mainstream mental health institutions continue to practice the categorical knowledge of "Personality Disorder" as authorised in DSM-5 (2013) despite its criticisms (lack of validity, vested professional and institutional interests, political pressure regarding categories, etc.) and some of DSM-5's critics are from equally centripetal competing forces such as the Research Domain Criteria bio-project of NIMH (Insel, 2013).

This chapter has gone further than the current critiques of DSM-5 in arguing that the pathological personality traits used to diagnose personality disorder (such as unforgiveness) are predominantly moral habits of excess and insufficiency formed in local moral frameworks within everyday speech genres

re-worked into a medical/scientific professional genre as symptoms of mental illness/disorder. This perspective raises the argument that not enough research has been undertaken on the personal take on morality in relation to experiences of mental and emotional distress and I address this directly though my analysis chapters.

Rather than medicalised as health problems, this chapter suggests that moral habits need to be investigated within people's moral careers (Harré, 1993) as they pursue their valued 'good life' or telos. As people perform everyday social tasks working towards the good life they desire within their believed narratives *dramas of character* are played out where habitual ways of achieving narrative goals are judged to be morally valuable skills (e.g. patience, perseverance) or devalued as excess and insufficiency (e.g. theft, violence, dishonesty). Foucault's ethical concepts allow some habits to be viewed as morally valued *moderation or skills* and others as morally excessive or insufficient. What habits are morally problematised and valued varies between locally situated narratives and moral orders. Ethical work on the self to reduce moral excess only make sense in the context of someone pursuing a believed narrative goal of becoming a certain kind of person (telos). The believable narrative motivates an individual to do ethical work on themselves through techniques-of the-self to reduce morally problematised habits into moderate habits in pursuit of their telos.

By medicalising moral habits into pathological personality traits DSM-5 has taken these moral habits out of their local moral framework into a *remote context of understanding* of a medical diagnostic text. This raised the question in terms of power-relations as to whether the power of DSM-5's health/illness narrative holds back people's moral development by taking problematic habits into the remote context of health where people become relatively passive patients being treated by relatively powerful professionals and their knowledge.

The biographical trajectory of someone trying to live their 'good life' (telos) and their habitual ways to live that life are evaluated morally by themselves and others. When an individual's narrative is failing (an experience DSM-5 defines as 'not functioning socially') they may have a mental health assessment within a medical genre that links this narrative failure to habitual personality traits resulting in a diagnosis of "personality disorder".

In contrast to the authorising positivistic medical/science categorical approach of DSM-5 (2013) a dialogical approach would allow problematic habits in failing narratives to still be understood in relatively remote contexts of understanding (new narratives, new genres) but would always resist privileging professional knowledge and medical/science narratives above all other narratives. We do not know enough of what people's stories are and so the following analysis chapters are going to examine such stories. This chapter has addressed my second research question – 'how do the moral and medical categories of

personality disorder *currently* interact?' Chapters two and three also anticipate my final two research questions that will be fully explored in my empirical study;

1. How do the medical and the personal narratives of "Personality Disorder" interact in lived experience?, and,
2. What narratives aid recovery in troubled journeys involving mental health crisis?, with an interest in contrasting how medical and non-medical genres might be used in recovery narratives.

Chapter Four

Methodology

So far in this thesis I have outlined the philosophical and academic framework underlying this enquiry and examined the macro-level historical evolution of medical and moral categories of personality disorder, followed by a consideration of how they currently interact. Now I outline the methodology I am using in chapters 5 and 6 to analyse micro-level individual stories.

4.1 Theoretical Justification for Narrative methodology

There are different kinds of truth, as Bakhtin (1993) notes when drawing a distinction between truth as abstract (*Istina*) and truth as lived experience (*Pravda*). The kind of truth and understanding I am searching for in this study of madness is *Pravda*. *Ontology* refers to the basic assumptions being made about what it is to be a human being within any mode of thought (Smith, 2007, p. 70). *Epistemology* refers to the fundamental ways in which truth claims are being produced and accepted within a discourse (Smith, 2007, p. 70). It is important to be explicit about ontological assumptions before discussing epistemology, as ontology and epistemology are interlinked. Ontological assumptions can often be left unspoken if writers exclusively concentrate on only describing their methods for producing truth (epistemology). The key ontological point I want to be explicit about from the start is that I am assuming human beings are moral and narrative beings in line with Taylor (1989).

Taylor (1989) is crucial in developing this moral ontological position because he links narrative to morality. Taylor argues knowledge is the result of narrative experience. Narrative agents know the world primarily through engaging in relational experiences rather than 'knowing' through detached cogitative contemplation. This narrative engagement with the social world is, for Taylor, unavoidably a moral engagement with society, infused with strong (and variable) positive and negative evaluations of ways of being in the world (Taylor, 1989). Taylor says, "Selfhood and the good, or in another way selfhood and morality, turn out to be inextricably intertwined themes." (Taylor, 1989, p. 3).

Taylor rejects the Kantian view of ourselves as pure rational agents, in favour of seeing people as combinations of rational, relational, moral and emotional factors. Taylor argues identity cannot be separated from the moral views (the "strong evaluations") which we constantly make about ourselves and others, about what it is good, fair and right ways of being in the world and which ways are bad, unfair or wrong. Being human means we have moral reactions to events. Morality is the tripwire of our emotions (e.g. anger at injustice). Prior to *modernity* people would speak of their 'moral-emotions' as a unified experience (e.g. Hancock, 1824).

The success of modern natural science, argues Taylor, has cast a "great epistemological cloud" over the assumptions of much human sciences over the last two centuries. He criticises the widespread acceptance of modern scientific epistemology which in general fails to address the fact that people

are moral agents. Hence, while the DSM historically borrowed from narratives of Christianity, explored in chapter 2, now it has rhetorically obscured these narratives. Taylor also questions whether the methods of natural science can easily be applied to human beings. He argues modern science's errors are largely accepted because "...[the] moral ontology behind any person's views can remain largely implicit." (Taylor, 1989, p. 9).

Taylor argues we live under this "great weight" of a modern epistemology, from which the human sciences must escape to gain better ways of producing truth claims. Thus the modern identity dilemma is a moral dilemma - where we try to fit our moral selves into scientific facts, which simply does not work (Taylor, 1989, p. 10). Social plurality means a number of competing stories circulate about what 'the good life' is, which makes many of our moral beliefs tentative and unsure (Docherty, 1993). For some people the solution is to believe that science can give us moral answers about what are 'good', 'fair', 'right' or 'just' ways to live.

Thus the modern identity, according to Taylor, tends to be wondering "what is the good life to live?" and, "in *what way* shall I live life?" These questions cannot avoid bringing morality into play. The space we orientate within is inescapably a moral space in relationship with others who judge us morally (positively or negatively) provoking feelings in us of pride or shame. We judge and evaluate ourselves by a set of values, which can change over time. In contemporary society people tend to be unsure if others share their moral views on a range of topics. In fact, we may ourselves only be tentatively

tethered to our current moral framework, doubting how 'believable' it is. In a pluralist world of competing and conflicting ethical stories about what "the good life" is, some people choose to change the narrative (story) they orientate themselves within many times, re-orientating subjectivity until they settle within a good story.

The central relevance of Taylor to Personality Disorder is that he draws our attention to the narrative of being "on a quest". The object of the quest appears to be the "...finding of a believable moral framework" (ibid., p. 17). Finding this believable moral framework is crucial to understanding one's problems within a life story. It is through believable moral stories (with plots, goals, conflicts and characters in them) that people *make sense* of their lives. This process of "trying to make sense of our lives" takes on the form of a story as it becomes "the object of a quest." (ibid., p. 18). To illustrate this point, Taylor gives an example of a moral story in ancient Greece, as Plato's view that the good life consisted of dominating and controlling yourself by gaining mastery over your desires through the use of Reason, a plot line he argues modern science has adapted.

Comparing stories in a dialogue with each other and teasing out what parts of a narrative are general (e.g. Valuing Self-Mastery as a good way of being) and which are unique (e.g. Reason defined as scientific rationality) is one of the analytic techniques used in narrative methodology (Taylor, 1989, p. 21). I will apply this technique in this study, comparing different stories which made

sense of mental and emotional distress in a dialogue with each other, teasing out what elements were the same and which were unique.

I agree with Taylor's ontology of people searching for moral meaning within narratives, searching for a kind of *narrative truth*. We saw in chapter 2 how people sometimes describe their life metaphorically like a "journey", describing where they have previously travelled to get to their current identity/position, and then often expressing intentions to move forward with their life in some way. Thus people make sense of themselves within unfinalised and unfolding narratives orientated towards "good" ways of being in the world, interwoven with morals, emotions and relationships. There is not just one narrative available, instead multiple possible narratives exist within which people can choose to orientate themselves. These narratives, including 'self-mastery through reason', often compete with and contradict each other, or fuse into hybrid stories (Taylor, 1989).

Taylor's philosophical ontology resonates with two basic points of Polkinghorne's narrative analytic method: 1. Human beings constantly tell themselves and others stories (with plots), and 2. These stories can be analysed to create some useful insights and truth claims (Polkinghorne, 1995). In Narrative methodology the social (space) and time (history) dimensions are explored and analysed through the narrative elements of someone's told story, drawing heavily on literary theory. This can then shed light on important concerns such as the transformation of identity, people's relationship to social

space and the how plots and story-lines help people make meaning and sense of unusual, extreme or unexpected experiences in their life.

Narrative accounts can be seen to be positioned amongst powerful discursive practices and major institutions, and/or ongoing social change processes. The weight of the focus on the narrative voice does not preclude the analysis by the researcher reflecting outwards, from the narrative with its plots, to reflect on insights into the bigger stories at work in the wider social world. As Plummer (2001) argues, narrative method can be used as an analytic tool to allow the researcher to analyse the relationship between the dominant discursive practices and social change from the perspective of an individual narrative account. Plummer's narrative approach focuses on examining the relationship between social history and biographical narratives, teasing out the contingent social forces that may be at work on the body of the individual narrator.

Writers such as Plummer (2001) and Good (2001) have shown narrative analytic tools can be applied that enable the individual narrative to be linked to a relationship with social historic phenomenon. Macro-level social changes may be referenced in micro-level narratives, such as the growth of, and subsequent closing down of, asylums, or the growth of the post-psychiatry and service-user led movements. Thus the narrative account allows for sociological and social-psychological analytic observations to be drawn. Narrative approaches allow consideration of the structured spacial/temporal relationship between characters in a typical plot, such as professional and patient in a

medical drama - around the ever moving space of “what it seems reasonable” to do with someone in an extreme state. History shows us that anything can be justified as *reasonable*, the difficulty is that what is reasonable may not equate with what is moral.

Bakhtin (1981) criticises monological discourses, such as positivistic human sciences, in favour of ‘polyphony’ - a dialogue between multiple discourses in time/space. Such a dialogue is without a final outcome (see Morson and Emmerson, 1990). Thus narrative epistemological approaches have the advantage of freeing up the analysis from dominant ideological theories that shape ways of thinking and listening to (filtering) the individual detail of someone’s story. Instead such approaches allow reflection outward, from the micro ‘small story’ to shed light on macro ‘Big Stories’ (wider social discursive practices). In positivistic approaches powerful discourses dominate their subject whilst saying little about the power relationship they are gripping their subjects within, in order to examine and treat them.

There are multiple reasons human beings may believe something is true, such as; knowledge gained through training in a profession, they may trust a particular epistemology, or the authority of an institution/profession producing a text, or are emotionally moved by some information, or because it makes sense in a story (it is *coherent and plausible*), or they trust the teller through a relationship of built trust, or they may believe in a *revealed truth*, or people may believe the majority opinion, because it fits with someone’s values, sense of social-justice or ethical beliefs, or people may believe as ‘true’ what it is

traditional locally to believe (a variety being ‘clinical tradition’), or believe something is true through *personal experience* of some *knowledge working effectively* to solve a practical problem.

The authority of an author to claim truth can be linked to power-relations, for example if their speaking position relies on holding a professional role within a powerful institution. Stanley (1994) illustrates how a narrative approach can challenge positivistic scientific research by bringing issues of power relations into consideration. Individual mental health service users hold relatively little power (institutionally, economically, culturally, in terms of roles) in relation to established powerful psychiatric institutions and their discursive practices. Consideration of power relationships is usually downplayed by psychiatry’s monological narrative of its method progressively discovering more and more human ‘truth’ to its subjects. Although *relatively* powerless, individual subjects can always practice strategies of resistance such as refusing to take part in a study, or refusing a particular type of treatment. Monological discourses are ones which, desiring a monopoly over what they consider their business, often silence and invalidate alternative ways of seeing the world. This is significant because studies find *validation* is often important in recovery narratives from Personality Disorder (Holm and Severinsson, 2011), so it would seem wise to be mindful of narratives that can invalidate experience.

Professional psychiatric accounts tend to claim a monopoly on telling the truth of the subject they claim authority over. The reality is though that there are always multiple, competing, alternative accounts of how to make sense of

experiences, which a monological discursive practice like psychiatry undervalues, in order to exercise its authority over the subject. We touched on an example of this in chapter 2 when the Quaker's "moral treatment" of madness valued itself as being an "amateur" approach to madness in the late 1700's, but this was quickly taken over and professionalised by medical science as its success threatened its professional hegemony. As a strategy to devalue and disempower amateur discursive practices medical science began to claim (for example, in the *Asylum Journal* (quoted in Digby, 1985, p. 113)) that moral treatment could now *only* be carried out by physicians.

Narrative method itself can be put into its academic historical context within the hermeneutic tradition. The philosophical paradigm which narratives are analysed within will influence the interpretation, and thus the kind of knowledge produced. Qualitative research methodology in the human sciences has been particularly influenced by the philosophical paradigms of both phenomenology and hermeneutics. Husserl's (1975) phenomenological method involves bracketing off the researcher's beliefs to understand the other's experience in order to get at 'the truth' of an everyday subjective experience, from which to make broader generalisations (Husserl, 1975). Thiselton, trying to summarise the Hermeneutic approach says it: "...explores how we read, understand and handle texts, especially those from another time or in the context of life different from our own." (Thiselton, 2009, p.1). Taking this seriously in this study meant reading and re-reading my selected sample of accounts to understand their experience. This is explained in more detail below (4.4 and 4.5) where I outline

the steps of my analysis, but signposting the connection between theory and analysis here helps to demonstrate its practical benefit.

Hermeneutics as an approach, as outlined by Seebohm (2004), argues that the art of interpreting texts that recorded human experiences is the best method for investigating human experiences. Lived experience is seen as an internal subjective process that no one else can experience, but on the other hand, the *expression* of the lived experience (in art, music, language and other texts) allowed for interpretation and understanding to occur. Hermeneutics made epistemological claims to be the science of the interpretation of the symbolically expressed representations of interior lived experience. In this approach, understanding comes from interpreting from a particular perspective in time/space. Thus Hermeneutics allows for social and historical phenomena to inform the interpretation.

For Gadamer (1975), a dialogue process of mutual understanding and interpretation creates the meaning of the narrative. He calls this dialogue of interpretation the “fusion of horizons”. The meaning of a narrative is created in the relationship of the reading of it - from another space and time. In a dialogical relationship more than one interpretation of a narrative account is possible as it is interpreted by different people from different time/space locations and subject positions. The hermeneutic interpretive relationship is a dialogical one where the reader and the read are sensitive to their position and relative trajectories in time and space and yet make an interpretation of the narrative account. This meant this analysis involved interpreting both the

subjectivities created by an author of a text and interpreting the anticipated alternative ‘readings’ by different readers.

Gadamer (1975) developed the hermeneutic approach to argue we all have a ‘belongingness’ to our world which situates us within historical and cultural / social traditions. We interpret other people’s narrative accounts with certain questions in mind from our situated (time/social space) context, or subjective reading position. For example, only in certain time/spaces does the reader ask of the narrative, what unconscious desires are at play here? Or, is the protagonist seeking “closure”? The questions that form in us are not originating in us. This applies to my work in that I will be analysing and interpreting my narrative at some points at a distance of 25 years in time. I will also critically examine the questions that come to mind and ask if they are not originating from within me then where are they originating from in time/space? If questions come to mind about my unconscious, alienation, class, closure, trauma, etc. then these questions need to be related to the history of the social space I am thinking inside of. If I thought differently in 1993/4 then this may say something about the trajectory of my reading position and the wider social context.

Epistemologically, in contrast to scientific positivistic methods discovering ontological ‘facts’ about people outside of time and space *hermeneutic narrative method* searches for a ‘dialogical truth’ interpreting in-between at least two locations in time and space, which may change both the reader and the read. The co-ordinates of their relative positions will include factors such as gender, class, ethnicity, how long they have been alive, values, etc. A

dialogue can play out between them where they interpret the other from their positions. From this dialogue, epistemological claims can be made within the hermeneutic narrative method which acknowledges the unfinalised, dialogical nature of truths claimed.

Narrative method is able to value individual stories over social and political concerns, without ultimately ignoring them. According to Polkinghorne (1995) *Narrative* is defined as a story whose parts are unified in time by means of a plot. He argues human beings engage in a core activity of making meaning out of their experiences by organising multiple experiences into 'stories' with characters in them, where organised patterns help to connect the story together into a coherent whole. The patterns which organise the experiences into a kind of *narrative order,* or coherent story, are called a "plot" and can include such things as; beginning, middle and endings, cause and effect, co-incidents, co-operation, conflicts and goals. Other common elements in the stories people tell each other are emotions, relationships, moral evaluations and descriptions of other characters. So, in practice, my steps of analysis (4.5) involve looking at accounts in these terms, after reading and re-reading phenomenologically.

In narrative methodology the main unit of analysis is the individual life rather than a discourse, social group or institution. It focuses on specific and individual rather than seeking to make sweeping generalisations and resists the temptation to formulate grand theories, such as theories of madness (for example, DSM-5, 2013). It takes a contextual approach, where social/cultural

context is taken into account in its influence on the story but also the social/cultural question is inverted to consider what the story says about the historical/social/cultural context of the narrative account of a lived life.

Narrative method takes ***time*** into account, i.e. the historical context of the told biographical account being analysed. The subjective experience of how time is experienced can be analysed through plot, and other literary concepts such as chronotopic genre shifts indicated by time slowing down/speeding up. For example, Brunner (1986) argues analysing a biographical account through 'narrative plot' is much more effective in terms of increasing understanding than using a "paradigmatic" framework or theory where theoretical models with atemporal categories and theoretic frameworks are imposed over someone's story. If a person's conceptual lens is dominated by a framework that divides people into clear categories such as "personality disorder" and "schizophrenia" as they listen they may try to fit the person's story into one of these distinctive categories. The framework's categories may help a professional decide how to act next, but at the potential cost of downplaying significant narrative elements. Brunner (1986) simply argues it is more helpful to analyse the story in terms of what it is, namely *a story* with plot, characters, action, etc. rather than trying to reduce and fit the story into a simple framework of categories (formed from a theory). In addition to resisting imposing frameworks and categories, the narrative analysis I am choosing does not try to build up large theoretical frameworks from biographical accounts.

Within the fields of narrative analysis there are conflicting views about particular emphasis of techniques to produce truth and insight, but these differences are generally tolerated and even welcomed in keeping with the underlying philosophy which tends to have a Bakhtinian dialogical flavour to it (Morson and Emmerson, 1990). In a narrative approach poetic, artistic and aesthetic power and qualities are thought to contribute to the meaning of narrative, so these concepts can be analysed (e.g. as in Frank, 1995). In contrast Kleinman (1988) emphasises empathic attention to "the voice". Rejecting positivism, narrative practitioners emphasise considering the ethical stances of researcher, researched and reader in dialogical relationship. This ethical concern and the use of literary analytic approaches has been criticised (Atkinson, 1997) as being too loose with too much emphasis on ethics, lacking a rigid systematic structure or prescriptive method that others could follow as a systematic method. However, this criticism has since been addressed through publications of systematic methodological approaches to dialogical qualitative analysis (e.g. Sullivan, 2012).

Some narrative approaches emphasise being holistic and person centred within psychology and social psychology in their opposition to positivism (e.g. Polkinghorne, 1995) whilst others are more influenced by Post-Structuralist (e.g. Barthes, 1973) and postmodernist thinkers (e.g. Foucault, 2001). An example of this postmodernist section within the range of narrative methodologies would be Tamboukou (2003). An example of commentators who make such a distinction within narrative approaches would be Andrews *et al.* (2008). The reason I have not followed the group of narrative approaches

represented by Tamboukou (2003) is that I believe they go too far towards assuming the discourse tells the story of the subject and does not allow enough individual agency to come through to allow the subject to tell their story. I do believe subjects can have numerous discourses within them at one time, but I prefer narrative methodology that, on balance, allows for enough individual agency to be at play to respect that people have choices and resistance strategies in relation to multiple discourses in society and are not just told by the discourses. However, I do acknowledge that discourses enter and leave people, in that people have experiences of thoughts and feelings within them that did not originate within them. In this analysis this meant identifying words or phrases from authoritative discourses (outside-in) that people make use of to express subjective (inside-out) experiences, such phrases as; 'one day at a time', 'alienation', 'PTSD', 'trauma survivor', 'disassociation', etc. This also involved identifying the major genres these phrases have originally been created within.

In terms of *power relations*, narrative analysis empowers the individual over institutions (Frank, 2006). Narrative research methods emphasise listening to the individual story that is voiced, which has usually been silenced over time and left on the margins of public spaces and debates. Thus politically, in narrative approach, power shifts towards empowering the subject and away from powerful institutional discursive practices. Power relationships (between researched, researched, discourses and institutions) can be fore-grounded and considered rather than denied and hidden (Reissman, 1993). Thus ethically narrative method resists centripetal traditional forces by paying

attention to individual stories, analysing them using narrative concepts taken from literary theory (Bakhtin, 1981) as a way to open up a new space for thinking about a human experience.

Another reason for choosing narrative method is that personal biographical accounts contain evaluative statements (because we understand experiences in moral/ethical ways) and this allows us to align ourselves with others collectively. As Plummer (2001) has pointed out, once people are enabled to see their experience within a moral and ethical framework and share their story with others they can become politicised and connect with likeminded others, and start to relate to moral debates in the public sphere and collective action to improve society. Narrative method can allow social groups to form loosely, around similar biographical narrative plots (such as the 'survivor' movement campaigning against certain psychiatric practices). Thus *narrative* can threaten the status quo because its moral/ethical focus politicises subjects with madness instead of individualizing, depoliticising them into individually passive patients exhibiting pathological symptoms outside of space and time, subject to powerful expert treatments and opinion (Foucault, 2001).

The moral, when organised collectively can become political, and this is achieved through stories people can identify with, containing themes and plots (e.g. Blackman, 2001). For example, six alternate narrative plots for social change are: the system needs no substantial change / needs some improving / needs reforming / needs radical transformation / needs replacing with an alternative / needs closing down. If people feel morally strongly motivated on

the issues they orientate themselves within one of these stories (e.g. as seen with the anti-slavery movement). Whitaker (2010, 2017) would be an example of a change narrative calling for a 'radical transformation' of mental health services in America. Blackman (2001) has argued that enabling people to put their unusual or extreme experience into a moral/ethical story allows them to 'make sense of it' with other people and so the experience becomes social, real and "embodied". This allows people's stories to become political and they can then align themselves with others, through their story telling, and then work collectively and politically for social change.

Any resistances to monological discursive practices are more likely to succeed if individuals organise resistance collectively, which requires a narrative understanding in time/space (chronotope). Relating socially to others with similar biographical narrative plots, or sub-plots, can empower people to not feel alone and to believe their own account *more than* contradictory professional accounts of their experience. Developing narratives can be used to resist professional re-telling of experiences because they have their own power (Porter, 2008).

A criticism noted by Reissman (1993) was that narrative analysis in the 1990's did not have a set of standardised procedures to follow, however now standardised methodological approaches are much more established (e.g. Sullivan, 2012). The narrative analytic approach I will use will draw on the narrative methods of Mishler (1995), Reissman (1993), Sullivan (2012) and Bakhtin (1981). In chapter five this study aims to investigate an account of a

journey through, into and out of mad time/space, or what some people might chose to call madness, mental illness, mental health problems, moral insanity or mental disorder, depending on the time/space they are thinking and feeling within. The analysed narrative account includes experiences of receiving diagnoses from medical science (such as “psychotic depression” and “personality disorder” (documented in psychiatric notes) as well as a various treatments (for example; psychopharmacology, hospitalisation and psychotherapy (reflected on in diary entries)).

I justify my methodological approach by placing narrative epistemological methods within a stream (admittedly not a *mainstream*) of accepted academic tradition, with particular emphasis on the methods of Mikhail Bakhtin’s (1981) *Dialogical approach*. These narrative epistemological methods are positioned in an explicit relationship with the moral ontology of Taylor (1989). This is necessary in order to resist the often not-articulated positivistic ontological assumptions of psychiatry, which remove the human subject from its moral and social world, as explored in chapter 3.

Analysing narrative accounts of recovery is one way to challenge the power of the medical model of psychiatry because it can build an evidence base for alternative understandings of experiences which can challenge powerful professional understandings. Narrative accounts have the potential to allow mental and emotional experiences pathologised as symptoms of a disease process to be re-thought as normal variations of social being. For example, Romme & Morris (2013) challenged traditional psychiatric thinking on

schizophrenia by reflecting on the landmark publication researching 50 first-hand accounts of recovery from people who hear voices (Romme, et al., 2009). They concluded voices were better understood in relation to the person's problems in daily life and not as a 'psychotic symptom' of an illness.

Medical science tends to hide its ethical and political positions (its power relations with its subjects) within monological epistemological claims to be the only, or best, way to produce truth (see Burkenkotter, 2001, Hodge and Bryant, 2017, Shaw and Proctor, 2005). Dialogical narrative approaches are one way to redress this epistemologically supported power imbalance, through listening to individual stories of people with lived experience of psychiatric diagnosis and treatment. Thus narrative methods can empower survivor / service user accounts by privileging amateur accounts over professional accounts/assessments.

Narrative method favours those with less power in society and takes up an ethical and political position with a bias towards the relatively powerless, inherent in its methods of truth production (Frank, 1995). As Plummer (2001) argues, it is a strategy for giving voice to the marginalised accounts which tend to be silenced by powerful professional methods, such as medical science. Narrative method for producing truth claims have been criticised for this bias towards those with relatively weak positions in time/space (e.g. Atkinson, 1997) but all truth producing methods have bias. Large scale scientific studies are biased, before they start, towards those topics to be studied that someone, somewhere, *for some reason,* is willing to pay for. The dominant epistemology

of medical science has its own bias towards the already existing rich and powerful institutions (which pay for its studies) and their discursive practices (see Burkenkotter, 2001).

Tomas Kuhn has shown in his work (Kuhn, 1962) that even within the range of discursive practices called “science”, scientist always bring pre-existing beliefs and moral positions to their work (Kuhn, 1962, p. 4) and so are never fully ‘objective’, in the sense science often claims, when it tells its story. This is not to dismiss positivistic science, it has a story to tell and can be useful, but it needs to be seen in the context of its strengths and weaknesses, as one way of claiming truths amongst many.

My argument now develops to the position that, whist positivist science can be helpful at times, other approaches to making sense of extreme experiences exist within the academic literature. Examining the *macro-level* historical discursive shift from moral to medical understandings in chapters 2 and 3 showed there is a gap in the literature when it comes to understanding the moral narrative ‘quest’ that stories from diagnosis to recovery can reveal. The shift in perspective from examining *macro* level discursive histories over the past two centuries in chapters 2 and 3 to the *micro* level of auto-biographical accounts in chapters 5 and 6 is the reason for this chapter setting out a narrative methodological approach appropriate for analysing personal accounts of madness.

4.2 Top-down, theoretically informed narrative analysis

This chapter outlines the methodology I am using for this study, which is a top-down, theoretically informed narrative analysis of both an autobiographical account of a journey, diary entries, medical notes and an analysis of other accounts. Such an approach can be situated amongst others, such as Drake and Whitley's (2014) thematic narrative analysis of 'recovery' narratives, Adler et al. (2015) study of variability in mental health narrative identities, Holm and Severinsson's (2011) study of recovery narratives of those diagnosed with Borderline Personality Disorder, and Morris et al.'s (2015), narrative analysis of people referred to a personality disorder service (discussed in more detail below in 4.3). This chapter outlines (in 4.5) the specific steps of *narrative analytic method* I am adopting epistemologically, in order to claim understanding from analysing accounts of journeying through a space-time of chronic emotional and mental distress.

The kind of analysis I am attempting is similar to Peter Good's (2001) Bakhtinian narrative technique and I use the dialogical methodological approach outlined by Sullivan (2012). Good (2001) explores how the different time/space locations of professionals and patients influence their dialogues and sense-making, such as the extent to which they draw on official professional languages and/or unofficial everyday narratives. Essentially, Good analyses psychiatry through a Bakhtinian lens, focussing on the contrast between the formal language of psychiatry and the informal language used both by psychiatrists and service user. The following two chapters analyse narrative accounts and, in part, attempts to identify the different discourses

people draw upon in order to make sense of their experiences, which include both official/professional languages and unofficial/everyday languages.

Bakhtin's writings (1981) have established his way of thinking epistemology, and his analytic concepts as having significance beyond literary theory. Although he appeared at first (in Soviet Russia) to be thinking about the novel, it is easy to see how this way of thinking can reach over to look at the traditional territory of the human and social sciences. If ontologically people are basically moral people looking for a good narrative to make sense of and position (orientate) themselves (and other people) within, then it makes pragmatic sense that philosophical and literary narrative analysis can aid an intellectual questioning and analysing of what those stories are. The stories people are positioned within, or have imposed upon them despite resistance, by powerful institutional practices can also be considered, as there is always an ongoing dialogue between authoritative stories and the internal persuasiveness of individuals. Recent examples of narrative research into mental health crisis and recovery are discussed in the next section (4.3) followed by two further sections, outlining the steps taken in this study for my data collection (4.4) and data analysis (4.5).

4.3 Narrative and Autobiography research focussing on mental health crisis and recovery

Personal narrative accounts of experiences such as madness have always, and currently, exist. However, compared to the 1990's, when Reissman noted

they were largely ignored in research (Reissman, 1993) they are now increasingly paid attention to. Particularly over the last decade the use of autobiography as data in mental health research has become more established and accepted. Examples of this include McGrath and Reavey (2015), who used a thematic approach drawing on theories of embodiment and relational space to analyse published autobiographies. Examining how people manage mental health crisis they found people either *increase* or *decrease* engagement with *public* or *private* spaces. Drake and Whitley (2014) also examined autobiographical accounts, specifically of 'recovery' from severe mental illness. Making use of thematic narrative analysis they found common themes of; being 'on a journey', developing autonomy and agency and increasing involvement in community activity, education or employment.

The use of autobiography in mental health research often draw on theories of narrative identity (such as Hammack, 2008). Such theories view people *making sense* of their lives by constructing a narrative order and then narrating stories about their day to day experiences. Adler et al. (2015) draw on narrative identity theory in two longitudinal studies exploring the relationship between trajectories of mental health and variability in narrative identity. They found the way an individual constructs personal narratives are likely to impact their trajectory of mental health, particularly around how *challenging experiences* are constructed into personal narratives. Narrative themes *of agency, communion, contamination* and *redemption* were found to significantly impact people who developed mental health problems, when compared to those who did not (Adler, et al., 2015).

Holm and Severinsson (2011) conducted in-depth interviews with women diagnosed with Borderline Personality Disorder to explore how a recovery process changed suicidal behaviour. A thematic analysis showed two key themes of “struggling to assume responsibility for self and others” and “struggling to stay alive by enhancing self-development”. They concluded some key experiences are significant in allowing positive change to take place, specifically the narrative themes of *feeling safe, trusted* and *validated* (Holm and Severinsson, 2011). Another study, by Morris et al. (2015), examined the narratives of eight people who self-cut who had been referred to a personality disorder service. Five narrative temporal themes were identified, namely; “A vicious circle”, “Trying to turn my life around”, “A big release … to get rid of all the pain and hurt”, “A different world” and “Being seen and not heard”. They concluded there was a need for mental health service staff to have skills to be *validating* and *compassionate* to enable service users *develop more optimistic narratives* about their future (Morris et al., 2015). In another study Adler et al., (2012) draw on narrative identity theories to compare 20 people with Borderline Personality Disorder with 20 people without a diagnosis. They found three themes of significant differences became apparent in relation to narrative identity, which were; *narrative coherence, communion fulfilment* and *individual agency* (Adler et al., 2012). Thus there are examples of approaches to the study of mental health and Personality Disorder that use a narrative methodology and autobiographical accounts. I intend to take these forward via a turn to ‘dialogue’ by utilising key elements from Bakhtin’s conceptual lens, such as *dialogical ontology*, *otherness* and *understanding in a relatively remote context*.

However, whilst there has been an increase in studies taking a narrative approach it is worth noting some narrative accounts are looked at through the lens of a modern positivist methodology and agenda. For example, some historical narrative accounts of madness are read with the sole aim of diagnosing historical figures retrospectively with 21st century psychiatric disorders (e.g. Cox, 2003, in relation to King George in England).

4.4.1 Data Collection and Ethical Dilemmas for this study

To undertake this analysis I needed an auto-biographical account to analyse and reflect upon using narrative methodology. This throws up many ethical questions, such as: how to recruit someone who felt comfortable telling their story (Loue & Pike, 2007)?, would retelling their story cause them distress or damage in going over traumatic episodes?, whose benefit was this for? – to cast some light on the experience of madness?, to help improve approaches to madness or widen a debate around this?, or was it just to help Ray get a PhD and improve the status of his 'speaking position'?. These ethical dilemmas were not insurmountable, but on reflection I came to the decision to tell my own story and then analyse it using narrative methodology. This possibility had its own ethical dilemmas to consider, as well as methodological ones.

The use of my own data (medical notes and diaries) was discussed with the chair of the ethics committee, but at that time ethical clearance for this by

the committee itself was not needed, therefore it didn't go through the ethics committee. For the use of public domain material I attach an appendix (IV) of the relevant ethics form from 2012 (see annex 1 of the form which instructs supervisors to sign off public domain material themselves). Ethical consideration was given to the Internet-mediated research (IMR) aspect of this study as publically available online narratives were to be analysed using narrative methodology. Currently the most recent guidance around ethical considerations is published by the British Psychological Society (BPS, 2017). The consideration of the ethical concerns was made in discussion with my supervisors in 2012, and we considered it would be ethically justifiable to use these publically available narratives in the context of this study through a process of weighing up the potential harm against the potential benefit. Our decision considered that this data collection was passive (i.e. non-reactive) as the data about individuals would be collected unobtrusively as 'found text' in publically published narratives on a website. Current guidelines (BPS, 2017) are particularly concerned about *reactive contexts,* when participants are actively and knowingly participating in a study mediated through the internet. As this study was not proposing to set up a reactive context it was not necessary to set up consent, withdrawal of consent, and debriefing processes. Ethically with IMR there are particular considerations if the data is generated in a private or semi-private forum, such as a chat room. As this study only looked at pre-published narratives already in the public domain concerns around confidentiality of private data were not thought to be significant.

Consideration was given to anonymising the direct quotes, but this was considered to be potentially disrespectful to the authors of each narrative as they had identified themselves as the author in the public domain. Where someone identified with a first name only, or anonymously, this was respected by copying their preferred public and published way to identify themselves with their narrative. Direct quotations also respected author's autonomy and ownership of their narrative. The risk of this research disrupting social groups in terms of being social responsible was considered to be negligible. Scientific integrity was thought to be achievable as the scope of the research online was limited to these narratives and the methodology was appropriate and proportionate (i.e. narrative/dialogical methodology). Potential harm was minimised by directly quoting publically available narratives and not seeking to generate new narratives in a reactive way of recruiting people with mental health difficulties for the purpose of this study.

Thus the gathering of publicly published online narratives is considered to be in line with the latest ethical guidelines (BPS, 2017), specifically because The *Code of Human Research Ethics* states consent is not needed when public behaviour would be expected to be observed by strangers. The narratives of recovery used in this research were published on a publically accessible website, which could reasonably be argued as being in the public domain. We believe this puts this data into the category where participants expect to "…be observed by strangers" (BPS, 2017, p. 6) and thus not needing valid consent according to the ethical guidance. Although the ethical considerations were made in the academic context of 2012, on review in 2018 we believe they also

meet the requirements of the most up to date ethical guidance (BPS, 2017) for the reasons outlined above.

In terms of justifying the ethics of disclosing my own narrative in this study, I have criticised science for pretending to an objective, amoral and valueless reading, observing and speaking position which never fully exists in the real world (Kuhn, 1962). I then thought if I analysed another's story whilst keeping silent about my own speaking position (in space/time) I was in danger of mimicking that which I had criticised psychiatry for doing – of implying I had some neutral position outside of time/space from which I was observing and analysing someone else's narrative. Narrative method allows for the revealing of the researcher rather than revelling in anonymising them (as psychiatry tends to do). I concluded at the very least to be ethically consistent with the dialogical approach I needed to make my position clear in space/time from which I was reading any narrative account. To use the concept of a speaking and reading "position" may suggest too much stability to the vantage point because we are always already moving in time/space and so a speaking or reading 'trajectory' may be a more accurate concept. This point led me to consider using my own narrative as the subject of the study because I have been through mad space/time during my life journey. I would be a valid subject for this study because I was diagnosed with "Personality Disorder" during the 1990's alongside other psychiatric diagnoses from different psychiatrists, such as depression, psychotic depression, Bi-Polar disorder, anxiety, obsessive compulsive disorder and substance misuse disorder. I have experienced a range of discursive practices from mental health services; such as

psychopharmacology, psycho-therapy, inpatient hospitalisation and multiple diagnosis. If I had not had these experiences then my story would not be an appropriate one to analyse for a study such as this, looking at personality disorder, but as I had had this journey, to a considerable extent my narrative does relate to the research topic.

However I considered a risk that the account would be emotionally and mentally disturbing for me to revisit, and could do me some harm. I concluded that it would probably be emotionally and mentally disturbing, but not overwhelmingly so and that for me some emotional challenge was not sufficient reason avoid it. I thought the benefits of sharing experience and insights from receiving psychiatric services might outweigh the risks of personal upset at recalling difficult experiences or later regret at having put some of these in the public domain. One alternative considered was to interview someone else, in which case I would be willing to risk their upset for my benefit? So why not risk my own upset, as that seemed to me more ethical.

It is worth noting I did not decide this recklessly, as I considered that my writing position in time/space now has some distance from the events. Having gone through mad time/space in the 1990's I found ways to get better, relative to how I was, in a non-medical way and left behind a chaotic life and took on a much more stable life where I have been in full time employment, happily married with children, for over a decade. I thought that this decade away from using mental health services was for me, long enough to give me sufficient dialogical distance in time/space to revisit my story for the purposes of this

study. I also discussed the issue of the risk of psychological upset versus the possible benefits with my academic supervisors.

Another consideration for me was that in the 1990's there were very few positive auto-biographical accounts of coming through mad time/space successfully. In my 'getting better' journey of change it was important for me to hear stories of other people coming through extremely difficult human experiences, narrating, as Foucault (1990) puts it, the practice of "escaping themselves" to get to a better place. This influenced my decision, ethically, as I hoped in a small way my story and any analysis of it might be helpful to others going through some extreme difficulties. During my trips as a patient in and out of the psychiatric hospital in the 1990's I never heard an account of someone getting better from "Personality Disorder" - none of the mental health professionals who treated me ever shared a "getting better" narrative with me, even an anecdotal one, that they may have heard about from another patient. Such a story may have given me some hope for my future. Narratives hold the potential power to instil hope for a better future, both individually and for socially excluded groups of people.

There are precedents in the academic literature for auto-biographical narratives. Frank (2006) arguing on this point, says pretending it is desirable to avoid emotions is a scientific fallacy embedded in positivism. He argues we need to avoid pretended objectivity. However modernity has a strong influence on modern identity imposing a distrust of emotions and a false belief that epistemologically somehow emotion and truth have a spatial distance, and the

more we can eradicate emotion the closer we must be (spatially) to the “truth” – as in the *modern* Stoical approach (Taylor, 1989, p. 21). However, in reality the truth is not emotionally numb. It is a very modern fear that the ‘emotion’ might overwhelm the ‘rational’. This issue of allowing and validating emotions epistemologically in research methodology has been significantly acknowledged and addressed by feminist writers within the social sciences. For example, Gilbert summarises that,

> “Despite major shifts in social science research, emotionality is still constructed in opposition to rationality and professionalism, and the importance of emotions is denied.” (Gilbert, 2001, p. 19).

However, I will be mindful to resist emotions overshadowing the theoretical threads I draw from the woven story, whilst not denying emotion is an important element in mental health and truth telling.

There is also the ethical issue of how much to reveal of myself in the telling? Revealing certain episodes exposes me to the moral judgements of the readers, which could have many possible future implications, such as some employment prospects. This can usually be avoided methodologically by anonymising the narrator. However to achieve this here would, I think, be impossible without giving a misleading impression that I was analysing someone else’s narrative and not my own. Having considered the issue I will decide what an appropriate level of self-disclosure is in an ongoing way as I write the next chapter. Other authors who have narrated auto-biographical accounts have managed to edit what they share publically appropriately without having to anonymise their account (e.g. Frank, 1991).

Another influence on deciding to tell my story was that third party professional documentation was available to me, through data protection act (1998), such as all my medical notes, which I accessed. It would still be possible to apply a narrative analysis without these notes, but access to them allows for a richer analysis through reference to this professional discourse about my life. Interviewing someone else would be ethically justifiable, but not necessary for this study. In addition, it would be possible to compare analytic conclusions from analysing my autobiographical account to other autobiographical accounts in the public sphere to consider if similar themes can be drawn out from other accounts.

The narrative will be written for research purposes, so this will influence the 'telling' of it, but this in itself is not a good enough reason not to try, particularly as there is no neutral telling or reading position in life, only ongoing dialogues between locations in time/space. Therefore I concluded to take my subject matter as my first-hand narrative account of madness at the close of 20th century. Taking a narrative approach, one research aim is to increase understanding and the range of dialogue around extreme experience rather than seeking to establish objective scientific facts about difficult thoughts and feelings on the margins of time/space (historical social relations).

Alison Torn (2009) helpfully introduces another dimension to the ethical dialogue on narrative method, that of "the ethics of telling" (Torn, 2009, p. 176). Morally she argues, researcher's should identify who the possible audience is – who are the communities of powerful and marginalised voices (the

gatekeepers and policymakers) within a possible audience who the story intends to dialogue with and influence. Drawing on Plummer (1995), she argues the socially structured consumption of stories needs to be considered, in addition to the production and effect of stories. My hope would be in a small way this study may contribute to the wider debate between those commissioning and providing services and those experiencing chronic emotional and mental distress around what they can realistically offer (and the limits of what can be offered) in terms of helpful, and potentially new, dialogical practices.

4.4.2 Steps of my Data Selection

The data selected for analysis involves gaining access to my psychiatric medical notes and diary entries from the early 1990's and my autobiographical account from 2012, in addition to the selective use of non-medical successful recovery stories already available in the public sphere on The Scottish Recovery Network website (2018). I obtained my medical notes through requesting them under the data protection act. To begin with the non-medical successful recovery narratives are treated as both equal in status and independently analysed using the narrative methods outlined in this chapter, particularly drawing on Sullivan (2012). My autobiographical account was written when I had decided to use my own medical notes and diaries as a main source for the PhD, and the autobiographical account was a reflection from that time on what I read in the diary and medical notes. The fact that I wrote my autobiographical account after my theoretical reflections had begun and

after I had decided on a narrative/autobiographical approach is justifiable as I am doing a top-down narrative analysis which is theoretically informed. The top-down analysis is a selective focus, allowing the analysis to zone specifically in on the moral journey that emerged as a central theme from the earlier chapters.

In chapter 6 I use data from online narratives. In 2012 there were a total of 50 narrative accounts of recovery hosted on The Scottish Recovery website (2018). The clinical notes data analysed in chapter 5 showed six different psychiatric diagnosis were given, in addition to “Personality Disorder”, to the same individual (anxiety, bi-polar affective disorder, depression, psychotic depression, substance misuse disorder, obsessive compulsive disorder). This did raise interesting questions about arbitrariness and how inconsistently categorical models might be applied by different psychiatrists in clinical practice. I did not use 'Personality Disorder' as an exclusion criterion when selecting the 50 stories to analyse in chapter 6 because the academic journey so far has led to the conclusion that all mental health crises are a crisis of personality - understood as involving moral habits of excess and insufficiency - rather than there being a disease specific to the personality. So the accounts read for chapter 6 involve a broader variety of mental health diagnosis than just Personality Disorders, such as PTSD and Depression. Through an iterative and circular process of reading and re-reading the original 50 narratives gradually dropped to 7 accounts for the final analysis, because those accounts that were dropped lacked particularly relevant 'key moments'.

Having read all of the data I selected specific excerpts for use in this analysis. These excerpts were selected for analysis because they involved 'key moments' (Sullivan, 2012) which were particularly significant in terms of medical and/or moral understandings relevant to answering the research question; 'what narratives aid recovery in troubled journeys involving mental health crisis?'. The key moments selected for analysis in this study are quoted in their entirety throughout chapters 5 and 6.

4.5 Steps of my Data Analysis

Specifically the systematic steps I am taking for the data analysis use the dialogical methodological approach advocated by Sullivan (2012), applied in chapter 5 to my own psychiatric notes and diary entries alongside an autobiographical account and also in chapter 6 to online narrative accounts of recovery. This systematic approach involves five steps;

Step 1: Reading and Re-Reading all the transcripts/accounts;

Step 2: Looking for and selecting key moments;

Step 3: Identifying the major genres;

Step 4: Looking for the material features of narration (formal, informal, diegetic, intra-diegetic), chronotopic genre shifts, use of metaphor.

Step 5: Evaluation and validation of interpretations through dialogue with supervisors

Having selected my data (see 4.4.1 and 4.4.2) the first step I took was to read and re-read all the transcripts/accounts in order to familiarise myself with the whole data set. Having familiarised myself with all the transcripts/accounts, the second step I took was to re-read them looking for, and selecting, ‘key moments’. In narrative methodology key moments are described by Sullivan (Ch. 4, 2012) as significant utterances of variable length whose meaning is ready for a reaction/reply. These key extracts were selected on the basis of being the most relevant to the research questions, which for chapter 5 was; 'how do the medical and the personal narratives of "Personality Disorder" interact in lived experience?, and for chapter 6 was; ‘what narratives aid recovery in troubled journeys involving mental health crisis?, with an interest in contrasting how medical and non-medical genres might be used in recovery narratives. In addition to content, in terms of *form* key moments were given a boundary in terms of containing significant shifts in chronotopic genre and/or the emotional atmosphere surrounding the reflection. For clarity each key moment was then given a letter/number reference and an identifying title in term of its referent. All key moments selected are reproduced in chapters 5 and 6 in their entirety.

Having selected key moments I moved onto the third step of identifying the major genres and discourses the key moments related with. Discourses were identified by direct reference or by use of key phrases or terms, such as diagnostic labels indicating the discourse of psychiatry was being referenced. Genres were primarily identified through generally accepted common plot elements, for example, the introduction of being *set free by a spell being*

broken into an everyday/conventional narrative plot would indicate the genre of *magic realism* was being utilised.

Having identified the major genres I moved onto the fourth step of looking for formal and informal material features of narration involving the identification of metaphor, literary devices, structure, character(s) and plot along with the interlinkage of these to subjectivity. Such subjectivity is theoretically informed as being narratively changeable, in relation to the moral journeys someone orientates within. I am using these concepts in this study. Some are easily understandable from literary theory whilst others are hard to grasp due to the challenge to modern thinking that Bakhtin is making, in terms of ontology and epistemology. These narrative analytic tools, concepts and concerns include: the status of the author, narrative structure, the chronotope (representations of time and space within the narrative), dialogical relationships, voice, polyphonic complexity versus monological discourses, unfinalisability versus finalising texts, heteroglossia, the temporal structure of the narrative (when meaning is shaped in relation to time), threshold (crisis) and chronotopic genre shifts, change of identity in relation to threshold chronotopes (identity crisis), plot, sub-plot, character, textual inter-illumination and understanding something 'in a remote context'. I will relate these material features back to my theoretical understanding of subjectivity in crisis, considering the social forces that may be at work on the subjectivity of the narrator. Drawing on Mishler (1995) this analysis also considers the narrative appears to function on multiple levels, such as in relations of resistance to power (political) and social/institutional processes (e.g. mental health assessments).

This fourth step includes identifying differences between inter-diegetic (inside-out) narratives (where the narration comes from a character within the story) and extra-diegetic narration (outside-in) where a discourse is created from outside of the 'hero' of the text (see Sullivan, Ch. 7, 2012), such as in a professional mental health assessment. Consideration was given to how extradiegetic narratives *re-accentuate* intradiegetic utterances. Chronotropic genre shifts in the atmospheric representation of time and space (Sullivan, Ch. 7, 2012) were identified, and reflected upon, in terms of how they both restrict and allow different types of subjectivity to emerge within complex genre interactions involving hybridised dilemmatic identity and changing authorial power via narration.

Having analysed the material features of narration I moved onto the fifth step of evaluating and validating the interpretations through dialogue with supervisors. This final step in the process of evaluating my data analysis involved re-reading my interpretations through the dialogical methodological lens outlined above, in light of my supervisor feedback, and re-drafting chapters to draw out my key findings, themes and reflections on these. Persuasiveness (Reissman, 1993) was considered in terms of the extent to which there were similarities, but also differences, in themes emerging between different accounts in chapters 5 and 6. Thematic coherence (Reissman, 1993) was also considered in terms of validity in relation to the consistency with which narrative themes emerge regarding goals of narrators (e.g. *to gain identity*) and their justifications for ways to achieve overarching goals (such as *undertaking a staged journey*).

The evaluation step considered whether major genres were actually identified and the extent to which key moments were identified and then reflected on analytically. Evaluation of the quality of the analysis considered how well it tethered to the data, for example, reflection on how well the analysis-data relationship drew attention to transformative experiences of subjectivity through chronotpic genre shifts and interlinkages between dialogical subjectivity and discourses. Whether the analysis brought distinct voices (such as professional/amateur, medical/moral) into contact with each other in a polyphonic relationship between author and hero was also reflected upon during this step. This analysis was considered an intertextual product capable of being reconfigured within different space-times for evaluation. It was also held in mind that the truth being sought was a complex lived experience truth of ‘pravda’ and not an abstract truth (‘istina’).

Conclusion:

The purpose of this narrative approach is in part to value micro-level individual stories and illustrate that alternative ways of understanding madness are valid. My hope is to complement the macro-level in depth genealogical critique of psychiatric discursive practices examined in the preceding chapters. In order to avoid any conclusions from the analysis in chapter 5 being over-generalised from one data set in chapter 6 I will analyse other narrative accounts of madness available to researchers in the public domain via The Scottish Recovery Network (2018). The online accounts of recovery will be analysed independently and methodically, as outlined above, and then cross-compared.

This will allow both myself and the reader to weigh up for themselves how valid they believe the analytic conclusions are and how applicable they are to other accounts available in the public domain.

I have outlined and justified the methods I am going to use to analyse my diary entries, an auto-biographical account and my medical notes in chapter 5 and online accounts of recovery in chapter 6. Ontologically I am taking a position in line with the moral ontology of Taylor (1989). I am thinking human beings are moral agents in search of believable stories within which to orientate themselves (and others) towards “the good life”. In terms of methodology for producing truth claims I am drawing on *dialogism* as it is essentially an epistemology. I have argued a dialogical approach to narrative opens up the possibility to listening to how ‘the mad’ narrate their experience from outside the coordinates of the authoritative monological discursive framework of positivism. The next chapter will analyse that trajectory of moving coordinates in time/space that I call “my story” during a time when I was going through, in and out of mad time/space, re-orientating within various stories. I will analyse this story alongside my psychiatric notes and diary entries using the narrative analytic approach, drawing on the narrative methods of Sullivan (2012), Mishler (1995), Reissman (1993) and Bakhtin’s (1981) *Dialogism*.

Chapter 5

Analysis of Clinical notes, Diary entries and an Autobiographical account

So far I have clarified that “Personality Disorder” is laden with a hidden morality, with moral-emotions and power relations shifted to the background by the foregrounding of a literal medical disorder. Chapter 2 demonstrated the evolution of literal medical genres from religious genres by examining the disorder of “Moral Insanity”. Chapter 3 highlighted service-user resistance to this medical model through calls for a more systemic and trauma-informed approach (Allister et al., 2018). Now through a top-down analysis (Sullivan, 2012) this chapter addresses how these medical and moral genres play out in the lived experience of those diagnosed with a Personality Disorder, to answer the research question, 'how do the medical and the personal narratives of "Personality Disorder" interact in lived experience?’. I will do this by drawing attention to the different genres, including their emotional connotations, within which the self-self-other relationship is constructed.

How different genres interact biographically will be analysed by outlining an experience of Personality Disorder from diagnosis to treatment. This allows examination of how differing subjectivities emerge within complex genre interactions involving shifting chronotopes, hybridised dilemmatic identity and changing authorial power via narration. Sullivan’s (2012) dialogical method for analysing commentaries on subjectivity is utilised to analyse how extradiegetic (outside-in) narratives *re-accentuate* intradiegetic (inside-out) utterances. This includes exploring the emotional orientation of the author to their hero and the

atmospheric representation of time and space they create. This chapter analyses three data sets in relation to the subjective experience of having ‘a very troubled journey’ through life. The three data sets analysed are;

- Contemporary Diary entries [Text D] 1993 - 1994 (Appendix I)
- An autobiographical account [Text A] 2012 (Appendix II)
- Clinical psychiatric notes [Text C] 1993 - 2000 (Appendix III)

For clarity of discussion I label and number each extract, for example, C1 would refer to the first extract analysed from my clinical notes, and D1 would refer to the first extract analysed from my Diary entries.

5.1 Moral emotions within “Personality Disorder”

C1: Letter from a psychiatric assessment by a psychiatrist to my G.P., 28/05/1993

“Dear Dr K,

Thank you for asking me to see this interesting 22 year old man who told me about his alcohol dependence, drug abuse and even compulsive gambling in his early teens. He described all of this as self destructive behaviour and that even though he has conquered all of these he still has the same feelings. He tries to deal with them and usually can come through the bad patches but he is having a particularly prolonged one at the moment. He has suicidal thoughts and sees himself as being shot, dying or crashing his car. He has noted decreased motivation, feeling a bit depressed and feeling emotional pain from the past.

He said he was sexually, physically and emotionally abused by a woman when he was 11 and for a prolonged period over the following seven years. He now

has angry feelings towards many women he meets in different situations. This has never been revealed to his parents or anyone else. He said emotional pain has always been there but he has been lifted out of it by drugs and alcohol but never on a permanent basis. He no longer wants to avoid this – he wants to go through this and "come out the other end and enjoy life…

IMPRESSION

I do not think that Mr. Middleton has a mental illness. His description suggests that he has also felt alienated and has not felt as though he fully fitted in in terms of the people around him, both family and friends. He is questioning his early life and what he got out of it. He would like to feel differently about that. This is all complicated by the abuse which started when he was 11 and it was possible in this setting that the other addictive and compulsive behaviours occurred. He still has very painful memories and emotions as a result. He would like to work towards a better acceptance of this and would also like to think that one day he could have a normal and balanced relationship with a woman.

SUGGESTIONS FOR FURTHER MANAGEMENT

I suggested two options – one being contact with the therapist who works with male victims of abuse; the other being a referral to the psychotherapy department. He chose the second option and I will therefore send a copy of this letter with a covering letter to my colleagues there who I hope will see him with a view to further work. I have not arranged to see him again.

Yours sincerely,

Dr. R."

Analysis:

C1 is future-orientated and uses words like ‘hope’ and ‘one day’, describing a possible future-space for subjectivity that may contain better relationships by strategically using quotations from the intradiegetic narrative. Quoting part of the intradiegetic narrative referring to hopes for a better future *re-accentuates*, acknowledging and adding authorial value to these hopes as it passes through the medical drama genre. They deliberately re-contextualise the words and give them new meaning in the medical drama *cliff-hanger* of C1 where therapy is being offered (i.e. Author: His hopes may be fulfilled through our therapy offer). C1 can be read in different ways, but the emotional orientation of the author appears to be hopeful and optimistic in re-accentuating the hopes of the ‘hero’ they are creating, but also creates some distance from the hero by not explicitly saying if this is a realistic hope.

In C1 the narrator is telling the story from an *extradiegetic* speaking position, outside of the narrative, which contrasts to the intradiegetic speaking position in D1 (below) where the narration comes from a character within the story. This extradiegetic narration creates an ‘outside in’ discourse (Sullivan, 2012, p.127) in the genre of a medical drama framed within a letter where generic plot expectations are raised, in both author and reader, such as “will a diagnosis be given?” and “what treatment will be offered?”. The letter outlines two chronotopes of the patient, the present caught in past orientated painful self-destructive feelings is contrasted with a hoped for enjoyable future time-space. Their desire to shift *through the pain* into a different future chronotope sets the

scene for the offered treatment choice of different types of therapy, which may allow this desired chronotpic genre shift to happen.

C1 is intertextual in how it addresses the reader with a summary and psychiatric assessment, by drawing on a least two genres, the medical model and psychoanalytic genre. The author possibly anticipates the reader's generic expectations of a diagnosis within the medical model, so with a *sideways glance* at the reader she explicitly states she does not think Mr. Middleton has a mental illness and instead draws on a term from a psycho-analytic genre, *alienation* in her summary, before suggesting psychotherapy or trauma-counselling as *treatment*. 'Alienation' is a psycho-analytic construct indicating estrangement from the values and emotional connection with caregivers/society, formed as inadequate infant mirroring internalises an inescapable mismatched, split, 'alien self' based upon a mirrored fantasy (see Fonagy et al., 2002). By expressing her impression as a personal opinion drawn from the patient's narrative she may be anticipating, with a sideward glance at imagined possible future professional peers, who may read the medical notes and take a contrary opinion. In terms of power relations the discourse allows future space for other professionals to dialogue into her psychiatric assessment with alternative readings. C1 illustrates the discussion in chapter 1 of mental health assessments being a micro-level site mediated by meta-genres such as DSM (Burkenkotter, 2001), where the medical model structures the assessment even as it resists it ('he is not mentally ill').

Evidence for this anticipatory sideways glance can be read in the following assessment from a different psychiatrist in 1996, who does diagnose “psychotic depression” and “alcohol dependence” using the medical model genre, which summarises and re-describes this 1993 assessment as being by a “female psychiatrist” (which C1 is an extract from) who diagnosed “Personality Disorder”, despite that diagnosis not being mentioned anywhere in the letter. So Personality Disorder is not always immediately diagnosed but the conditions are established to open up a power-differential in the understanding of one’s personal life through the narration, into which subsequent professional readings may introduce diagnosis.

C 2 Extract from a Psychiatric assessment leading to hospital admission 04/01/1996

“Previous Psychiatric History: Bipolar Affective Disorder Diagnosed in august 1995 by G.P. Commenced on Lithium by GP after consulted psychiatrist.
Prior to this seen by a Psychiatrist 2 years ago at Uni – Thought he had Personality Disorder. Suggested Psychotherapy. Going for 2 years. Thought he was getting worse. Stopped three months ago…

Mental State: Well dressed.

Mood – “Subjectively – “Bit detached and harbouring self destructive thoughts”
Objectively: Low, smiles, laughs, suicidal intent present. “thoughts of being tied up by ropes, jumping out widow or from train.”

Thoughts – “for long time had usual thoughts of suicide, e.g. being shot, hanging myself. Often just didn’t take notice of them, they were just there.”

“Sometimes I feel I am possessed by an evil creature inside me. Struggle going on drawing on religious symbolism. Arch angel is struggling inside me with a demonic being.” He is grimacing and curling his body up knowing this is going on inside him. Has partial insight. Occurs 4 to 6 months out of 12.

August 95 - Believed he was Karl Marx, Fredrick Niche, and ‘the new Jerusalem’ when manic etc. and paranoia that he was about to be arrested and images of hell behind him (6 months ago) as hell falls away at his feet. (monthly) - “Two police officers coming to my door to arrest me” (pseudo-hallucinations).

Feels entrapped to do things by external forces but manages to prevent himself from doing these things. E.g. violence towards women or stabbing someone – this led to a psychiatric interview at Bradford Uni by female psychiatrist [1993]. Never acted on violent thoughts – Never hit anyone - either male or female.

Perceptions – Visual hallucinations – seeing himself falling out of a window whilst tied to a chair screaming – this is now, whilst in this room having this interview.

Insight: present.

Impression: Psychotic Depression + Alcohol Dependence

Plan: Admit + Urine drug screen + Symptomatic relief for tonight.”

Analysis:

In C2 the extradiegetic speaking position of the narrator is similar to C1 as an ‘outside in’ discourse, but in comparison to C1 they draw heavily on the medical model genre. This time the medical drama fulfils the generic plot

expectations of providing a diagnosis. In terms of intertextual power relations the psychiatric assessment from 1993 (that did not provide a diagnosis) is re-interpreted as having diagnosed “Personality Disorder”. This could be read and interpreted in numerous ways, including the possibility that an informal verbal genre exists between psychiatrists where adjectives such as “interesting” are read as a code for personality disorder when a clinician does not want to use such a diagnosis. For whatever reason the psychiatrist in C2 felt confident enough in their *authority as an author* to re-read the C1 assessment as assigning a diagnosis and assimilating this intertextually into their re-telling of this medical drama. C2 is deliberately intertextual in addressing the reader with an analysis resulting in diagnosis. The genre and discourse shifts between C1 and C2 helps to foreground and understand the dialogical power relationships between the texts. C1 tells a medical drama drawing on the psycho-dynamic genre and resisting the medical model (whilst also acknowledging the genre) and also anticipates possible future chronotopes that may involve re-imaginings and re-telling(s) by professional peers.

C2 tells a medical drama using medical analysis and diagnosis. There is a shift in language characteristics of the genres, from combining informal terms like “interesting young man” with psycho-analytic terms such as “alienated” in C1, to formal medical terms like “personality disorder” and “psychotic depression” in C2. In C2 the narrative presents a singular truth in ‘making-sense’, reducing into traditional diagnostic categories the reported trauma-informed story and past assessments *through the lens* of a medical drama framed by psychiatric

discourse. C2's authorial narrative leaves little discursive space for the subject to have agency to disrupt or disagree.

Contrasting C1 and C2 reveals chronotropic shifts in the atmospheric representation of time and space. These act to support their genres and also allow different types of subjectivity to emerge. In C1 the emotional orientation of the author appears to be future-orientated and optimistic by re-accentuating the hopes of the 'hero'. In comparison C2 describes the atmospheric representation of time and space as an institutional space of immediate admission to the psychiatric hospital, and does not look very far forward in time – only to "tonight". Planned activity within this space includes a urine drug screen, which suggests some need to check the accuracy of the intradiegetic narrative in relation to drug taking. C2 can also be read in different ways, but the *emotional orientation* of the author to their created *hero* appears to be mistrustful, fearful and pessimistic when compared to C1, both in relation to the subject and towards other professional intertextual contacts, such as C1.

The author's narrative position in C2 allows them to move freely backwards in time by reading past medical notes (including summarising and re-interpreting) to create the subject of the text. Whilst they freely travel backwards in biographical time to the subject's childhood, future-time is severely limited to 'tonight', creating a subjectivity predominantly constructed from the past with a limited future. C1's hoped for better future does not make it into C2's summary, in favour of summarising C1 as diagnosing personality disorder. Childhood sexual abuse is also edited out in C2's summation of C1 as they

foreground diagnosis. This supports the discussion in chapter 1 of the damaging role pathologising medical discourses can have in under-playing the aetiological significance of childhood sexual abuse (Hodge and Bryant, 2017).

Thus the potential subjectivity of the hero shifts through different chronotropic atmospheric representations of time and space. In C1 the hero is adventuring into a world with potential futures, through more pain, hopefully into an enjoyable world of better relationships and reconstructed memories. This shift in C2 into creating a subjectivity predominantly defined by mental illness and narrative expectations of hospital and medication, where the future is fixed and certain, but only for tonight. In this limited future the role of 'truth' appears partly mediated through a drug urine test, whose purpose is not explicitly articulated, inviting the reader to wonder if the test will match the drugs the hero claims to have taken? This professional medical mistrust may reflect the research findings discussed in chapter 1 of medical professional's poor attitudes towards their patients (Sansone and Sansone, 2013).

The authors of C1 and C2 both create a 'hero' (or *other*) within the text with varying degrees of power to 'answer back'. C1 gives a greater degree of freedom to *other voices* compared to C2, with a genre that leaves open future possibilities. For example, she summarises the future-orientated hopes of the subject ("He would like to work towards… and would also like to think that one day he could have..."). Thus creating a subject with some agency whilst resisting answering anticipated questions that may arise in the reader (Reader: is this likely? Author: he hopes so). Thus C1 takes less *authorial control* over

the *reader response* than C2, by allowing possible space to open up between the author and reader by drawing on the literary genre of a “cliff-hanger” where the story is not resolved, but has further chapters to play out (Reader: will he get better or worse? Author: Who knows? - I have given him some choices and will not see him again). In comparison the author of C2 assumes less space between reader and author by taking a more informational/educational tone. This suggests they anticipate a reader that will be in close agreement with their narrative/diagnosis and they assume more *authorial control* over the *reader response*.

C1 and C2 both create a narrative summary of the subject’s difficulties and attempt to solve them by placing the hero in *a relatively remote context* of a medical drama using either a medical model (C2) or a hybrid genre - psycho-dynamic/cliff-hanger (C1). Both remote contexts of understanding allow new possible futures to emerge for the subject to re-orientate their self-other relationship within. The reader is invited to anticipate the future subject positions made available through the text (Reader: Is he mentally ill? Author (C1): No I don’t think so, but his future may benefit from therapy, or, an alternative answer, Author (C2): Yes he is mentally ill - he has psychotic depression, he needs psychotropic medication, urine tests, and hospitalisation).

These shifts in genre and discourse allow the changing relationship between author and hero (self and other) to be reflected upon. Both C1 and C2 are extradiegetic narratives addressing the reader in a relationship of explanation.

They author the ‘other’ as the subject of an explanatory narrative from a distance and from particular reading positions (medical drama, medical model, psychodynamic, cliff-hanger). C1 uses the strategy of quotation from the subject’s intradiegetic narration to describe a self/other future-orientated relationship moving through social time/space, who hopes to ‘go though’ the pain and ‘come out’ the other side to an enjoyable life. By contrast C2 reduces the intradiegetic narration in the assessment to quoted utterances that are used in support of a conventional diagnosis where the self/other relationship created is structured in terms of needing to take medication and stay in hospital for observation.

Another ‘other’ in C1 and C2 is the reader, or superaddressee, who is addressed imaginatively as a reader with *doubts and questions* which these texts try to *anticipate and answer* so the reader understands the hero in a particular way. These anticipated others structure the narrative differently in C1 and C2, shifting the subjectivity and relationship between created subject and creating author. For example, in C1, the anticipation is - Reader: What is his diagnosis? Author: he is “interesting” but “not mentally ill”, and he hopes to get better. C2 then anticipates a reader who may read C1 and their text - Reader: But C1 did not think he was mentally ill? Author: But he is mentally ill, I can summarise the 1993 assessment – it diagnosed personality disorder, and in case you overlooked it, the psychiatrist was female. C2 illustrates a discursive tendency to assume a dyadic relationship between professional and client, even within the more psychotherapeutically informed criticisms of DSM (e.g. Livesley, 2012) discussed in chapter 3. This analysis suggests a greater

plurality of author-hero-reader positions are available, with different constructions of subjectivity emerging as professionals re-interpret their peer's previous 'heroes' within their preferred genres. To develop this analysis further it would be useful to consider some intradiegetic narrative extracts, from contemporary diary entries:

D1 Diary entry relating to anger, 21/04/1993

"Forgiveness is what?????.... I'm angry. She f**king sent me to Hell, how do you forgive an unrepentant child molester for sending you to an emotional and mental Hell?... I have to deal with this. No it does not sound fair."

D 2 Diary entry relating to justice, 27/04/1993

"Lot of pain. Wondered why I am in Hell for what someone else did to me, it does not seem fair/just."

Analysis:

In D1 and D2 there is intertextuality as, although I considered myself an atheist, I draw on a religious genre by using the metaphor of "Hell" and the allegory of being sent to Hell for wrong-doing. However, my subject position in relation to this allegory is one of disagreement and ethical protest. I express my subjective distress like being in Hell but then voice that it does not seem "fair/just" to have been sent to Hell for someone else's wrongdoing. Bakhtin's concept of authoritative and internally persuasive discourses is helpful in analysing this. Traditionally the allegory of going to Hell from a Christian genre refers to a time/space of unpleasant after death experiences. It is a popular

adaptation of the chronotope to use it to describe pre-death experiences. The author compares this narrative with experienced lived life and highlights a difference to ethically protest that it appears to be the wrongdoing of someone else towards the hero, not their wrongdoing that has sent them “to Hell”. The authoritative discourse of going to Hell is used to both express the degree of distress and morally to protest that I do not think lived life matches the narrative. In the transition to becoming internally persuasive the time/space is brought forward in time (post-death to pre-death) and the moral wrongdoing is re-positioned in someone else to protest, in a kind of carnivalesque literary mode that subverts and frees the hero from the dominant atmospheric meaning of the allegory. Thus in contrast to the *literal* narrative in C2 of a medical drama where my subject position is created as being literally mentally ill (psychotic depression) in D1 and D2 we have an intradiegetic voice creating a subject position using a *literary* narrative, in a literary attempt to understand and make sense of subjective distress. This raises questions about the relative effects of *literal* compared to *literary* understandings.

Thus the intradiegetic voice in diary entries creates a subject position where anger is linked to my story of what happened to me in the past and its effect on me reaching my future desired ‘good life’, combined with beliefs about justice and ‘fairness’ (i.e. because the hero believes sexual abuse of children is morally wrong they feel angry about the unfairness of it happening to them). Anger features in the narratives in other ways, for example, sometimes I feel angry towards myself, “He has suicidal thoughts and sees himself as shot, dying or crashing his car” (Clinical notes, 28/05/1993) Sometimes angry

feelings and thoughts take on a visual or auditory expression such as seeing myself “shot” or “dying” or hearing things that others cannot, such as a voice saying “destroy yourself Raymond” (Clinical notes, 30/01/2000). Sometimes I get angry feelings and thoughts towards other people, such as wanting to kill other people. However, because I believe being violent is morally wrong I then feel guilty about having these feelings, and anxious that I may lack self-control and act them out. Again these emotions can manifest as a visual experience of seeing myself stab or hit someone. Although I was ethically motivated not to be violent towards other people I did sometimes harm myself, for example, “He has on two previous occasions, aged 15 and 18 taken overdoses” (Clinical notes, 28/05/1993). However I describe resisting the desire to commit suicide on ethical grounds, “...because I felt guilty about committing suicide due to the affect it has on it has on other people” (Clinical Notes, 04/01/1996).

Analysis of these diary entries and third party recordings in the clinical notes, suggests my anger is described best as a ***moral emotion*** because it is always linked in a narrative with strong evaluations of ways of being that are right and wrong (e.g. violence to self or others) and beliefs about what is just or unfair (e.g. being subject to sexual abuse). If I did not hold ideas of justice drawn from my local moral order (Harré, 1993) I could not be angry at being treated unfairly by being sexually abused as a child. I also am angry at being too anxious in relation to women, to whom I am attracted, to form a relationship with them. After some years of unemployment I also express anger at not being able to work and hold down paid employment. If I did not have the strong value of wanting a job and a girlfriend as my desired ‘good life’ then I would not be

angry at failing to live my good life successfully. Thus it is only in the context of my narrative and in relation to my strong evaluations of desiring to live a particular kind of "good life" that I develop angry emotions. This develops Taylor's (1989) concept of ontology as a social-self orientating within moral narratives by illustrating the gap between present lived life and desired future 'good life' can not only remain at a significant distance for years, but *the gap can grow*, thus developing a powerful moral emotional atmosphere of anger, fear, etc. Applying Bakhtin's concept of *chronotope* to Taylor's ontology allows us to see the need to find a believable narrative to transport/transform the subject as a need to negotiate the hero into *a chronotpic genre shift* which begins to close this gap between current entrapped space-time and the desired future space-time of *the good life*.

Time is an important factor in the data because the more years that go by with me failing to achieve my desired 'good life' the angrier I get towards myself and others, and the more prolonged my failure to live my desired life, the more hopeless I feel about my prospects of sorting myself out in such a way as to 'succeed' in my narrative. For example, on my first admission to the psychiatric hospital I am hopeful the professionals' prescribed treatment will make me better and "relieved" that my failure to succeed in life was not my responsibility, but down to my "illness" (initially diagnosed as Bi-Polar Disorder (C2)). There is a historical tradition in clinical practice of initially relieving people's feelings of guilt by telling people and their family that their problems are not their fault because they are "ill". As this practice is seen as a 'good' thing it makes it difficult to discuss morality and emotions in mental health discourses as it goes

against the grain of that narrative. Anti-stigma arguments are built up around not judging someone “because they are ill”, whereas it is possible to argue the value of engaging in ethical dialogue and ways of being non-judgmental for reasons other than illness, such as the unique co-ordinates of our biographical trajectories make interpersonal moral judgements unfinalisable, at best, as they are intertextual. In contrast the historical tradition within the medical model genre is to present diagnosis as ahistorical literal ‘facts’, as if outside of time and social space, as discussed in chapter 3, where Guilfoyle (2013) argues the initial moral relief of being “ill” traps subjectivities within their diagnosis.

Time is a factor because after my initial relief at being told I was mentally ill and the hope treatment would make me better, when I got worse over time I then began to disbelieve the illness narrative as I compared lived life to the generic expectations. Some years later after seven repeat hospitalisations, and diagnostic shifts, I despair of, and start to disbelieve, the psychiatric medical drama narrative of diagnosis of illness and psychopharmacological solutions. This shift in subjectivity can be understood as it ceasing to be internally persuasive to my subjectivity and I start to relate to it doubtfully, in Bakhtinian terms, as an authoritative discourse. The range of discussions and decisions over time (years) with psychiatrists around the failure to recover within the medical model genre were severely limited within the psychiatric genre, around re-diagnosis or changes in medication. This resonates with the discussion in chapter 2 of Peter Good’s (2001) work observing psychiatry as a powerful monological, *unitary* language which views diverse alternative

language genres surrounding it as irritants (kept at a distance and limited in power) in order for psychiatry to maintain a monopoly over its subjects.

C3: Clinical Notes, Psychiatric Hospital discharge summary, 21/05/1998

"**Diagnosis:** Obsessive Compulsive Disorder with secondary anxiety and depression, also Long-Term Personality Disorder…"

Progress on the ward: On admission he was tense and agitated, expressing feelings of anger. He became more settled but it was not clear if it was related to a small increase in Clomipramine.

Review: He felt that his thoughts had become less severe and felt well enough for discharge though was still prone to violent thoughts and thoughts of self harm but he recognised that these thoughts were longstanding.

Discharge Medication:

Clomipramine 200 mg nocte.

Chlorpromazine 200 mg. tds.

Procycladine 5 mg. tds"

Analysis:

In C3 my expression of anger is included in a summary under "progress on the ward". The medical drama genre does not appear capable of articulating it as a moral emotion as it is expressed in intradiegetic narratives, as shown in D1 and D2. The author leaves the reader some interpretative space as to whether clomipramine is *'treating'* the hero's anger as "it is not clear". The moral anger at the injustice of harm done to me and my own failures to live a successful life are removed from their local moral order and re-described, once I am

dialoguing with psychiatrists, by a powerful psychiatric discourse not as '*moral emotions'* but instead as 'medical symptoms' of mental illness. Strong emotions are viewed as evidence of mental disorder. The psychiatric narrative is what Bakhtin (1986) calls a *monological* narrative because it is powerful and attempts to silence all the alternative narratives and their differing ways of 'making-sense' of these experiences.

Within the polyphony of narratives surrounding psychiatry C3 shows a psychiatrist's attempts to contain, close down and *finalise* what he has heard in my moral narrative of my life so far through the practice of *diagnosis* and medication, converting a moral narrative into a medical drama. As we saw in chapter 1, Bakhtin distinguishes between narratives that attempt to finalise, that is, to dominate and have *the final word* on a subject, and those that tend more to open up dialogue to the unfinalisability of being human, with always more to say. In this *difference*, psychiatric narrative discourses attempt to be monological and dismiss alternatives in a desire to diagnose people into clear categorical containment.

However this data set opens up the finalising psychiatric monolog by allowing comparison of different psychiatrist as authoritative narrators with each other. By showing how each different psychiatrist (e.g. C1, C2, C3) as an ***authoritative narrator***, took the basic intradiegetic utterances of the hero's narrative with its expressed moral emotions and concluded different diagnosis (e.g. Bi-Polar Affective Disorder, Obsessive Compulsive Disorder, Anxiety, Psychotic depression, Substance Misuse Disorder, Long-Term Personality

Disorder, “Not mentally ill”, etc.). The psychiatric gaze claims an epistemology of systematic method and repeatable reliability, which would mean that it did not matter which psychiatrist dialogued with me, they would all draw on their positivistic knowledge base and clinical training and consistently conclude I had the same diagnosis. Clearly the reality is *different*, in that each psychiatrist interprets an extradiegetic biographical narrative from their particular location in time and space and demonstrate significant *variation* in how they “read” the story and its emotions. Hence intradiegetic biographical narratives are “read” in multiple ways, even *within* psychiatry, by different authoritative narrators (psychiatrists) as they create the subjective hero in a relationship to their authoring authority. Although the clinical notes clearly indicate I get considerably worse during my time being subject to psychiatric narrative practices, none of the authoritative narrators (apart from the first and last, seven years apart) suggest that perhaps the solutions to my problems do not lie within psychiatry and maybe I should be discharged to look for alternative non-medical narrative discourses to re-orientate my subjectivity within.

The meaning of my experiences is formed in-between myself and authoritative narrators in a dialogical process where, for example, I describe hearing a voice which I interpret as meaning one day I might achieve something (“You are the new Jerusalem”) but ‘the other’ I dialogue with (a psychiatrist) speaks back an interpretation *with authority* that I am “psychotic” and “hallucinating”. Analysis of the data shows moral emotions, such as anger at unjust harm done during childhood sexual abuse, is dialogically taken out of its moral context by the authoritative practices of modern mono-logical medical science (psychiatry)

and re-accentuated into a new genre of medical drama where psychiatric pathological symptoms of diagnosable mental disorder are in need of treatment. Thus in a dialogical process of unequal power relations (professional/patient) moral emotions become medicalised and pathologised into a subjectivity of self/other. As I become the subject of the medical gaze I begin believing it, and in good faith start to tell others a story of my life that includes “I am Bi-Polar” or later, to explain my failures in life, “I have a Personality Disorder”. This appears to be a biographical example of repeating a pattern discussed in chapter 3, where we saw it is possible to appropriate a medical diagnosis to re-form subjectivity, but at the significant long term cost of limiting the subjectivities available to the hero (Guilfoyle, 2013).

5.2 Pathologising desire within Personality Disorder

D3 Diary entry attempting to make sense of my repetitive excesses, 02/04/1994

“I have such hunger I fear it. I fear I will devour myself trying to satisfy it. What do I ‘hanker after’?, what do I wish to entomb in my stomach, or mind or soul? I know not what I crave. I long for something. Something within cries out, but is it satiable?, “Satisfaction” refers to the atonement or reparation (repair) of an injury or wrong. Repayment of a debt. Is that why I always hanker after something more, trying to satisfy my unhealed wounds? Pouring repetitive acts into bottomless wounds. Or is it a desire for wholeness? To be ‘at-one’ with God, often mis-read as concupiscence.”

Analysis:

D3 shows I fear excessive repetitive acts to satisfy *possibly* insatiable desires may destroy me. D3 is narrated from intradiegetic speaking position. The text can be analysed as dialogical because it is un-finalised and creates a number of different hero/author self/other subject positions in an attempt to make sense of subjective distress. The author starts by suggesting possibly the hero has some excessive part of himself – a desire - that needs putting to death, "entombing", in the stomach. But the hero fears he may *eat himself* trying to solve the problem in this way. *At the same time* a different understanding is suggested, that the hero has an unhealed injury from a trauma and these repetitive acts of excess are attempts to repair (satisfaction) a painful wound or repay a debt. Immediately a third subject position is suggested to the reader – that the hero may have an insufficiency (rather than an excess that needs eating) which means the hero is incomplete, not whole, with repetitive acts made sense of as attempts to fulfil this lack. The author then places the hero into the genre of Catholic theology by raising the possibility it as a strong appetite which is in opposition to reason ("Concupiscence") but immediately problematises this explanation as perhaps a *misreading*, as it may be a desire to be completed/whole through a relationship with God. D3 is intertextual, as if the reader is familiar with Catholic theology they read concupiscence as a strong appetite in powerful opposition to reason. The entry on "Satisfaction" is delivered in the genre of a dictionary definition, with a pedagogical tone, as if the author is trying to teach himself something. The author uses five question marks and places alternative explanations simultaneously into the hero (eating excess, filling insufficiency, repairing unhealed injuries, desire for God,

unreasonable desire). D3 is dialogical in resisting committing to any subjective position, which invites the reader to reflect and consider which, if any, becomes internally persuasive. In 1994 this was written as a diary entry, so primarily it was intended as a dialogue with different parts of myself, or with several possible alternate selves. As part of me values continuing to live I am anxious that I may destroy myself with the awareness that some of my techniques aimed at surviving may ironically kill me, such as self-harm or excessive drinking, whilst trying to stem the pain of past hurts. The clinical notes record my belief that it is morally wrong to kill myself and so my repetitive excess causes me anxiety because I know my way of being *may result in my death*. Thus my anxieties are moral and linked to desire expressed in the private space of a diary, but become medicalised within psychiatrically controlled space (e.g. C6). This links with the discussion in chapter 2 of poorly controlled anxiety being viewed differently in different space-time, such as becoming medicalised in DSM I (APA, 1952) into *personality disorder* as it supersedes Schneider's (1923/1950) *psychopathic personality*. However anxiety can be viewed in space-time instead of individualised pathology, as the next entry illustrates:

D4 Diary entry in relation to space, time and emotion, 21/04/1993

"...the unknown terror-tory I'm in these days, or am it, in."

Analysis:

D4 shows that being in my system of social relations in my early 20's was generally terrifying. In D4 the intradiegetic narrative breaks down a word into an unconventional chronotropic organisation of meaning by playing on the word "territory" to express a fear ('terror') of the social space (territory) I am in and express an anxiety about not knowing where the boundary lies between my identity and my relationship to the social space I am in. Playing on a word is a literary technique usually used for humorous effect, but here appears employed for horror. Linking back to Sullivan's (2012) focus on 'emotional connotations' as part of chronotopic analysis, the emotional atmosphere of the narrator appears to be fear. I do not know whether to locate the fear inside myself or outside in my social space, hence the grammatically strange sounding phrase "...the unknown terror-tory I am in...*or am it, in."* The reflective self is invited to consider if their social identity is equivalent to their social space? Or have they a distinct identity with a boundary and are just "in" their social world? The author creates an *other* who is unclear as to whether they are a fearful social space or in a frightening social space (from which I could escape?) or will the fear somehow travel with the hero if it is part of them? I appear to be unsure of where the boundary is between my social space and my individual 'self' as I reflect on whether I am the territory I am anxiously inhabiting and trying to escape?

As well as feeling anxious about killing myself I am also fearful that I will be harmed by a woman if I start sexual relations with them. Intellectually and at a rational level I know this fear is linked to my being sexually abused by a woman

as a child but this intellectual knowledge (that I fear a repeat of past trauma) does not stop me feeling the fear of attack by women I am attracted to, for example,

D5 Diary entry trying to make sense of my fear of women, 22/05/1993

"Fear, sweat, pain, regret. Went out. Found it hard to interpret women's intentions / signals. Seems very confusing / complicated. Felt threatened by women. Were they out to get me? Do me some harm? Want to be with a woman but when they get near I feel threatened and cannot escape. This is before we even speak! Felt sick, panicky. They might come and get me."

Analysis:

I fear a repeat of the harm done to me as a young person. The difficulty and central relational conflict is that: the object of my fear is also part of my over-arching desired "good life", in that I do want a sexual relationship with a woman. Hence the strong emotions stirred up - because I am desiring what I fear most. If I was frightened of spiders, I could just avoid them! This contrasts with the medical framing of fear in C6 (below) that summarises a lengthy mental health assessment interview as the main problem (*today*) as anxiety, guilt and feeling persecuted, but the anxiety is detached from desire and presented as a symptom, also detached from yesterday and tomorrow within the chronotope of "today".

C4 Clinical notes, partly summarising past clinical notes by others, 05/01/1996

"Referred to psychiatrist R in 1993 – No mental illness present at that time. Thought sexual abuse had led to drinking problem. August 1994 seen by psychiatrist Dr W – "Depressive illness due to sexual abuse" – referred to and commenced psychotherapy. August 1995 – Diagnosed Bipolar Affective Disorder."

C5: Clinical notes quoting an interview on the ward on 05/01/1996 following admission to psychiatric hospital the previous evening

"Feeling persecuted by something / vague / 'a force' – "I think it is my abuser, also it is more general" – "No one in particular at moment" Increased anxiety – 'wound up' "feeling like someone might approach me and harm me." (no change from being in hospital from being out of hospital) Feel it is unfair. Get resentful that 'I feel persecuted because I haven't harmed someone.

I was harmed. Things are the wrong way round. Where my abuser seems happy and well adjusted. Don't know this really – haven't seen her for 5 years…"

C6 Clinical Notes 05/01/1996 following interview, summarising the main problems and a plan:

"Main problems today: 1) Anxiety 2) Feeling persecuted 3) Guilt

Contacted psycho-therapist – story confirmed.

Plan: haloperidol 10 mg tds, lofepramine 2 nocte *Observations*: To stay on ward."

Analysis:

The feeling of anxiety (C5) that someone might come and harm me is similar to my diary entry of 1993 (D5) and my anger at the injustice of childhood sexual trauma is consistent with Dairy entries (D1 and D2). However the reading position in time and space of this psychiatrist is different in that their goal is to categorise with authority within a medical drama and to practice treatments on the body of the patient. They are deciding whether to say I have “no mental illness” and discharge me, or to admit me to the psychiatric hospital, prescribe anti-psychotic medication and diagnose me with something. They chose the latter practice and admit me on this occasion. The context was that I had taken a life threatening overdose recently and was reporting “feeling suicidal”.

C4 and C5 makes use of quotation marks and bracketing to *re-accentuate* at the level of words used by others (not the author). The 1993 (C1) view that I had no mental illness is not put in quotes, but with a sideward glance at the reader the author instead qualified C1 with the phrase “at that time”, which intertextually serves to address the reader with the idea that the passage of time may have reduced the authority/power of C1’s view that sexual abuse had led to a drinking problem (Reader: What about C1? Author: That was *in the past*, I am speaking *now* in the present, which has more authority than the past in this chronotope). However a diagnosis given in 1994 is put in quotes, “Depressive illness due to sexual abuse”. The alternative diagnosis is closer in time and in genre as it uses the medical model but includes an aetiology of trauma. Perhaps this is why it is put in quotes, to create distance from the original context as it is *too close* to the author’s different diagnosis and

treatment plan. The original context of “Depressive illness due to sexual abuse” is clear, but invested with new meaning and value through this intertextual contact and re-accentuation. The authorial intonation could be read as casting doubt on this diagnosis and aetiology in favour of today’s “psychotic depression”.

In C5 a list of utterances selected by the author from the intradiegetic narrative are put in quotation marks, but the statement that hospital makes no difference is instead put in brackets by the author. Why not just quote the hero saying hospitalisation makes no difference? Perhaps this view is read by the author as a threat to their authority and the medical model narrative in the medical drama. With a sideward glance at the superaddressee the hero created by the author is given much less room to answer back within brackets. The contours of the self/other relationship between author and their created *hero* reveal themselves as the reader reads along as the words the hero speaks are quoted in support of the diagnosis and plan, but when they speak against the authority of the author (i.e. the plan includes hospitalisation) the authorial intonation exerts its power. Switching to brackets instead of direct quotation assumes more *authorial control* over the *reader response* as the author anticipates a superaddressee who might use the hero’s words against the author (Reader: Why treat him with hospitalisation if it makes no difference? Author: Do not listen directly to him, he is ill/psychotic, his words serve to support my plan, not challenge it). Thus there is a shift in the self/other relationship of hero/author as the author of a medical model drama allows the subject to speak until they speak against the author’s plan at such points they are bracketed.

Thus C4, C5 and C6 gives clues as to the emotional orientation of the author to their *others*, intertextually, it suggests they feel threatened when the hero speaks against the plan but more relaxed when their words can be used to support the author's plan. Alternative professional intertextual texts appear also to provoke a threatened emotional orientation, an anxiety which the author contains by creating an analytic distance through time (e.g. "at that time") or by using quotation marks.

Of dialogical interest is that within the medical genre psychiatrists record the subject's emotional state but never their own emotional state in the clinical notes, as that is not the tradition within this set of practices, but this psychiatrist may well have been feeling anxious about taking a therapeutic risk and discharging me. He may have felt it was better for me (or for him) and a safer practice to *admit, diagnose, medicate*. He was in a set of discursive systems himself which influenced how he felt, what range of responses seemed 'reasonable', and what choices he could make. His range of responses was limited by his dialogical context.

This decision, to *admit, diagnose, medicate,* amongst many others in my life, involved me in the psychiatric system even more deeply. I spend the next years of my life as a "revolving door" long term psychiatric patient on high doses of anti-psychotic and anti-depressant medication. It would have been difficult and anxiety provoking for the assessing psychiatrist to say I had "no mental illness" because if I had gone home and committed suicide they would have had to justify their actions within current discursive practices, such as in a 'critical

incident' process. Like most people he will have wanted to be able to justify his actions within the set of systems and sub-systems that dialogues like this take place within and so the hero/author position created may have had more than one sideward glance, anticipating readers as regulatory bodies of the hospital institution, potential critical incident review panels, and the professional governing authorities. Thus the structured genre of the clinical assessment concludes with a plan, C6, which reduces the problematic narrative to a brief list of three emotions; Anxiety, Feeling Persecuted, and Guilt. Intertextually contact with the psycho-therapist is simply put as "story confirmed", which serves to support the overall creation of the subjective hero with the narrative concluding with a plan; medication, observations and staying an inpatient – holding the subject in a chronotope of medicalised observed space within a chemically altered subjectivity which allows little agency for the hero to move, despite their view that *hospitalisation made no difference*.

Through this dialogue, involving C4, C5 and C6, I became involved in a medical drama in the medical model genre with a conventional plot involving diagnosis, hospitalisation and medication, and believed myself to be mentally ill. Orientating myself with a subject position offered to the hero in a medical drama I believed I was being treated by professionals in mental health whose treatment would transform me to become mentally healthy. Initially I felt relieved that I could explain my failure to live a successful life to others with a different narrative, that I was not morally responsible for my failure to live a successful life because I was "mentally ill". Within this narrative responsibility shifted from myself to the professionals and I waited for the medication to work.

As previous narrative understandings of myself appeared to be failing when the medical model narrative was presented to me through authoritative narrators (psychiatrists) I willingly re-oriented myself into the subjectivity it created with the hope it would enable me to live the good life I desired, but had so far failed to achieve.

It was only several years later that I came to doubt this psychiatric narrative as I appeared to decline and get worse rather than better whilst receiving psychiatric treatment. On the other hand, if the psychiatric assessment had not admitted me to hospital then I may have gone home and committed suicide. So maybe hospitalisation saved my life until a later point in time when I found a narrative that did help me to live the "good life"? I cannot say for certain (it is *unfinalisable*) if this intervention prevented me committing suicide or not in 1996, although obviously, I am alive today to recall the dialogue.

The data shows a pattern emerges where I tell my story to different psychiatrists over the years who take the basic elements of my story and repetitive excess/insufficiencies and 'read' them into a different narrative of being mentally ill or disordered. This shows that the process of being read into another powerful narrative like psychiatry is dialogical and varies significantly depending on the beliefs of the *authoritative narrator*. C1 thought I was troubled but not mentally ill whilst later psychiatrists, in the same role of *authoritative narrator*, listen to my story and diagnose me with "Obsessive Compulsive Disorder" and "Personality Disorder", with underlying "anxiety" and "depression". The authoritative discourse of the medical model narrative

became internally persuasive for me for several years and thus my subjectivity shifted into it (outside-in), and then out of it (inside-out) later, as I came to disbelieve its story. The medical drama gave me very little agency to disrupt or disagree with the authoritative narrative and a narrow range of subject positions for me to negotiate. The range of subjectivities offered shifted around seven diagnostic categories. Conversations about my difficulties with psychiatrists often ranged around increasing or changing medication, admission (or not) to hospital, or re-diagnosis. This links with the discussion, in chapter 1, around the damaging role pathologising medical discourses can have erasing the social production through trauma of subjective distress, by re-describing them as symptoms of disorder within the individual (Hodge and Bryant, 2017).

5.3 Trapped in a chronotope, desiring escape into a recovery journey

D6 Diary entry about anxiety and its relationship with repetitive excess, 25/03/1994

“What is called “addiction” is a possibility of being. It is an unwillingness to feel anxiety. An always referring back to some repeatable sensation, always unsatisfying, one chooses to repeat into a vertigo of endless repetition. Trapped into a circle without a future. Going nowhere. An unwillingness to feel anxious.”

D7 Diary entry about anxiety about the direction of my life, 13/04/1994

“I fear what I am becoming. Despite my desire to be alright. I dislike myself more. I seem to be getting worse. What am I doing? Waiting for Godot?”

Analysis:

D6 and D7 involve intradiegetic narration, which can be thought of as an ‘inside-out’ discourse compared to the ‘outside-in’ narratives of C1 to C6. D6 draws on a geometric metaphor of a circle without a future in a horror genre of being trapped forever. D7 contrasts my desire to get better with my fear I am getting worse, directionally descending rather than ascending or trapped in a circle. Mindful of the conflict between my desire to get better and my experience of decline and dislike of myself more, I evoke the genre of tragicomedy to help express my anxiety, drawing on Samuel Beckett’s play “Waiting for Godot”. This suggests the hero identifies with the two protagonists in the play who engage in circular dialogue searching for meaning whilst waiting for someone who never arrives.

The literary understanding can be contrasted with the literal understanding of C4 where I am literally mentally ill within a singular truth with little room to negotiate a subject position. My anxiety is consistently related to perceived success *or failure* to live the ‘good life’ I strongly value leading by having a job and a relationship. As time passes my anxiety increases as the trajectory of my lived life becomes clearer to myself that I am moving further away, not closer, to living out the life I value living. Thus part of our emotional life relates

to evaluations we make of our biographical movement (trajectory) in time/space towards our desired life. The more distance that opens up between the way I am living and my valued ideal life the more I dislike myself. Over time my fear grows as my doubts grow that I will be able to succeed at life within my current narrative.

The analysis shows that anxiety and fear is *moral* within the ethical time/space opening up between lived life and desired/valued 'good life' (Taylor, 1989) as I am trapped in a circle, declining. Morality is the tripwire of emotion. 'Time' was an important factor as short term failures can often be accommodated within a narrative, in terms of 'trying harder' to practice it or seeing if any narrative techniques have been missed. Narrative techniques are ways of moving the subject towards their goals but can themselves be the subject of anxiety (e.g. "Am I doing it right?"). However, the longer the good life is not lived reasonably successfully, especially if it seems to be getting further away, then the more moral anxiety produced and the subject's desire to escape their current narrative (rather than practice it more efficiently) starts to emerge.

<u>D8 Diary entry making sense of shame and guilt, 22/03/1994</u>

"A 'pleasant youth' seemed to mock mine, and I thought of hanging myself or stabbing myself from 'shame'. I am unaware of how ashamed I am, of myself. We only notice the moods that pass, if it were icy winter all year we'd not note it. For years I've not stepped outside of shame to note it. From the age of 11 I felt ashamed of every sexual encounter I had. I felt such guilt I wanted to be

physically ill. And such fear of discovery I wanted to die. Over seven years sex and death fused into one for me. The “beast with two backs” is death to me.”

Analysis:

D8 is an intradiegetic narrative attempting to make sense of the connections between guilt, shame, feeling humiliated (mocked), suicidal urges, the urge to vomit, fear of discovery, the urge for death and early sexual experiences. It uses a confessional genre of self-disclosure. The author uses the allegory of seasons changing to communicate the idea that we subjectively become aware of our emotional states as they change like the seasons but then shifts the reader to consider what if you were permanently caught in an emotional winter of guilt and shame? D8 also references the play Othello by using Shakespeare’s euphemistic metaphor for sexual intercourse. Quotation marks around “beast with two backs” may be creating some authorial distance positioning it as someone else’s concept, but then it is re-accentuated into a subject position by saying this has become death to me. This suggests the emotional orientation of the author to the hero of some fear for his safety as he has created a subjectivity walking around an endless winter with life-threatening beasts within a horror genre. This can be compared with C6 where guilt is listed in a *numbered list genre* (*1,2,3*) in a medical drama as today’s main problems. Summarisation of guilt into a number/list genre positions the subject in the present (today) and re-orientates guilt towards the plan (medication, observation, hospitalisation). By comparison D8 creates a subject position where guilt is connected to several problematic habits over several years, with a pessimistic future-view of endless icy winter.

D8 appears to contradict itself by saying the hero is unaware of 'shame', whilst articulating an awareness of shame using literary devices. A dialogical analysis would argue it is possible to think in different ways about the same thing *at the same time*, so the author could be creating a hero who may fluctuate in future between consciousness of guilt and shame and unconsciousness of it - as *winter has come* again. The dialogical normalisation of *thinking in different ways about the same thing at the same time* contrasts with the literature on Personality Disorder where medics assume attempted manipulation of the emotions of others is being attempted if patients express different views to different people about the same issue (e.g. Bowers, 2003) or such dialogical subjectivities are over-pathologised as "splitting" or dichotomous thinking (e.g. Coifman, et al., 2012). Thus D8 may be an attempt to capture a moment of insight into subjectivity that the author may fear may be lost if not written down to allow later reflection. The next data extract analyses experiences within a chronotope which other people cannot see or hear.

5.4: Communicating in-between literal and literary chronotopes create misunderstandings

D9 Diary entry about not being happy and seeing and hearing unusual experiences, 28/04/1993

"A good morning free from the tyranny of unwanted thoughts... I felt uneasy, uncomfortable. I thought reality was an illusion and I was starting to see that in fact I was in Hell as my illusion vanished (reality). Heard a voice saying "I am the new Jerusalem". Wondered what that meant. No one to talk to about

these experiences. What does it mean? – “I am the new Jerusalem”? Saw some angels and trumpet in the sky about a book I would write, what does that mean?. Seems a bit weird. Thought “this will pass”... Feel “sane” now, but not happy with life at all...My delusions may be alternative to remembering how she abused me.”

Analysis:

D9 tries to make sense of some unusual experiences, hearing and seeing things that other people did not see/hear and the question of what is real and what is illusion? I am struggling with the idea that my sensory experience of lived life might by illusory and in reality I am in “Hell” and the metaphor of vision is used (*starting to see*). As also mentioned earlier in this chapter, seeing angels, trumpets and hearing about the New Jerusalem are imagery drawn from Christian narratives. The meaning for me is left unresolved as the hero says they do not have someone to talk with about their meaning. The genre of 12 step recovery is drawn through a slogan related to coping, but re-accentuated in quotes, “this will pass” (Reader: Will it?). The genre of mental health is also drawn on as feeling “sane” *now* implies a possible subject position for the hero being *insane* hearing and seeing things. However, an alternative subject position is opened up for the reader drawing on psychoanalytic genres as these auditory/visual experiences may be “delusions” with a purpose, to avoid painful memories of trauma. Thus D9 presents a wide variety of subject positions for the hero; sane/insane (temporarily), trauma survivor, deluded/reality-seeing, sane but not happy. To try to make sense of them I dialogue with others (such as psychiatrists) and,

as Bakhtin (1981) would argue, the meaning is made in the space in-between people. Earlier we saw C2 describe my fear I am going to be arrested as *paranoia*, my perception as experiencing visual hallucinations during the assessment, and my seeing two police officers coming to my door as *pseudo-hallucinations* (enclosed in brackets to re-accentuate the experience). These audio/visual experiences are not linked to my chronic feelings of guilt linked to childhood trauma in the key summary sections, but positioned in a medical drama where I am mentally ill with psychotic depression. In the next data extract we see how psychiatric narratives will take unusual audio visual experiences and write them into a new narrative with diagnoses, hospitalisation and treatments.

C7 Progress Notes of assessment and inpatient ward observations 30/01/2000

"No [thought disorder] but describes fleeting illusions whilst in bed of someone chopping his foot off. Informally admitted to ward. Currently complaining of lowered mood, anxiety and thoughts of taking an overdose, has made superficial scratches to his arms. Abused by older woman aged 10 – 18? Several previous admissions to [psychiatric hospital] following overdoses and also experienced alcohol related problems but states he has not drunk for 3 days and receives support from A.A. Recently been drinking 3 to 4 bottles of wine a day - but had been abstinent for a year prior to this. Smokes 20 cigarettes a day. No illegal drugs for one year, used to abuse amphetamines and cannabis. Drank heavily 14 to 19 then rehab. Off alcohol 19 – 24. On/off anti-depressants. Psychotherapy for 2 years. On/off alcohol last few years.

Seven psychiatric hospital admissions in last four years. Says his occasional "lapses" with alcohol helps with symptoms for 1 hour but then feels worse. Shadowy figures hover over his bed at night "torturing" him, feels pain over entire body…"

Analysis:

Having my ankle severed had been a visual experience I had shared with mental health professionals for some years and in C7 it is described as "a fleeting illusion". In 1996 I had a conversation with a student psychiatrist when I was an inpatient about seeing my ankle cut open and bleeding (when it was not actually physically damaged). The student psychiatrist asked me about this experience at length. I had reflected previously on this experience, which I found distressing, depressing and anxiety provoking. I had read about the myth of Achilles, who was a hero of the Trojan war, in Homer's Iliad. Achilles was invulnerable to harm except for his ankle, but despite being 'a hero' he eventually died from a wound there. His mother, the nymph Thetis, had tried to make her son immortal by dipping him in the river Styx, but had held on to his ankle and so this area remained vulnerable to harm despite his mother's efforts to protect him. Thus the phrase *Achilles heel* is used in speech genres as a metaphor for someone's vulnerability, etymologically derived from the Greek story. Thus my chronotope (time/space) from which I drew meaning included the Greek myths.

I noticed I felt vulnerable to harm when I saw my severed foot, so I thought that I saw this vision because I wanted to be invulnerable to harm, but I knew in reality other people could harm me (as in being sexually abused). Thus I made

sense of my visual experience using a *Greek tragedy genre* as an expression of a subjective experience I found difficult to articulate in words and this picture allowed my subjectivity to express to itself my fears of vulnerability to harm.

When the student psychiatrist asked me about my severed foot I assumed that his professional training in psychiatry would include a wide range of discourses on madness, including metaphorical interpretations of the Greek tragedies. However, his line of questioning seemed strange to me, which made me suspicious that he was not thinking about the Greek myth at all. I had mistakenly assumed his chronotope (time/space) was similar to mine, but conversationally he did not appear to be travelling very far back, at least not to ancient Greece.

I felt anxious about interrupting his flow of questioning. I did not want him to think I was patronising him by pointing out what seemed obvious, given the cultural currency of the phrase “Achilles heel”. I wondered why he brought the subject up at all and wondered if he thought this picture was ‘the essential clue’ to my escape from mental health difficulties, so eventually I found the courage ask him why he was asking me about this visual experience in particular? He said because he had been “told to ask me about it” by the consultant and it was *part of his clinical training* to ask such questions.

I remember suddenly realising I was the object of study, part of the process of this student becoming a qualified professionally practicing psychiatrist and felt disappointed that he appeared not interested in me and my problem living life

in itself, but in me as a vehicle to his profession. This changed the emotional atmosphere of the dialogue and I decided not to tell him my 'Greek' theory, partly as he had not asked me what I thought, but instead I asked him what the meaning was of my frequently seeing my ankle severed?

He told me that visual hallucinations were clear evidence that I was indeed 'psychotic', and so he said he could reassure me that I was in the right place at this time (I was an inpatient in a psychiatric hospital) and that the anti-psychotic medication prescribed for me to take would likely stop me seeing such distressing things, that I should not worry as "hallucinations were not real" and that soon I would "feel better" and so be able to leave the hospital. If their approach did not work, he re-assured me, there was lots they could do, such as increase the dosage or try a different anti-psychotic. Thus *a literal explanation* of the severed ankle being not real in a medical drama evidencing my psychosis contrasted with *a literary explanation* of it being a real experience expressing my vulnerability to trauma through a Greek tragedy.

5.5: The self-self-other relationship

Next I build on the previous sections by drawing attention to the self-self-other relationship by presenting six data extracts, followed by an analysis;

D10 Diary entry regarding the judgements of others, 08/05/1993

"People judge me, but by whose moral standards are they judging me, their own? Have they experienced what I have experienced?"

D11 Diary entry regarding self esteem, 11/05/1993

“Obviously I hate myself to try to kill myself. Surely better to kill myself than kill someone else, that would be morally worse.”

D12 Diary entry making sense of emotional pain and disintegration, 27/12/1993

“Darkness. Depression. Felt I was possessed by a seven headed serpent daemon last night. 3 weeks now. I felt I was disintegrating. Pain. Longing for death. Self-destructive urges. Agitation. Dislike of myself. Spent Christmas trying to think up alternatives to suicide other than homicide. Must go to therapy, might help? “where are the leaves?, must be dead/ No more weeping.”. Difficulty forming and maintaining relationships with women. Unresolved anger. Self-harming impulses. Food problematic.”

D13 Diary entry concerning the structure of my personality, 7/04/1994

“An ill constructed damaged self like mine is always prone to structural implosions and tectonic shifts, reformations, etc. The solution eludes me, obviously not accessible via intellectual effort or I’d have got there by now.”

D14 Diary entry making sense of repeated identity crisis, 8/04/1994

"What I do seems like so much theatre. Identity Crisis after Identity Crisis. Re-running the "I can't cope" and "I want to die" scenes over and over again. I just need to grow up and walk away from all that. Just do what I need to do and stop talking about it. I'm like an alchemist searching for the philosopher's stone that will turn my base metal into gold."

D15 Diary normalising identity crisis and considering direction on life, 14/04/1994

"My identity Crisis is normal. I am looking for some purpose, meaning and direction in my life."

Analysis:

The data shows I have a difficult relationship with myself (e.g. D11, I hate myself, D12, I dislike myself). However other diary entries show the author creating a hero which allows some critical distance from the author. A subject is created within several literary narratives who does have difficult self-evaluations and self-judgements, but who attempts to make sense of this with more than one narrative and possible futures are constructed. For example, D10 is an intradiegetic narration creating a *hero* who is having a sideways glance at an imagined reader (their other(s) - "people") whom they feel morally judged by. This creates a subject with some agency that can speak back to the reader and challenge the grounds they judge from. This suggests an

emotional orientation of the author of shame imagining the judgements of the reader (others) on the hero's way of being in the world but the author also provides some textual resources for the subject to resist these judgments.

D13 draws on geological metaphors to create a subject whose surface can shift and reform like the earth's crust, suggesting powerful instability and earthquakes, where molten lava may spill out. It also creates a subject like a structure that may implode due to damage or poor construction. This draws on a disaster movie genre where *anxiety over surviving* is a theme, but adapted so the building or nature is the self rather than the context that must be survived. Whilst creating a self as an unstable inevitable disaster it also holds some hope for the hero as *reformation* is possible after the inevitable implosion/explosion. The damaged self is seen as a problem with a possible solution (hope) but within an *anti-Reason* genre in rejecting intellectual effort as having the power to solve it.

D14 draws on the genre of *the quest*, searching for something that will transform subjectivity, using the narrative of the alchemical search for the philosopher's stone. At the same time the narrative creates a subject who needs to develop and just grow up, implying it may not be difficult for the hero and so the power of repeated identity crisis is reduced by placing it into the genre of theatre as "scenes" in a play. This creates some distance from the author and hero and allows the reader to respond by agreeing or disagreeing with narrative explanations (Reader: What is wrong with the hero? Author: You decide; he is a child, he is play acting, or he on a *quest*). The author creates

some critical distance from the hero to enable him to be read in a critical way (child/actor who needs to grow up/act differently). Whilst self-critical these narratives also open up hopeful possible future spaces for the subject to enter – into the adult world, an actor in a different narrative, or transformation *through a quest* if he can find the transforming stone. By creating multiple narrative explanations the author may be increasing the power of the hero over these repeated crisis points (self-harm and suicide attempts) and creating several escape routes for the hero into different narrative futures. However he complicates the dialogical direction to move in by creating so many, perhaps choosing one narrative and sticking to it would be easier for the hero.

A theme emerges of my evaluation of my own self-performance at living life. I consistently describe 'hating' myself, not valuing myself and having no self-worth. I describe lacking direction and being *in search of something* which would give me some value/purpose and some self-esteem, all of which I appear to be painfully aware I lack. As my current narrative appears to be failing to transport me to the good life I desire to live I appear to search dialogically for an alternative narrative to re-orientate my subjectivity within (a quest to find a transformative stone, a child to grow up, an actor in a search for a different play, a disaster waiting to happen and then reform, etc.). This dialogical search for a new narrative when my current one failed can be seen in the autobiographical account, as the next example reveals.

5.6: A dialogical search for a new narrative

A1 Autobiographical narrative extract regarding leaving Alcoholics Anonymous (A.A.) and Psychotherapy

"Anyway, at this point in my life journey some of my friends in AA had 'relapsed' and gone back to drink and drugs. This contributed to me thinking about that way out of my increasingly desperate emotional state. I decided AA and psychotherapy were not working for me and went to the pub on the way home from my last therapy session. I was in a desperate state of inner tension where I just wanted to change how I felt as the pain seemed unbearable so I ordered a pint of Guinness. After a few more pints I found my bad mood started to lift. Then I drank excessively until I 'blacked out' (memory loss). I started drinking every day as an attempt to manage my mood and I was determined to "have some fun", which I had always found hard to do..."

A2 Autobiographical narrative excerpt about being admitted to the psychiatric hospital, diagnosed and medicated

"I remember feeling a great relief that the psychiatrist felt there was something wrong with me. I did not feel guilty for messing my life up any more. I recall thinking; "I knew there was something wrong with me."

It seemed very validating to me to be admitted to the hospital, like a professional endorsement saying that I did have some serious problems, I was not just a failure at life through bad choices. I was not guilty because I was ill – what a relief I felt. I could explain this to others now as a way to explain how badly my life had gone so far...

…Through this process I started to see myself in a new light - as someone with "mental health problems". Someone had mentioned "Bi-polar affective disorder". I was hopeful that the professionals would diagnose and treat me and I would get better.

Surprisingly to me the opposite happened - I seemed to get considerably worse and deteriorate in my mental health..."

Analysis:

A1 and A2 are intradiegetic narratives within the autobiographical genre. They do describe the process of dialogically searching for new narratives (self-help, psychotherapy, mental illness, Christianity, etc.) once I believe the current one is not transporting me to the good life I desire (a job and a relationship). A1 describes the 'hero' on a journey (both allegorically and literally) journeying home from the psychotherapy session when I decide to call into the pub for a Guinness, creating a plot twist, into an adventure genre, where the expectation that self-help and therapy will help me get better is challenged by a sudden turn in a different direction. The author appears to create the hero with a sideward glance at an anticipated reader who might judge this decision negatively, as they do not allow much room for a *reader response*. For example, they say the hero's social network had relapsed recently and the author does not speculate on alternative directions the hero could have taken, such as asking for a different therapist or therapy. The emotional orientation of the author appears to be anxious and protective (Reader: He was foolish to go drinking, he could have made better choices. Author: The emotional pain was *unbearable*. Reader: Was it really?)

A2 describes a fairly clear transition into the medical model of mental health, which reflects the way the story is organised and told into a narrative with clear transitions between narrative understandings (A.A., therapy, mental illness, Christianity, etc.). However comparison to the data from diary entries and clinical notes raises questions about the smoothness of these transitions because they often overlap and hybridise. This is an important point regarding hybridised genres creating complex subjectivities, often missed in the existing Personality Disorder literature (e.g. Livesley & Clarkin, 2015, Bodner et al., 2015, DSM-5, 2013) For example before I enter fully into a mental health narrative I draw on this genre in order to wonder if I am insane (e.g. D9) although I re-accentuate the concept of sanity by using quotes ("sane"). Also a year after I have decided to re-orientate my subjectivity within a Christian narrative in 1999 I am re-admitted to the psychiatric hospital. This analysis is not saying the autobiography is false, or not "true" as all narratives re-organise actual events into a narrative plot in order to tell a story. The difference between actual events and emplotted story itself can be analysed fruitfully. Perhaps the author wanted the hero to progress on his journey in clear stages and the idea of believing several narratives at the same time seemed difficult to recall accurately. Perhaps the author had a sideward glance at the reader whom he wanted to understand that the hero had travelled through several narratives. However, having the diary entries and clinical notes allows a critical perspective from the reader to wonder if the story has been over-simplified, particularly in these transition points between narratives.

Comparison with other texts (diary and clinical notes) allows a more complex picture to emerge where *hybrid narratives* are drawn upon by the subject making sense of their journey through life. Thus although the hero travels through many different narratives, perhaps they see themselves in more than one at the same time, or in a hybrid of narratives, especially during these transition periods, such as in 1999 when the hero is in a faith narrative, but also attending self-help and has a "relapse" in their mental health requiring hospitalisation. Thus someone may negotiate several subject positions drawing on (foregrounding/backgrounding) a number of different narratives, some newer and some older, with varying levels of importance to their social identity.

5.7: Problematising personal agency, self-control, motivation and direction

D16 Diary entry making sense of acting in opposition to moral values, 3/05/1993

"This is the root of my unease considering the ethical or moral dimension, the contradiction between holding moral values for ways of being and me acting opposite to them. Am I just a thrill junkie? Searching for a sense of self worth and value? Does this obsession direct my life?"

Analysis:

The author creates the hero in a confessional genre as well as a diary genre. The hero is troubled by their apparent lack of self-control acting in opposition to their moral framework and values. More than one subject position are created, opening up the explanation that he is excessively attached to excitement *('thrill junkie'*) alongside a quest genre searching for self-worth. Both are given a question mark inviting a reader response. It is unclear if the "obsession" refers to seeking excitement or the quest for self-worth, but either reading invites the superaddressee to consider if this directs the course of the hero's journey through life and is dialogical in allowing room for several reader responses. This suggests an emotional orientation of uncertainty towards the hero by creating multiple subject positions without telling the reader in a didactic way why the hero acts contrary to his moral framework.

D17 Diary entry making sense of lack of self-control, 28/03/1993

"Lack of power over myself appears to be my problem. I am a land full of battles but the bits I loosely group together and call myself (the bits in the battles I identify with) are always losing the daily battles I have with the other bits that land on my island and leave, regroup, attack, taunt, leave, revisit, I am a small part of me holding out in the fog of war, why am I always losing the battle for control over myself? Other people appear in total control of themselves, no signs of a battle raging within them?"

Analysis:

D17 draws on a *military battle gen*re to create a hero who is allegorically a geographical territory (an island) at war. The hero is created spatially as a small part of themselves, suggesting to the reader they are at constant war with other parts of themselves they wish to defeat and banish from the island. This subjectivity is contrasted with another kind of subjectivity, the hero's "other", people who are in total control of themselves without raging internal battles. However the author creates some uncertainty in the reader by saying they "appear" that way, prompting the reader to wonder if people who look in control actually lack self-control secretly? Lack of self-control is presented as the only problem for this hero this day as none others are mentioned. The subject position created creates a conflict between parts of themselves that lose battles with the parts of themselves they do not identify with. So two selves are created, the larger self and the smaller self whom the hero identifies with, creating a civil war within the territory of the self. This is contrasted with the *other* people with a singular subjectivity in total self-control, not at war with themselves. The central question asked and unanswered is why does the hero loses these battles and lacks the power of self-control to defeat the repeat visitors to the island? The emotional orientation of the author towards the hero appears to be uncertainty expressed through the phrase "fog of war" drawn from military genres it evokes the uncertainty of combatants about their awareness of their situation, powers and capacity of their enemy. Visually it prompts the reader to see the hero as directionless, lost in the fog, on this island making victory less certain. Controlling myself appears to be a real daily battle, full of tremendous effort and emotion. The subjectivity emerging here,

the sense of being at war with oneself, is distinctly different too much of the existing literature on Personality Disorder, as either manipulating others (Bowers, 2003) or having a dominant, singular personality that is disordered (DSM 5, 2012). It is also interesting in being written from the perspective (time) of 'losing' the battle, different from the 'recovery' perspectives analysed in the next chapter. The next section in this chapter demonstrates how the author can place the hero into radically different genres (from terrestrial battles to celestial struggles) in attempts to make sense of lived experience.

D18 Dairy entry searching for meaning in a philosophical genre, 19/03/1994

"In my 'Dasein' I can feel the centrifugal force or pull of urge or addiction. It's always a possibility. I felt it tonight. How am I to interpret these urges, Heidegger? The 'ars interpretandi' depends on what texts I've read... Satellites of sensation orbit my being and I can always orbit them, If I can't find a more meaningful existence. I have a habit of choosing to give 'urge' power over me. Can I choose not to do this?"

Analysis:

In D18 the author draws on philosophical narratives, Heidegger is addressed directly with a request for guidance on interpreting addictive forces. The German philosophical term for being (Dasein) is perhaps an intertextual reference to Heidegger's Being and Time (1927/1962). The art of interpretation is written in Latin, which is from the genre of philosophy, and foregrounds the intertextuality of interpretation. This appears to address the reader with a

cautionary warning that their reader response will be intertextually based on what they happen to have read. The self is created as a celestial world that could be orbited or could orbit something else, using gravity as a metaphor to make sense of the hero's lack of power to self-control. This creates a double sense of self as powerful being orbited or lacking power and orbiting something else (a desire). Seeing the self as a powerful planet (implied by having satellites) is undermined by the idea that the hero may be orbiting their own satellites of sensation. The author appears to place the hero in a philosophical genre and be asking philosophy, personified by Heidegger, what answers they have for lack of self-control? Two days later the satellite metaphor for self is used again, this time using the *lost in space* genre from science fiction:

D19 Diary entry making sense of feeling lost, 21/03/1994

"I am lost. A satellite without a body to orbit...My subjectivity spins from one orbit to another."

D20 Diary entry considering motivation, escape and likelihood of relapse, 3/05/1993

"What motivates me now? A vague woolly positivity? Which direction should I go leaving the pit????????? What would I choose as my motivation (direction) in life?...

…What/who could I trust to lead me away from the pit's edge? I'm bound to fall back in. Looking for a means of escape from the pit. Voyaging to?"

Analysis:

D20 uses the genre of *gothic horror* to create a hero caught in a pit and searching for a means of escape. Having placed the hero on the pit's edge, creating a narrative tension (Reader: will he fall back in? Author: he is bound to fall back in) the author gets him to ask the question of what motivation and direction should he voyage in, the uncertainty communicated via nine question marks in a row. Voyaging could be in space, which contextually would make "the pit" a black hole, which then re-contextualises the hero in tragi-comedy as the gravitational pull of a black hole is compared to the power of "a vague woolly positivity" which may power the escape from the pit. Overall the emotional orientation of the author to the hero seems comic and pessimistic, but still asking questions of the reader which leave a glimmer of hope for escape. Power over my subjectivity is a theme in the data and in most narratives I describe a consistent desire to get away from intensely uncomfortable moral emotions and escape myself via practicing a new narrative or "escape to a better place" by drinking or taking drugs. Although I get out of one narrative into another, repeatedly I appear to doubt the power of the new narrative to hold me out of "the pit" and empower me to live a good life.

When I came to disbelieve the psychiatric narrative about professionals treating my illness/disorder and making me better I moved into the Christian narrative and orientated myself within that discourse through dialoguing with other Christians and reading my Bible. This was done through building a friendship with a Christian when we were both washing up in voluntary jobs in

a community café. I wanted some occupational activity washing up to help me stay away from drink and drugs. I came to believe he was quite genuine in his Christian faith (an *authoritative narrator*) and built up some trust in him as a friend. Partly my trust was helped by the fact he had been addicted to heroin and alcohol and been in prison, so I thought he had lived experience of some of the difficulties I had and so I felt I could trust him. Thus he was an authoritative narrator of the Christian narrative to me partly because he had overcome similar difficulties to me through this genre and was able to describe how he had put the narrative into practice. He also spoke about being 'emotionally healed' which as a phrase appealed to me as something I needed. He appeared to genuinely care about me as an individual. I started attending a small home group with him to explore the Christian faith. In terms of my problem with self-control subjectively I shifted to think of Jesus as "Lord" of my life, that is, a powerful figure I was subjecting my will to (i.e. 'seeking God's will in my life') and prayed for the power of the Holy Spirit to help me resist some of my unhelpful habits of repetitive excess such as alcohol and drug use.

Irrespective of whether or not someone believes in the Christian narrative, reading the autobiographical account shows believing in this discourse orientated and organised me, and gave me direction in how to live my life in a way that the psychiatric narrative had not been able to do. I was also dialoguing regularly with a church community of others who, more or less, shared a belief in this narrative which helped to keep me believing and practicing its techniques or ways.

The emotions I felt could be made sense of within this new narrative and techniques were available within the narrative to help free me up to live a "good life" I still desired, namely to get a paid job and a relationship with a woman. For example, when I dialogued with other Christians about my resentments and anger at being sexually abused they agreed that that was morally wrong and unfair and suggested I admit the hurt done and how it made me feel in confidence with another Christian and forgive the wrongs that had been done to me, in line with Jesus' teaching in the Bible. This was a different kind of confession to the confessions of the therapy room (e.g. Fonagy et al., 2002) mediated by a superaddressee intertextually referencing *'forgiveness'* in the Christian New Testament. When I practiced this technique found I was relieved of my angry resentments.

Other examples were around being encouraged to be brave around my fears and to admit what I had done wrong in my past and be forgiven, which when practiced as a technique relieved me of longstanding feelings of guilt and shame. Thus orientating myself within a Christian narrative converted the emotions that had been seen as pathological symptoms of illness back into a moral narrative with techniques to handle them, such as forgiveness, which allowed dialogue about feelings like guilt, anger and fear as moral issues rather than symptoms of an illness. Viewing habits such as resentment within a Christian ethical narrative provided me with techniques of the self to do ethical work on myself, techniques such as confession, turning away (repentance) from harmful habits (like repeatedly getting intoxicated) and being forgiven. The narrative encouraged me to see myself as a valuable person within this

genre as a “new creation” whose ‘old self’ had metaphorically “died with Christ” on the cross and risen with him through adult baptism, to be a “new creation”.

As this identity was different from my previous one (of seeing myself as a mentally disordered patient with a personality disorder being treated by professionals) this helped improve my self-esteem. People in church invited my round for a meal and built relationships with me which helped me feel valued and loved and they appeared not to mind about my psychiatric history, accepting me as I was whilst believing I could get better. However, as noted earlier, the autobiographical account in A1 and A2 describe a more clear-cut narrative transition that the clinical notes suggest. During 1999 I experienced a relapse into excessive alcohol use and re-admission to the psychiatric hospital whilst attending my church community and self-help (Alcoholics/Narcotics Anonymous). Thus this analysis would suggest in actual lived life multiple narratives are negotiated at the same time by a subject in a dialogical search for a new narrative, with hybrid genres being engaged with to make sense of experience, such as mental health, self-help and faith genres. Later this journey may be simplified into a narrative account with clearer transitions between narratives.

Conclusion:

A narrative analysis of the data sets revealed some key themes. *Fear, low mood, anger, guilt* and *shame* appeared significant habitual states of repetitive excess. However analysis showed these were moral emotions which made

sense within particular narratives in relation to failing to achieve a ‘good life’ desired and valued. These habitual emotions of excess were shown to be transferable into a medical drama where they were re-positioned within a typical plot structure to justify diagnosis, hospitalisation and treatment. *Direction* and *motivation* were also identified as significant themes placed into several literary genres.

Self-esteem and *self-control* were also identified as significant in terms of an ethical evaluation during this life-journey of *insufficiency* (too little) rather than *excess* (too much), but these habits of thought and emotion were also shown to be thought about differently within different genres. In particular the analysis highlighted differences between *literal* and *literary (allegorical, metaphorical)* understandings of habitual excess and insufficiency. Most medical dramas were shown to claim I was literally mentally ill/disordered in need of psychopharmacology, hospitalisation, etc. Literal understandings in extradiegetic medical dramas were shown to create little agency for the subject to negotiate their subject position when compared to intradiegetic literary understandings, especially when several literary explanations were created at the same time.

Over a significant timeframe (years rather than weeks) what can best be described as *a significant narrative failure* was shown to occur multiple times within different genres (self-help, medical drama, philosophical, etc.). *Significant narrative failure* sometimes provoked strong moral emotions such

as suicidal urges, and for some *a dialogical search for a new narrative* to re-orientate subjectivity within, as alternative narratives are always available. However comparison of the autobiographic account with clinical notes suggests these transitions are more complex and overlapping than may be remembered and re-told in a simple narrative account of a journey through life. Instead of a clear cut re-orientation from one narrative to another, it is possible to draw on several narratives at the same time in different ways in order to make sense of experiences/re-orientate the self in time/space.

Authoritative narrators appeared significant transmitters of genres in addition to the power of the genres themselves (e.g. psychiatrists for the medical model, recovering addicts for the 12 step genre) as they more or less embody, believe, practice and dialogue about their narrative with curious others who may be in a dialogical search for a new narrative. Even within one genre there was variation which showed the power of the authoritative narrator, as different psychiatrists interpreted the medical genre differently, in order to create a variety of 'heroes' in their medical dramas. This chapter has primarily focussed on a dialogical narrative analysis of the major literal/medical and literary/non-medical genres encountered in pre-recovery chronotopes, *prior* to a chronotopic genre shift into 'recovery'. The next chapter takes these findings forward to focus on recovery chronotopes, by analysing several diverse autobiographical accounts of *'successful'* recovery, in order to answer the last research question: what narratives aid recovery in troubled journeys that involve some kind of mental health crisis?

Chapter 6

Narrative Analysis of autobiographies of recovery

This chapter applies dialogical narrative methods to analyse some autobiographical accounts of successful recovery from serious mental health difficulties already available in the public sphere on The Scottish Recovery Network (2018). These are first person accounts of recovery from people who identify having personal experience of mental health problems. My aim in this chapter is to identify the different genres and discourses people draw on to explain their process of 'getting better'. In the last chapter I considered how, in my own narrative of recovery from a serious mental health crisis, I had found a non-medical route to recovery through a belief system and its practices that helped me to deal with my own troubled journey through part of my life. In this chapter I want to broaden this analysis to look at other stories of how people have made sense of having their own 'very troubled journey' through life, but I cannot assume that their route through will be the same as mine. Because of this I analysed this data to understand how people drew on both mental health genres and genres outside of mental health discourses when making sense of their own troubled journeys. This led to the final research question I want to answer in this chapter – what are the narratives that aid recovery in troubled journeys that involve some kind of mental health crisis? More specifically I wanted to analyse narrative accounts holding the question in mind of whether people draw on moral discourses and/or non-moral discourses when organising their experiences into an account of recovery, which they intend to be read by the public.

Initially I read the data set of all fifty the accounts available on the website in 2012. I then selected the fullest narratives that express predominantly genres from outside of mental health and those whose narratives involve genres from within mental health. I have organised this chapter this way to provide a good point of comparison between predominantly medical and non-medical recovery narratives. This also allows different emerging themes to be explored and contrasted with my own data analysed in chapter 5. Having selected narratives on the basis of the fullest examples of contrasting medical/non-medical genres, *key extracts* were selected from these narratives to focus on in this analysis.

Selecting 'key extracts' from the data set is a narrative dialogical approach favoured by Sullivan (2012, p. 72). These are utterances of significance of variable length which embody a readiness for reaction or reply on the part of the reader (either from the author disagreeing with their hero or the reader response of the audience). Key extracts (or key moments) contain significant aspects of the experience that is trying to be communicated linguistically. These key extracts were selected on the basis of being the most relevant to the research question asking what narratives aid recovery in troubled journeys involving mental health crisis, with an interest in contrasting how medical and non-medical genres might be used in recovery narratives. What counted as a key moment in terms of content included descriptions, anecdotes or reflections on moving into recovery (including both before and after experiences) and descriptions involving significant discourses. These key moments were given

a boundary in terms of form in terms of significant shifts in the emotional atmosphere surrounding the anecdote or reflection.

The Scottish Recovery Network (SRN) was launched in 2004 as an initiative to raise awareness of the experience of 'recovery' from serious mental health problems. Part of the initiative aims to make publically available personal stories of recovery from "experts by experience", that is, people who have direct experience of mental health problems. Part of their stated aims in doing this is to show that people do recover. Another stated aim is to inspire and inform people experiencing mental health problems, and those in a caring relationship with them (family, friends, employers and professionals) as to what helps and what hinders people getting better. It should be acknowledged that these accounts will represent a cross section of people who see themselves as having made positive changes in their life and found ways to get better, to varying degrees. The accounts analysed are limited to people who feel comfortable to put their stories into the public sphere. As such their accounts may be more edited than if they were talking to a researcher under the promise of anonymity. Their accounts may also be influenced by regional variation in mental health narrative practices, such as if more people receive certain diagnosis or treatments in Scotland than in England then these narrative practices are more likely to feature in individual stories.

For clarity of discussion I label and number each key extract by initial(s) of the author and by number of extract from each author, for example, CE1 would refer to the first extract analysed, CE2 would refer to the second extract analysed from the same author and JB1 would indicate the first extract from a new author.

6.1: **Part 1: Recovery narratives with heroes that resist medical genres**

CS1: Magical Realism and transformation

"I, more than most, have had to learn how to live my life one day at a time. I've believed for many years that "labels are for jars and not people", but the penny hadn't dropped that this also applied to me. I'd worn the mantel of grieving mother and PTSD (Post Traumatic Stress Disorder) sufferer since witnessing my five year old son Anthony burn to death in the back of my car in November 1987. My seven year old daughter Samantha had also suffered severe facial burns…

Fast forward to 15 February 2007 when my good friend, a former TV personality, took away a series of articles which I'd written and said "Jesus Christ, you've got talent, but we've got to get you away from The Dead Kid Bollocks." * Outraged and simultaneously relieved, I almost wet myself laughing. The spell was broken and I was suddenly set free. My Day of Atonement which had lasted for nearly twenty years was over.

It was another major turning point for me…My friend's remark enabled me to reconnect to my joie de vivre which had been dormant for more than twenty years. I immediately gave up the psychotherapy course I was studying at the time and the crucifying need which had dogged me to make sense of what had happened to me and my children.

I allowed myself to own my outrageous sense of humour, to abandon the survivor guilt once and for all and to rejoice in my sense of being different in all of its various manifestations. Today I feel very comfortable being a combustible mix of Catholic guilt and Jewish neurosis, and to no longer feel completely identified as a "bereaved mother". That is very much in the background now.

(*This is a direct quote and was considered by the author to be important to the story. It is not intended to cause offence.)"

Analysis:

The author utilises a number of genres to create differing subjectivities. Before the friend's utterance the hero had a singular view of their identity as a grieving mother with PTSD, created from the *trauma survivor* and *medical model* genres. Intertextually labelling theory is referenced through a quote from popular culture connecting the reader with the hero's realisation they had labelled themselves *in the past*. The hero is then transformed/transported by their reaction to their friend's remark. The narrative is organised around *anagnorisis,* the critical moment within *ancient Greek tragedy* when the hero realises their true identity by making a crucial discovery, which shifts the hero's subjectivity from ignorance to knowledge. The hero is transformed into someone who *can enjoy life* through a multifaceted subjectivity through *abandoning the subjective excess* of needing to make sense of past trauma and the moral repetitive excess of survivor guilt. The transformation/transportation of the hero into a new chronotopic genre is also achieved through *catharsis*, a plot devise also taken from ancient Greek

tragedy, where emotions are purged through extreme emotional shift (outrage and relief) of the hero which creates a renewed/restored identity.

The shift from singular identity, as a label, to multi-dimensional subjectivity is achieved through the genre of *magic realism* by introducing magical elements into the conventional plot (i.e. the spell was broken/ I was set free). Christian discourse is referenced intertextually as the past need to make sense of trauma was *crucifying* the hero. Jewish biblical discourse is also reference intertextually as the Day of Atonement (where annual guilt from the community's sins are purged through elaborate rituals) *ends*. This represents an intertextual chronotopic genre shift because in the original text (Leviticus) the Day of Atonement only last a day, but in the hero's life it lasted 20 years. Similarly, in Christian biblical discourse the crucifixion lasted 3 hours, but in an intertextual chronotpic genre shift it lasts 20 years for the hero's pre-recovery subjectivity. This analysis allows us to see the kind of subjectivity emerging from genre shifts, where until they are *set free* the hero is trapped in an atmosphere of suffering and guilt of Biblical amplitude *for an extended amount of time.*

After the cathartic/*anagnorisis* remark the hero's subjectivity travels in a different direction (a '*turning point'*) and their previous (*dormant*) capacity to enjoy life is *freed from the spell* that had held them captive in crucifixion/atonement space-time. This has elements of *fairy tale* genre, as in sleeping beauty awakened. The 'self' created by the author was enchanted to not be free to roam outside of the crucifixion/atonement chronotopic genre for

20 years until a dialogical reaction to a remark frees the hero into a space of joy and humour in present-time.

The author creates some distance with their old self by placing the hero in a new landscape. The author shifts subjectivity back and forth - by placing the old subjectivity '*very much in the background'* the humorous/joyful space is foregrounded and brought into the present time of the *12 step recovery genre* (*'one day at a time'*). Before the spell is lifted subjectivity is dominated/trapped in the past chronotope but afterwards the hero's space-time is located more in the present.

Thus this hero recovers through a dramatic *chronotopic genre shift* - from unending crucifixion/atonement within a hybrid genre (dominated by *medical model/trauma survivor*) into a multi-dimensional subjectivity capable of humour and joy (foregrounding comic/Catholic/Jewish/12 step). The author uses *literary* (not literal) ways to create the transformation/transportation into recovery, which allow both author and anticipated reader (superaddressee) to negotiate the hero's subjectivity through a transition out of a trapped narrative into a more dynamic narrative with a go-ahead plot. The hero's subjectivity shapeshifts and pivots via *catharsis/anagnorisis* through magic-realism and fairy-tail.

The transformation is complex and nuanced as it has allowed the medical model and label of PTSD to be purged along with survivor guilt, but the *bereaved mother* to remain, re-positioned with less narrative power *in the*

background, whilst the sleeping joie de vivre awakens and is foregrounded. Literary techniques transform subjectivity through purging ethical excess which is formed from psycho-analytic discourse ('survivor guilt'). The subjectivity's perceived habitual insufficiency is formed from a non-English language (joie de vivre), suggesting it had been exiled in a foreign land, before being restored.

CE1: Realisation of a transformational journey

"I am no longer the same person who started this journey at sixteen. At the time I didn't know or feel I was on a journey, but looking back over twenty-two years I can see it was a very long journey that actually, if I had anything to do with it, would have ended very abruptly. I almost feel I had to go through this whole journey to emerge a better and more capable person, and most of all grab back and attain my own identity…"

Analysis:

The author creates a hero and places them in an allegorical journey which frames and links the series of shorter stories that follow. The literary technique of *flashback* is used to adjust the time sequence and take the reader back to when the hero was sixteen. The hero (speaking now) addresses the reader with the information the hero (aged 16) no longer exists. This literary framing device sets the scene, acting as an interesting dramatic narrative hook to keep the reader reading. The author draws on a number of genres including mystery (where has the 16 year old hero vanished to?) and suspense (Who is the hero speaking now? How have they transformed their identity?). The author creates

a past hero (age 16) with *insufficient knowledge* (naïve). Realising *they were on a journey* creates the chronotopic genre shift which transforms their subjectivity.

The chronological time (22 years) is given a metaphorical description in space as *a very long journey*. It is not an adventure genre because if it were whatever happened on the journey would not have transformed the 16 year old hero at all, only tested and confirmed in their unchanging teenage character. By contrast this narrative appears the mirror opposite of an adventure genre, as the journey completely changed the subjectivity of the hero and erased the original. The new subjectivity emerging from the recovery journey is better/more capable indicating the author compares two selves (the 16 year old hero and the 38 year old hero) and creates a dialogical relationship between them (the journey). The author creates reflective distance by giving the hero a view on the journey itself. This journey enables the new (better/more capable) subjectivity to emerge (be attained) suggesting *a developmental genre* where overcoming challenges on the journey develops the dynamic character of the hero.

However, another subjectivity is presented in parallel, where the journey allowed them to “grab back” their identity (rather than develop it) suggesting it had been unfairly taken before the journey began. The reader response is opened up to wonder how the hero developed skills along the journey and/or who stole your identity and how did you grab it back? The hero is placed in a *quest genre* where they set off on a long and difficult journey to obtain

something stolen from them, the object of the quest being their identity. Achieving/regaining a better/more capable subjectivity (the object of the quest) makes the hero *almost* feel they had to go on this journey. This addresses the reader by raising questions around the subject's *will power;* did they go willingly or were they forced by another's will? *'Almost'* is double voiced allowing the hero to disagree with the author. It speaks from an ambiguous boundary position leaving open the idea that the hero feels they could have chosen a different journey, or achieved their quest in a different way. In the next excerpt CE explains why they set off on their recovery journey;

CE 2: An invisible monster forces the hero to journey

"…Psychiatry is like no other medical profession out there, it's invisible, internal and destructive. There are no tests, examinations and even assessments are never 100% absolute. My admission in 2000 was to be my last and I vowed never to return there again.

Having come away dejected by lack of care, support and sensitivity, I laid out a path to follow…"

Analysis:

Because the author is writing about their own experience the hero expresses an emotionally invested embodied subjectivity. The words they place in the hero have an intonation that can be read, for example in this dialogue with psychiatry I hear an intonation of heaviness, anger, despondency, and fear. The author draws on a *supernatural horror genre*, as the medical profession is

described as harmful character with supernatural powers. The power relationship between the will of the hero and the will of the authoritative discourse of psychiatry is negotiated through a hybrid horror/quest-journey genre. In a dialogical reaction a supernatural character is created to communicate its threat to the hero and explain the beginning of the journey. This suggests the author may have hit a *sore spot,* where an authoritative voice *wedging* into subjectivity (from outside-in) attempts to penetrate the subjectivity at a vulnerable place, where they *are* supersensitive to the idea that psychiatry is right, and the dialogical reaction is to expel (inside-out) the invader as a supernatural beast.

'*Invisible'* character suggests it could approach the subject unseen without warning and do them harm. '*Internal'* suggests the monster is able to invade the subjectivity of the hero and got inside their subjectivity (outside-in penetration). This reflects the hero's *other* as the authoritative discourse of the medical profession entering into their discourse about themselves. The hero struggles with psychiatry's *will to order their subjectivity* and judge them ("assessments are never 100% absolute"). Thus the monological 'outside-in' discourse of psychiatry is moved into the dialogical 'inside-out' narrative of quest-journey in order to express a conflict between the author and their other. This intense emotional struggle is around the boundary of the self-other where the hero has been penetrated (internal) by the unforeseeable (invisible) malevolent force of the medical profession which has harmed her and left her feeling dejected.

This is a sub-genre of *the quest genre,* where a malevolent character forces the hero to go on a journey-quest to find something that will fulfil what they lack, restore an insufficiency, heal a harm or restore something lost. The hero reacts to the harm done by psychiatry by going on a quest-journey where the object of the quest is to *grab back their identity*. Moral responsibility is placed outside the self onto psychiatry for causing traumatic harm. This resonates with the discussion of expert by experience, in chapter 3, who saw systemic lack of care by mental health services being part of the re-traumatising aetiology of personality difficulties associated with complex trauma (Allister et al., 2018). Despite the trauma the author persuades the hero to say (and so *hears back*) that without this journey they would not have developed into the person (subjectivity) they are today. This can be contrasted with the next extract which describes a recovery experience from a different person.

S 1: Life turned upside down

"My whole life had been turned upside down by personal circumstances and as I sat there I contemplated what I saw as a bleak future. Illness had seen my employment terminated and I had little income. I felt that I was at the bottom of a deep dark void, I was very emotional, lonely, frightened, totally lost and in many ways detached from life and I didn't know what to do. It was as if I were the victim and everything was being done to me, I had tried to outrun my problems but had found that they followed me everywhere. I had tried to talk to people but my detachment from life seemed to prevent the right words from coming out. People looked at me and as I usually appeared clean and tidy they

assumed I was alright, but no-one saw inside to the emptiness and loneliness within. To where could I turn for help, what could I do?"

Analysis:

The author creates a hero on a journey, who having run from her problems now felt *totally lost* in their chronotope. The hero experiences a narrative failure (loss of; employment, income, health) with very little interpersonal power, *as a victim* created by the actions of others. The subjectivity has an *insufficiency of words* to communicate this experience to others. This connects with JB1 (below) who did not have the mental health vocabulary in the culture of her youth to describe her experience. Thus constructing a narrative of recovery can involve a sub-plot (a story within a story) of going on *a quest to find the words* to describe experiences the hero initially does not possess.

The author of S1 creates distance from the hero by saying it was *'as if"* they were the powerless victim of other actors, which is *double voiced* in raising doubt and a question in the reader response: Is the hero entirely the passive victim of others wrongdoing? The subject's chronotope creates an emotional atmosphere of despair as future-time looks bleak and the present chronotope has been "turned upside down" with the hero detached and placed at a great distance at the bottom of a deep dark void. The narrative is structured around an implied other space-time which is the mirrored opposite of their current one, if it were turned upside down again - where they would feel attached to *life*, to people, fulfilled (not empty), light (not dark). This draws on a fairy tale or

fantasy genre where the hero may pass through a mirror into another world where everything is reversed (big/small upside down/back to front).

S 2: Crossroads causes recovery to begin

"Deep inside me, I knew that I had three choices – to go down the road of drink and drugs, to commit suicide or to plan a way forward. I recognised that the first two choices would lead to suffering and grief for those friends and family who loved me and who would care for me should they realise how ill I was – but I had never had the courage to tell anyone how I felt and therefore what right did I have to cause them many years of grieving. Slowly I turned my thoughts to the third option, and as I did so, I felt for the first time in ages, a very slight stirring of hope and excitement, and I reached for a pen and a piece of paper…"

Analysis:

The author places the hero at crossroads, extending the journey allegory with three moral choices/roads they could travel down. This visually strengthens image of *the hero on a journey* by creating three new space-times the subjectivity could move into depending on the direction they re-orientate. This pivot in the narrative is described as a moral dilemma, as two of the choices are resisted for ethical reasons because in the hero's moral framework they do not believe they have the right to cause anticipated others (friends and family) grief and suffering, particularly as they *had insufficiency of courage* to tell them how they suffered. The cinematic technique of slow motion is used, indicating a chronotpic shift as '*slowly'* they turned and a future space-time of hope and

excitement emerges as a possibility for the hero. However this feeling is *'very slight'* and double voiced allowing some doubt about these future hopes and communicating an emotional intonation of feeling still dark and heavy, but allowing a little light (*very slight*).

S 3 Twelves steps of the journey: Flipping the Script

"…Excitement began to seep into every cell of my being as I gradually made a list of the steps that I needed to achieve in order to take me from where I was – in a deeply depressed state, to where I wanted to be – a happy, normal individual. In all there were twelve steps, starting from a small challenge to simply sit still for 5 minutes and gradually increasing in difficulty to the last step – entering the world again as a healthy adult.

In doing this small activity I felt that at last I was beginning to take back an element of control over my life."

Analysis:

The articulation of the life they desire/value (happy/normal) as a destination illustrates the importance, as discussed in chapter 1, of the desired 'good life' which Taylor (1989) argues forms the basis of a quest to find a believable moral narrative to orientate the subjectivity within. Intertextual reference to 12 steps of recovery and mention of drink and drugs anticipates a reader response and raises expectations of the 12 step (Alcoholics Anonymous) genre of recovery. When the hero reveals the first step is 'sitting still for 5 minutes' the literary genre of *parody* is used. This anti-establishment anti-

authority genre addresses the anticipated reader and allows a range of reader responses, such as; surprise and celebration with the author that they are writing their own plan of recovery, or disapproval and disappointment that it is not a typical 12 step plot, or it could be read as *coincidence*. Using the literary genre of parody disempowers the 12 step discourse in relation to the hero and so the author gives the hero a gift - more agency to resists the 12 step discourse (as an authoritative discourse). It may indicate the 12 steps of A.A./N.A. is not internally persuasive for the author and so is parodied, disempowered and so not opened up as a possible subjectivity for the hero. Instead the hero's journey is broken into 12 stages (steps) of incremental difficulty with a clear start (deeply depressed) and clear desired destination of a *good life* (happy/healthy/adult/normal).

S 4: Flipping the Script again - from medicine to trauma survivor

"… My journey to recovery took me along the complementary route, simply because there is no medicine to cure extreme grief and trauma and I knew therefore that the healing had to come from inside myself. Learning new skills would allow me gradually to heal, to achieve the steps on my list and also to rebuild my self confidence and self-belief."

Analysis:

The author uses a health/illness medical drama genre but resists the medical model version. They take a *sideward glance* at their anticipated reader response and use an element from the typical medical model plot (medicine) to challenge the authority of the medical model by saying there is "…no

medicine to cure extreme grief and trauma". Using this technique the author *flips the script* on the medical model genre and takes its authoritative power to govern the subjectivity of the hero away by doing something unexpected with a typical plot element. Flipping the scrip dramatically pivots the hero into a different genre, that of trauma survivor genre. Healing of trauma is the destination for the hero but this route is not from traditional medicine, instead healing comes from; rebuilding a healthy self-confidence, learning skills, from inside-out and from the complementary route of medicine.

The subjectivity that gradually emerges along the recovery journey is one of *increasing agency* as a trauma survivor. The author transitions/transforms the hero *via a journey genre* which positions the subjectivity pre-recovery as; a victim, lost, in a lonely chronotpic genre of deep dark detached void without words, without a future. The journey out of the void has a clear destination and is achieved in self-defined steps of incremental difficulty. The author negotiates the hero's subjectivity past authoritative discourses through *parody* and *flipping the script*. Thus this analysis shows both comic (parody, S3) and tragic (horror, CE1) literary genres can be used strategically to resists powerful discourse's will to order subjectivity. Time features significantly in these recovery narratives, as the hero is lost/trapped for years/decades rather than days/weeks. Entry of the hero into a recovery chronotope is usually heralded by alteration of time (it slows down (S2) or speeds up (CS1)) The metaphor of being 'totally lost' is a *chronotopic clue* to the reader that *insufficiency of direction* in life is of significance, until a chronotopic genre shift supplies subjectivity with direction.

Part 2: Recovery narratives where mental health genres are internally persuasive

JB 1: The hero's initial dialogue with racist discourse

"I am a mixed race woman (Scots-Irish mother, my father from Peshawar). Within the context of that background and culture, "mental", health as a subject was never in the vocabulary and "depression" was a word and concept never used or discussed.

From a personal perspective, on reflection, I can see now where the roots of depression took hold for me. I am the oldest first-born girl, from ten younger siblings. As for my youth…. think of the film "East is East" but much darker. I can relate to that film – it was the first time I saw my family life reflected on screen.

Having been subject to racism in the school playground in the early 60's definitely affected my self esteem. Even worse, I felt so ashamed of the often daily name calling. I never told my parents about being called "darkie", "paki", "get back to your own country" but this experience affected my sense of mixed race identity, and my self confidence."

Analysis:

Jamila is creating an intradiegetic (inside-out) narrative where the originating chronotopic genre ('*my youth*') is a traumatic space located *in the past* where habitual insufficiencies grow out from, where "…the roots of depression took

hold for me". The author draws intertextually on her cultural resources to reference the comedy film "East is East" to connect the reader to her experience of a complex and conflicted mixed-ethnicity British household. She then amplifies the emotional atmosphere of the film, creating a difference to establish some distance and uniqueness between the hero's subjectively and the comedy film (i.e. '*but much darker*'). The film East is East itself intertextually draws on Kipling's poem, *The Ballad of East and West*, which transports colonial cultural tensions into the genre *of Scottish boarder ballad conflicts*. This evokes a subjectivity trying to negotiate culturally differing but conflicting chronotopic landscapes (Scots-Irish / Peshawar). The hero's habitual experience of shame is interlinked with orientating their subjectivity within a racist discourse as the relatively powerless subject of such a discourse. Remembering, re-imagining and re-articulating the past into a present ethical narrative (roots of depression lay in unfair racism) politicises the hero's subjectivity by linking political (outer) with the psychological (inner) experiences. Remembering past trauma through an ethical lens and naming racist discourse in the narrative as an early influence could be a way for the author to decolonise their subjectivity of the racist discourse's power to govern and create *a subjectivity of shame*, *low confidence, low self-esteem*. It also resists the medical model genre of individualised and depoliticised symptoms (e.g. shame) of (inner) ill health by placing shame in a social context on the boundary between inside-outside.

JB 2: The hero's dialogue with other discourses

"I've experienced depression on and off for the past two decades. I became very skilled at covering it up. I started to feel a bit low and anxious, not quite on top of things (which I now understand to be disassociation)…

Also, in the early days, I studied for a drama degree and I loved it, received exemptions in the 1st and 2nd years (unknown to me, I had undiagnosed dyslexia and P.T.S.D). So I subsequently struggled, and left university (minus my degree). Also at that time, I was also going through a traumatic divorce, and facing life alone as a single mother. On reflection, that experience was my first serious bout of depression. Work wise – I became involved in community drama, and I eventually found my niche as a group facilitator – working with different culturally diverse and ethnic groups in the community. Having depression (especially if it's undiagnosed) can leave you feeling very isolated (you never completely trust people) and I did not have the ability to develop close relationships with other people. Again, having two young sons, gave my life purpose and meaning – but often it feels as if I was leading a double life."

Analysis:

The author find the genres of therapy and the medical model internally persuasive and draws on them to re-imagine the past chronotope through these genre lenses in order to explain partial narrative failures (failed degree/divorce). The pre-recovery hero had unknown/undiagnosed conditions (i.e. undiagnosed PTSD/dyslexia/depression/disassociation/lack of trust). This

illustrates the discussion, in chapter 1, which considered how habitual ways of thinking, feeling and/or acting can be reformed and re-conceptualised as "*mental health issues"* when viewed within mental health discourses, such as the reporting of habitual feelings of guilt *and shame* (Hodge and Bryant, 2017). However this analysis expands this point to show how mental health discourses from both medical and therapy genres can be used creatively by an author to help negotiate their hero out of a pre-recovery chronotope by retrospectively recreating it as *undiagnosed/untreated* space-time for the hero, and thus relieve the present-time hero of *excess of guilt and shame* as their previous subjectivity had *insufficient knowledge*.

Taylor's (1989) concept of identity orientating around the narratively negotiated desired good life helps us to understand this hero does not have a total narrative failure, because parts of the good life they desire are achieved, particularly through the role of mother and work. However, the author problematises the hero's subjectivity by giving them a double-voiced emotion that they were living a "double life". The author gives the hero room to answer back and question what these two worlds are. It is also double voiced in addressing the anticipated reader and allowing them to imagine the two lives differently from the author and hero. The reader response may think the 'double life' is the 'outside' world of fulfilling socially valued roles (parental and employment) and the 'inside' world of depression, low self-esteem etc. But the hero may connect intertextually with two ethnically conflicting chronotopic landscapes (Scots-Irish / Peshawar). However, the author themselves holds a dialogical subjectivity never identical with themselves, but always in a relationship with their hero/other, and so they are free to think differently from

their hero, for example, they may read the double life being between the fulfilling life they dream of/desire and the partially fulfilling one they are living.

JB 3: The hero is inspired by reading other authors

"Over the next decade or so (from the 80's) I felt that the "recovery" process happened gradually.

I am a voracious reader, and I found various writers who reflected, some experiences of my life, and I related to this. Alice Walker, Maya Angelou, Zadie Smith, I admired and found these writers, really inspirational and I joined a creative writing class. The first class, was therapeutic writing class, and it helped me to get my feelings out through poetry and sharing work in a group setting. I started being more open, and honest, about my hidden feelings of despair, being isolated, and feeling different from other people. Even better than that – I could now write about it. I wrote about racism in the playground, being mixed-race and "different" in a positive and empowering way, and I began to construct a 10 minute, spoken word poem – about the journey, of depression and recovery called "BLUE"."

Analysis:

Reading texts (novels, short stories, essays and autobiographies) written by female writers whose texts intertextually resonate with the author's lived life inspires the hero to imagine herself as a creative writer. Thus reading relevant resonating texts opens up new subject positions to re-orientate within. The hero has a relationship with both the published authors (as role models) of

those texts and the fictional heroes created by them. Alice Walker, Maya Angelou and Zadie Smith could be seen as *authoritative narrators* for the hero, with their authority partly drawn from being seen as creative trustworthy 'experts by experience' as they also resist racist and sexist discourses that had attempted to govern and create their subjectivity. The hero is then inspired to write about their own movement through depression and oppression through poetry and journey genre. Re-articulating the lived life experience through these genres allows a new subjectivity to emerge, one that is empowered, positive and creative/productive.

JB 4: The hero's dialogue with medicine and therapy

In my process of recovery getting the right information was crucial. I have received different types of counselling, and also psychotherapy (some NHS and some private), which have all proved profoundly helpful. This was particularly the case where the therapist was from a culturally mixed background…

Initially Prozac was suggested (which I found not to be helpful) and my name was put on the list for psychotherapy (my request). At the same time I started a ten week course at the local women's counselling service to teach childhood sexual abuse survivors (I am one) how to manage the long term effects of post traumatic stress disorder (PTSD). I don't particularly believe in labels but in my case identifying my conditions was helpful. All of this, proved to be a turning point for me in terms of my recovery and healing process because at last I had

identification of all those untreated conditions I had been living with in isolation for so long made sense. And – I was not to blame for my conditions."

Analysis:

The author creates a hero who has been helped on their recovery journey by counselling and psychotherapy, but this medical drama empowers the hero in rejecting the initial treatment offer from the mental health genre (psychopharmacology) and emphasising that the hero had to assertively request psychotherapy, thus creating a hero with active dialogue within the medical drama rather than a passive recipient of a subjectivity initially offered (i.e. the narrative *patient recovers by taking drugs*). The subjectivity is transported into the genre of *being a trauma survivor* who learns skills to manage the effects of trauma. The author negotiates a complex subject position in relationship with the medical model with a sideward glance anticipating a reader with negative judgements about labels by saying they "…don't particularly believe in labels..". At the same time the hero found these labels helped their recovery journey as naming (identifying) untreated conditions helped make sense of the past and helped not feel morally responsible for them ('I was not to blame'). This double voiced believing/not-believing in medical labels reflects the discussion in chapter 1 around survivors of trauma being given mental health labels of disorder, as this creates a subjective tension as deliberately inflicted trauma needs to be understood within a local moral order that makes sense to the survivor. The double voiced *'not particularly believing in labels'* utterance shows the author taking less authorial control in this section by leaving room for a range of reader

responses. For example, a reader could intertextually bring Shaw and Proctor's (2005) view, discussed in chapter 1, that a medical label pathologises moral experiences of surviving unfair sexual abuse, to the hero, but still remain close, as the author *does not particularly believe* in them either. This shows *double voicedness* and *degree of belief* is significant in negotiating narratively formed hybrid subjectivities. The power of the medical model over the hero is reduced through the author *not particularly believing* in a key feature of that genre (labels). However the genre is then used to relieve the hero of emotional pressure of moral responsibility (blame) as *in the past* as they had *insufficient knowledge* they had these post-traumatic conditions. Here the absent other in the author's subjectivity structures the narrative as it turns to address the hidden voice who is critical of the medical model/labelling.

The author is also having a sideward glance at *anticipated absent others* wedging into their subjectivity from outside, those who may judge the hero morally for some of their narrative failures (failed degree/divorce). The author turns the hero to address them with the *past* unknown/undiagnosed but *now* officially sanctioned medical conditions (PTSD, disassociation, etc.). Thus the power of the medical model genre is used strategically in nuanced ways by the author to resist moral judgements of anticipated others whilst at the same time 'not particularly' believing in labels. The outside-in discourses of mental health penetrate the subjectivity's inside-out boundary as it is allowed in to explain the past, but also oscillates around the subjective boundary (outside-inside) as it is pushed out through some doubt (*not particular* belief).

JB 5: Chronotopic genre shift from East is Ease to international Buddhist community

"Five years ago, through working with 7:84 company (as a writer), I connected with SGI Buddhism, and I am now an SGI Buddhist. This act of mentally becoming, and committing, to Buddhism, has probably had the most profound effect on my recovery journey – I have found a sense of community locally, nationally and internationally – the twice daily, rituals of prayer, and chanting puts me, in a state of calm, and extreme positivity – the clear, rational, thought, and thinking, is referred to "high life state" by Buddhists…

From being a young, bullied, mixed race girl, with no self-confidence and self-belief – I feel I've become an expert in the area of human relations! I could now say I could live next door to a hungry lion!!

…One of the most inspirational quotes that kept me going through recovery is from the black Afro American writer – Maya Angelou, "the question is not just to survive, but to THRIVE, with passion, compassion, humour and style."

Analysis:

Different degrees of value are ascribed to different genres and discourses, for example, having drawn on medical, therapy, faith and fictional genres, a quote from Maya Angelou is highlighted as "one of the most inspirational" in helping the hero. The faith genre of Buddhism is also foregrounded and raised in value relative to other genres as *probably* having "the most profound effect" on the hero's journey. However, *'probably'* is double voiced in allowing the hero and

anticipated reader some room to disagree. Significantly, the subjectivity is located in a new chronotopic genre that is local, national and international. This international relational space contrasts dramatically with the chronotopic genre at start of the hero's journey ('a young, bullied, mixed race girl, with no self-confidence and self belief') where their subjectivity lives in "East is East" in a complex and conflicted mixed-ethnicity British household and outside the house is a racist discourse governing and oppressing her subjectivity.

Jamila creates a dynamic hero travelling from *my youth in East is East* (where outside the door was a powerful racist discourse) into an international self-confident subjectivity (able to handle the hungry lion outside the door). The journey allegory enables past, present and future space-time to be in dialogue with each other. Narratively shaped subjectivities differ in the degree to which the coordinates of their biographical trajectories orientate the hero towards past, present or future space-time and such differences can be fruitfully analysed. For example, CS1 and JB2-5 describe getting better by locating themselves more in the present/future and less in the past. In order to transition/transform the hero into a present chronotopic genre they need to place their hero's initial mental and emotional distress into a *past* chronotpic genre. The narrative allows this to happen by creating *distance* between two chronotopes and then connecting them in a way that makes sense - via a journey. They appear to make different sense of the past through new *genre-informed* lenses, glancing backwards as they journey forwards. It is interesting that CS1 and JB1-5 negotiate a different relationship for the hero on their recovery-journey (acceptance/inside or rejection/outside) towards *the medical*

model's PTSD label, but both still recover. Both allow new, but differing, hybrid subjectivities to emerge with new capacities to enjoy life and have increased agency and self-confidence. In the next extract from a new author the complex and nuanced negotiation of recovery subjectivities with multiple discourses within overlapping genres is further explored.

FG 1: Writing their own wellbeing and recovery action plan (WRAP) was empowering

Recovery gave me back my self-respect; I had spent so many years being put down that I put myself down. My self-esteem was slowly rebuilt over time and even more slowly I became confident in myself, meaning and purpose was the key to this. When I was faced with responsibility I could no longer be a passenger in my life I had to take personal responsibility and make my own fate in life. My parents played a big part in making this journey happen for me, so I am truly grateful for their devotion and hope that I've made them proud of me. Asking for help when I needed it and fighting for my rights was hard at first but is now second nature to me. Self harm is a thing of the past which when I look back, I can't imagine how I could have done all this harm to myself and how I suffered the pain, but I carry the scars as a constant reminder of how bad life was for me. I'm so pleased to now have healthy coping mechanisms which will live with me forever. Writing my WRAP was such an important part in my recovery as I had a wellbeing manual on myself written by myself and that felt so empowering."

Analysis:

The author creates a hero whose recovery journey begins by taking personal moral responsibility when faced with it. Their pre-recovery subjectivity inhabits a landscape where others put them down and consequently the hero had a self-other relationship with themselves where the voice of their abusive *other* (outside-in) became internally persuasive and penetrated into their subjectivity as they put themselves down, creating a hero with low self-esteem, low self-respect and low confidence.

In this chronotopic genre *down-space* is pre-recovery mental and emotional distress and *up* is the space of recovery. The “key” to unlocking the hero from their pre-recovery chronotope was finding *meaning and purpose* in life. Once the sub-plot quest for the key to unlock the hero is achieved and taking personal responsibility moves the hero, subjectivity shifts into a new recovery chronotopic genre. *Taking personal responsibility* empowers the hero to travel up from being down (by *building up* self-esteem). As we have seen in previous narratives, hero’s entry into recovery space alters time, as going up happens “*slowly*” and “*even more slowly*”, contrasting with CS1’s hero’s entry into recovery space heralded by time speeding up (*fast forwards* and change experienced *suddenly)*.

The hero's recovery chronotope builds up; self-confidence, self-esteem, self-respect and builds interpersonal power (agency). Now the hero is writing their own recovery plan (WRAP) and fighting for their rights (inside-out). This recovery chronotope becomes about increasing agency by switching subjectivity from *passenger driven by others* to *driver of the vehicle (the hero's life)* by taking moral responsibility for the direction of travel. The words placed in the hero's mouth are that she had to "make my own fate in life". "Fate" refers to the predetermined events in our life outside of our power/control but the author repositions it in an opposing utterance about taking personal responsibility for life. This is double voiced reflecting the author's inner-outer struggle with the authoritative words of others (outside-in) urging her to take personal responsibility containing the old notion of fatalistic passivity. It could also be *a pun, or parody,* to express the author's disagreement with the old subjectivity's idea of fate. The utterance allows the hero, reader and author to disagree about how much subjectivity is shaped by outer or inner forces. In this context "fate" is also a *word with a loophole* as it offers an escape from the position that our life-journey is entirely down to taking personal moral responsibility for our choices and not determined to some extent by powerful external forces ('fate').

<u>FG 2: The hero experiences *anagnorisis*, through an accidental discovery</u>

"Around about this time I accidently found out my real diagnosis was Borderline and Dependent Personality Disorder. I wasn't meant to find out but as I had, the psychiatrist gave me books to read about it so I could get a better

understanding. For the first time in my life I understood a little bit more about me….

I manage my symptoms of mental illness everyday in a healthy way and have gone from having a very poor quality of life with no hope at all to having a meaningful life with lots of hopes for the future with even more dreams and aspirations, so never give up on your dreams. I am now proud of myself, proud of what I've achieved in such a short space of time and hope that I've now made my family proud of me too. Not only that but my journey is not completed yet so I'm excited about what the future holds for me. My son has so much to answer for, as he made all this possible. I hope that he too will one day read this and be proud of how I turned my life around for his sake."

Analysis:

The author draws on the medical model genre of a medical drama to see the hero's subjectivity as mentally ill, and then conceptualise some everyday difficulties as *symptoms of the illness* that they manage in healthy ways. In the failed attempts by professionals to keep this secret knowledge away from the hero the accidental discovery takes the literary form of *anagnorisis,* as a critical moment when the hero realises their true identity by making a crucial discovery shifting their subjectivity from professionally managed ignorance to personally discovered knowledge. Once the medical knowledge of diagnosis is discovered the hero is given books they find helps her on her journey. This hero has several other turning points, such as *finding meaning and purpose* and the *realisation taking personal responsibly* was essential (*the key*).

This up-future (space-time) is also populated with several *anticipated others*, a future grown son who is proud of his Mum (when he reads this), and family members (parents, siblings) who are looking at the future-hero with moral judgement on the hero's journey and feeling proud of the hero's turn around in life. The author is also proud of the hero as time now speeds up ('*in such a short space of time'*).

The author integrates a medical model genre into the hero's journey allegory as a way to structure their narrative and communicate change. This does produce subjectivities that potentially contradict each other, such as being self-confident/healthy and mentally ill, so in this recovery chronotope the author may think *in different ways* about their hero *at the same time*. However, the good life the hero desires (is achieving, and is working towards) in recovery is not defined primarily in health terms but in achieving socially valued roles of being a good mother and being employed. Personal responsibility is also analysed in the next extract, from a different author's experience.

<u>AM1: Taking partial responsibility for some of the past is emotional and empowering</u>

"Through his practice, I was also in close contact with a psychologist who had a very patient nature and a real enthusiasm for CBT (cognitive behavioural therapy). Through my work with her I came to realise my own part in many of the negative events which I believed had "been done to me!" As painful as it was at the time to realise that I had in fact played a part in some of my own

misery, it was exciting to learn that I did in fact have some control and through this realisation, had a choice as to whether it would happen again…

I realise that within this story of recovery, there are elements which are out with our control.."

Analysis:

Here the author creates a hero who changes their subjectivity in part through dialogue with a psychologist. Narratively structured as *anagnorisis,* the dialogue is a critical moment in the narrative when the hero realises part of their true identity by making a crucial discovery that they were partly morally responsible for some of their misery. This has an emotional atmosphere of pain as it shifts their subjectivity from ignorance to knowledge. However the pain is mixed with excitement as their subjectivity emerges with a new sense of agency through control and choice. Thus taking some moral responsibly for part of what has happened in the past transforms the hero from passive victim to someone who can choose to protect themselves from repeating past patterns in their future chronotope. The emotional element in this narrative section of excitement and pain transforming the hero also employs the literary device of *catharsis* where an extreme emotional shift in the hero (excitement/pain) transforms the hero into a new subjectivity. The author however qualifies some space-time boundaries to this pre-recovery and in-recovery journey, by saying although taking more moral responsibility for the past was part of her recovery/transformation there are also elements in the hero's chronotopic genre that the hero is not/was not in control of. This

contrasts with JB who was not to blame for her past due to unknown/undiagnosed disorders.

B1: A hiccup after biting off more than he could chew causes chronotopic genre shift

“Things have moved mostly forward since that time, though with the odd hiccup. I am now in a long-term relationship and more in love every day. Worrying about the past and fearing the future has always been my curse, so I try to look at the positives and keep my thoughts in the present.

Recently I changed jobs and perhaps bit off more than I could chew. I became very stressed and depressed thinking that all I had achieved had gone and I was back to square one. My lovely partner and kids were saviours.

I went for help. This time I was not too proud to take advice. I took medication as prescribed and, for the first time, received local counselling. What a difference! I also tried to do positive things when I was off sick and this time recovered very quickly.

My recovery was greatly helped by realising that others (family and friends) can often be a better judge of how I am than I am!”

Analysis:

The pre-recovery hero could move through extended space-time, but this was problematic as they would travel into *past* worry and *future* fears. By contrast

the in-recovery hero lives in a present chronotope of positive thoughts and love where the hero is mostly *moving forwards*. This shows the chronotopic genre shift required for recovery can be from past/future orientation into present-time and not necessarily past-oriented to present/future time. A challenge for authors of recovery narratives is explain to themselves and others periods where the hero returns to some or all of their pre-recovery subjectivity with its problematised habitual excess and insufficiencies. They also need a literary devise to rescue the *'fallen hero'* and return them to the recovery chronotope or risk them living in a genre of *decline and fall* rather than back *in-recovery*. To achieve this B1 uses the metaphor of a "hiccup", as a hiccup is not deliberate but may be caused by something the hero ingests. The intense emotions of stress and depression when he "bit off more than he could chew" resonated and reminded the hero of his pre-recovery subjectivity. Initially he framed (understood) this experience as *losing everything* and *being back at square one*, intertextually temporarily placing the hero into the genre of a board game - *snakes and ladders*. However, he hero is saved from this catastrophic snakes and ladders narrative by his "partner and kids". He subjects himself (is not too proud) to medical advice in the form of medication and counselling. Time alters as he enters the recovery chronotope for a second time (recovered very quickly).

The author explains the hero's hiccup as a sub-plot (story within a story) which is *cathartic*, shifting the hero's self-other relationship in his recovery journey. Now the hero is more willing to subject their outer-inner relationship to the differing (from the hero's) judgements of other character's in their story, such

as family/friends (a better judge of how I am than I am!) or doctor/counsellor (I took medication as prescribed). This contrast to other recovery narratives (CS, CE, S, JB, FG, AM) where increasing agency appeared to be part of the journey. In contrast B1 describes the opposite, of letting others have more influence (outside-in) over his subjectivity (shared responsibility for wellbeing?) and so a *reduction* in excessive agency/autonomy (pride) can also be part of a new chronotpic recovery genre.

Summary:

This analysis has expanded our dialogical understanding of what narratives aid recovery by demonstrating a wide spectrum of subject positions in recovery relationships with authoritative mental health discourses and this has taken us forwards from the conclusions of chapter 5. This moral/medical spectrum in recovery space-time ranged from holding mental health discourses morally responsible for causing emotional distress/trauma and trapping the subjectivity in a pathological *pre-recovery chronotope* (CE) to those that varied in degree of allowing medical discourses (outside-in) in to shape their subjectivity (JB, FG, AM, B). My own data analysis on chapter 5 can now be seen on this wide moral/medical spectrum as a subjectivity that felt trapped/held back (close to CE) by medical discourses shaping subjectivity with a pre-recovery chronotope.

Those recovery narratives that partly accept medical genres were shown to do so in complex and nuanced ways which hybridised with non-medical moral genres. Often the medical drama was contained as a sub-plot (story within a story) within an overarching moral narrative aiming to fulfil socially valued roles (B, JB, FG). Although dialogical differences could be discerned between recovery narratives making use of medical drama genres. For example, JB had a more complex and assertive relationship with the medical drama than B, by resisting some aspects (medication) of mental health discourse's will to order her subjectivity, whilst requesting others (psychotherapy). She then used the language provided by both medical and therapy genres to relieve the hero of past problematic moral issues (guilt and shame). Differing from JB, AM used a medical/moral dialogue to say CBT therapy helped her take more moral responsibility for her part in her misery, an insight increasing her agency to resist repeating painful patterns in her future. Thus narratives that aid recovery do position subjectivity in complex relational dialogue with authoritative medical discourses within a spectrum of often overlapping moral/medical genres.

Those narratives that reject authoritative medical discourses were also found to vary in the subjectivities they allowed to emerge. For example, CS rejects the label of PTSD to allow humour/joy to enter the hero whilst CE takes a stronger position in judging medical discourse as morally responsible for causing her trauma and forcing her to make her own path. However, moral recovery narratives were also found to be relationally shaped by medical ones, for example, although CE creates a moral recovery quest-journey it is

structured around her rejection of psychiatry's will to order her subjectivity. This shows narratives that help recovery at either end of the medical/moral spectrum both need to negotiate a dialogical power relationship with authoritative discourses, either as a sub-plot within a moral narrative or full rejection involving creating authoritative medical discourses as impotent (S) or supernatural characters (CE) to be escaped, or excessive characteristics to be abandoned on the journey (CS). The way journey-narratives help some heroes was demonstrated to be by bringing powerful discourses (outside-in) into a drama where they could be engaged with, in an emotionally charged struggle with the hero's will (inside-out). At both ends of this spectrum experiences appear to be filtered through two genre informed lenses, a moral lens and a medical lens. Experiences diffracted through these lenses create a range of images of subjectivity within recovery space-time where the moral is in a dialogical relationship with the medical, creating subjectivities ranging from the hero escaping a re-traumatising medical trap to being relieved of guilt through validation of a disorder.

This analysis found similarities as well as these differences. Narratives that help recovery all involved the transformation of subjectivity through *chronotpic genre shifts* which transported the hero between distinct space-times which allow different subjectivities to emerge. Subjectivities formed in pre-recovery chronotopes were all described as having moral habitual insufficiencies or excess (guilt, pride, fear, agency, self-esteem, etc.) Consistently the hero is described as having insufficient *personal agency* to escape (is *trapped/imprisoned/cursed/caught* in a chronotope) and/or had *insufficient*

direction (*lost in a fog*). At both ends of the medical/moral spectrum the chronotpic genre shift consistently *frees the hero to move* in in a direction they value and simultaneously addresses the hero's pre-recovery habitual excess and insufficiencies (guilt, pride, shame, fear, self-esteem, personal-agency, etc.) Irrespective of the hero's relationship (inside-out/outside-in) with medical discourses the transportation/transformation of the hero was almost always achieved through a narrative employing *journey genres*. However journey-genres do not hold a monopoly on narratives which help recovery, as B showed in his chewing-hiccup narrative.

My data analysis on chapter 5 showed lack of self-control was a strong theme, however this did not emerge strongly here. This could be explained by the difference in the data set, where chapter 5 was primarily analysing experiences in the pre-recovery chronotpic genre described at that time. Perhaps the perspective of the hero in-recovery is from an author that feels more *in control,* so descriptions of *gaining more agency* might be a retrospective description compared to chapter 5's pre-recovery experiences of insufficient self-control. Also admitting lack of self-control invites moral judgements from the reader response, so the author may want to protect their hero from these.

Narratives that help recovery consistently provided enough dialogical power to the hero to free them from the power the pre-recovery space-time held over their subjectivity, for example GF's finding *meaning and purpose in life* empowered her to leave her pre-recovery chronotope. This resonates with chapter 5's analysis, and chapter 1's discussion of Taylor (1989) where the

desired ‘good life’ or destination emerged as a strong theme which drove the dialogical search for a new narrative. The importance of *authoritative narrators* emerged from chapter 5 as significant figures of trust who embodied particular discourses. This did not emerge as a strong theme in this data, though there were examples such as JB’s relationship with authors sharing similar experiences of ethnicity and gender, or AM’s CBT therapist ‘passionate’ about CBT.

There were descriptions of *significant narrative failure* pre-recovery (S, FG) similar to this theme drawn out from chapter 5. However, JB showed a more nuanced experience of how having only a partial narrative failure can help the hero survive if the responsibilities and benefits of the ‘successful’ parts (e.g. parenthood) can maintain the hero’s journeying. These narratives did show heroes engaging in *a dialogical search for new narrative* (JB) however they appear not to have had as wide a range of ‘tried and failed’ narratives as chapter 5 found. This could be due to the writing position of the in-recovery author, where the range of narratives tried that failed during the years trapped in pre-recovery chronotope may be simplified or forgotten as the author emphasises the most recent narrative that worked to free the hero. The data in chapter 5 included contemporary dairy and clinical notes from the pre-recovery chronotope that may help capture more of the failed narratives. Overall there was support for several themes from chapter 5 in this analysis and additional themes emerged, outlined above, which have taken our dialogical understanding of recovery further than had been reached in chapter 5.

List of recovery narratives and authors analysed from the Scottish Recovery Network:

CS - Cynthia Spillman, "You don't have to suffer to feel good" (2008)

CE - Catherine Eadie, "Emerging from a Cocoon" (2008)

S - Stroma (pseudonym) "Twelve Steps to Recovery" 13/01/2010

JB - Jamila Brown "Coming Home" 13/09/2011

FG - Fiona Gray "There was never a truer saying than life begins at 40" 01/06/2012

AM - Abbey Macleod "There Is No Rehearsal" 08/08/2006

B - Billy "The story of Billy" 15/04/2010

Chapter 7

Conclusion

7.1 *Ethical dialogue in social networks* during very troubled life-journeys

When I reflect on the journey I have been on, working on this study, I recall initially entitling this thesis as being about people experiencing "*very troubled journeys"* through life. This was because I wanted to create some critical dialogical distance from the dominant medical categorisation of *Personality Disorder* in order to allow the thesis to develop in ways that were not overly restricted by current medical/scientific ways of thinking. The people who are the focus of this thesis are usually positioned outside of mainstream society and often experience ineffective contact with traditional statutory services.

During my journey through life, in my years using psychiatric services and later when employed as a manager of Personality Disorder services, I became curious about the very real emotionally charged ethical and moral dilemmas experienced by people during *very troubled journeys* through life. I noticed these emotionally charged ethical dilemmas were experienced both by the people on very troubled journeys and by their relatives, friends and staff in services within their social networks. I noticed the habits that concerned people within someone's social network, including staff, revolved around repetitive excesses and insufficiencies, such as, too much or too little guilt, too much anger, too much alcohol, too little compassion, too little employment, etc.

I became curious about the variation of views between staff and clients about which habits of thought, emotion and/or actions to problematise. I was also curious about variations between staff, clients and family members as to what *level* any habit was problematised and judged excessively or insufficiently practiced because these judgements appeared to be related to the differing social networks, narratives and local ethical frameworks people were embedded within. I also noticed professional staff tended to judge the habitual excesses of their patients but rarely reflected on their own ethical practices, for example, they may comment that part of the problem was the patient 'lacked empathy for others' without also wondering if the workers involved in the patient's care also 'lacked empathy' for the patient themselves.

In 21st century economically developed countries people not *functioning socially* in employment and stable housing, who are positioned outside of mainstream society, tend to be subjected to a professional mental health assessment in order to judge if there is a link between their lack of social functioning and a mental disorder of some kind. However mental health assessment can prove difficult for people with complex combinations of needs around trauma, homelessness and substance misuse, as they are often leading chaotic lives which do not easily fit into a professional middle class appointment/diary systems of service delivery. Also when assessed they often meet the diagnostic threshold for several different overlapping categories of mental disorder, including Personality Disorders.

One of the findings of this thesis is that moral judgements about habitual excess seep into the medical discourse of DSM. Chapter 3 explored the current moral judgements implicit in DSM-5 (2013). Mental health assessments were found to include moral judgements about whether a person has a range of excessive or insufficient habits including guilt, empathy, self-esteem, impulsivity, impatience, unforgiveness and shame. DSM-5 does not acknowledge these are ethical or moral judgements, nor is medical science currently capable to deal with moral dilemmas of this kind. These habits of excess and insufficiency are formed in local moral frameworks within the narratives of people's lived lives. However for any problematic habit, where to judge the line between valued habitual moderation and negatively valued excess or insufficiency will differ dialogically in the relationship between the psychiatric professional and their patient. This is because each will draw on different local moral narrative frameworks to judge the degree to which their habits are problematic, and to whom they are perceived as problematic (the patient, the professional, or others within their social network).

7.2 *Remote contexts of understanding*

Chapter 3 showed the health narrative of DSM-5 (2013) transports several problematic habits into the *remote context of understanding* of medical science in order to diagnose people with a Personality Disorder. This often then leads to offers of medical treatments adopted from physical medicine, such as chemical psycho-pharmacology or psychiatric hospitalisation.

This thesis did find evidence to support the view that people with very troubled journeys through life had more than the average amount of traumatic abuse and neglect in their childhood and less than the average amount of resilience or skilful habits to deal with trauma (e.g. Livesley, 2003). In addition many problematic habits in adulthood were found to be formed in reaction to past traumas (e.g. Livesley and Larstone, 2018). However it should be noted that not everyone who experience childhood abuse and/or neglect goes on to live very troubled journeys outside of mainstream society. The evidence suggests the combination of early trauma combined with lack of skills to deal with trauma were significant factors to consider. Although higher levels of trauma increase the likelihood of accessing mental health services (Livesley, 2003, Allister et al., 2018), this study found that people's experience of being traumatically harmed and neglected was a moral experience rather than a medical one. To feel angry at the social injustice of being harmed or wronged requires a local moral framework with an ethical axis around socially acceptable and unacceptable behaviour. For example feeling guilt or resentment about perceived unfair mistreatment involves believing in a local moral framework where some behaviours (such as physical or sexual violence towards children) are considered morally wrong. Therefore not only are the current problematic habits of people on very troubled journeys *moral* rather than *medical*, but their past experiences of trauma and/or neglect were also experienced ethically within local moral frameworks. Chapters 5 and 6 showed the importance of the range of narratives and genres available to individuals, as this influenced the range of subjectivities allowed to emerge as people tried to make sense of emotional and mental distress.

Thus this thesis has challenged the medical model by putting the narratives of people's troubled journeys into a moral framework. In order to do this I needed a social scientific and moral philosophical standpoint that could deal with moral issues in the real context of the various situations of individuals' everyday lived lives. Thus, ontologically I took a position against positivism alongside the moral philosopher Charles Taylor (1989) and the social psychologist Rom Harré (1993) considering human beings to be both social and moral beings who attribute strong evaluations to their own and other's habits of emotions, thoughts and behaviors. These moral habits are formed when human beings are relating with each other in their pursuit of narratively driven goals. Foucault's (1990) work around *ethics* and his concepts of *telos* and *techniques of the self* was also utilized to justify the legitimacy of analysing moral issues within the human sciences. Epistemologically this study also drew on the work of Bakhtin (1981) taking a dialogical approach to truth claims with an emphasis on narrative understandings. Thus this thesis undertook a dialogical analysis (Sullivan, 2012) which included considering the relationship between narrative discursive practices concerning the moral habits of excess and insufficiency that affect social functioning during someone's life-journey.

Whilst this study has attempted to be explicit about its ontology and epistemology it is worth noting that positivist medical science texts (e.g. DSM-5, 2013) often assume their readers and their authors share implicit ontological assumptions and make no attempt to articulate explicitly those which underpin their research into human beings. This study's analysis of DSM-5 (2013) in chapter 3 went further than the current critiques of DSM-5 in arguing the

pathological personality traits used to diagnose personality disorder are moral habits formed in local moral frameworks within everyday speech genres (Bakhtin, 1981), which have been re-worked into a different medical/scientific professional genre - as symptoms of mental illness/disorder. The analyses of auto-biographical accounts in chapter 6 supported the idea that habits such as guilt, shame and resentments are formed in local moral frameworks and are best understood within believable narratives. Narratives that aid recovery were shown to involve chronotpic genre shifts, often organised around a journey genre.

7.3 The heteroglossia of the historical context:

Chapter 2 explored the historical process through which moral habits became medicalised. Bakhtin's (1986) concept of *heteroglossia* helped in the analysis of the historical process by which moral habits become enveloped within the medicalisation of madness. This study showed that this process was occurring within the wider context of increasing scientific and medical centripetal forces during the 19th century. For Bakhtin the meaning of any text on madness is made in dialogues governed by the contextual conditions within which its meaning is created and operates (historical/social, political, economic, local contexts, etc.). Unique contexts are the primary factor in understanding a text as it cannot hold priority over its context in the meaning making process. Historically changing contexts create the meanings of any text. A unique matrix of forces, including discourses and institutional practices are at play when reading or producing a text. Heteroglossia is this unique cultural mix of meaning-making contexts where *centripetal* centralising forces holding the

traditional social world together are constantly colliding with decentralising currents of *centrifugal* forces for change. From a dialogical historical analysis this study resisted arguing for a singular linear explanation that modern secular medical science of madness (e.g. Prichard, 1835) took over the Christian based ontology of Hancock (1824) or took over the Christian innovative amateur practices of Moral Treatment (Tuke,1813). Instead this study demonstrated in chapter 2 that medical science adopted both Christian ontology and moral treatment practices in a dialogical relationship between Prichard (1835) and Hancock (1824) and Tuke (1813). This dialogical relationship was explored in chapter 2 in the wider epistemological context of Prichard being a pro-modern medical scientist of madness and Hancock writing a non-medical anti-modern treatise.

In addition, the adoption of moral treatment by the medical profession was considered dialogically as it originated at The Retreat, which was originally set up as a practical amateur protest at professional maltreatment of the mad in the York asylum. However, Bakhtin would say these battles, discursive thefts, deaths and rebirths are constantly going on in the heteroglossia of competing narratives as texts collide with each other in the opposing centripetal and centrifugal forces at work. The context of the early 19th century was one of the rise to power over its subjects of modern medicine and science.

However, Bakhtin argues any monological discourse can never finally succeed in silencing all its rival narrative explanations of its subject matter. It is possible to find all kinds of practices and ideas from the archaeological layers of

alternative ways of thinking about madness being absorbed into the *centripetal* forces of medical/science discourses on madness over the previous two centuries. Perhaps these moral habits of excess, such as unforgiveness, which were sucked into the centripetal monological forces of medical science in 1835 and remain in the current DSM-5 (2013), can be understood differently within the polyphony of decentralising discourses, such as post-psychiatry and service user/survivor movements, which are creating centrifugal forces for change within the current heteroglossia. That this study was capable of observing and articulating the medicalisation of moral habits in ways that make sense to the reader is perhaps a sign that at this moment in time the centrifugal forces may be gathering momentum and opening up new discursive spaces. At the same time the monological powers of medical science's centripetal forces may be strengthening in reaction to these challenges to its authority. The historical lens shows us powerful monological discourses symbiotically supporting intuitions do not give up power over its subjects willingly, as evidenced in 1970's with the neo-Kraepelinian movement increasing the power of medics in reaction to challenges, resulting in DSM III (1980). More recent examples discussed in chapter 2 include the APA rejecting its own working party's fairly conservative proposed changes to defining "Personality Disorder" in DSM 5 (2013) (see Livesley, 2012) and NIMH's bio-project which aims to create a new mental health nosology based on biology (Insel, 2013).

After examining the macro-level historical development of "Personality Disorder" in DSM through chapters 2 and 3, this study made use of narrative methodology to examine micro-level narratives in chapters 5 and 6, drawing

on the methods of Sullivan (2012), Mishler (1995) and Reissman (1993). Human beings were considered to be moral agents in search of believable stories within which to orientate themselves to a desired *good life*. In terms of methodology for producing truth claims, the narrative analysis also drew on Bakhtin's (1981) *dialogism* as an epistemology, arguing a dialogical approach to narrative opens up the possibility of listening to how 'the mad' narrate their experience from outside the coordinates of the authoritative monological discursive framework of positivism. From this methodological position, Chapter 5 analysed the three data sources; my psychiatric notes accessed via the data protection act, my diary entries from the 1990's, and a written autobiographical account. In chapter 6 this study analysed seven further autobiographical accounts of mental health recovery in the public sphere using a dialogical narrative analytic approach.

In texts such as DSM-5 (2013) and Hancock (1824) spanning two hundred years, this study has found evidence of people forming a number of habits of emotions, thoughts and/or actions, such as guilt, anxiety, unforgiveness, intoxication and self-harming, which do affect people's ability to function socially. Chapter 5 and 6 found evidence to support the view that these habits are *moral habits* that have been formed in the *local moral orders* of an individual's social network within the narratives of their lived life (Taylor, 1989) and everyday speech genres (Bakhtin, 1981). Evidence was found that human beings have capacity to form emotionally charged moral habits; however, these will be judged differently in different narratives because they are only

morally problematised as *excessive* or *insufficient* within particular believable local moral narratives and frameworks.

Chapters 5 and 6 also found evidence to support the view that moral habits are formed within narratives whilst people are pursuing their desired good life (Taylor, 1989) or telos (Foucault, 1990). Chapter 6 found evidence that people who had experienced significant mental health problems, who wanted to share their experiences of recovery, predominantly re-organised their lived experiences into a narrative with the allegorical structure *of life being like a journey*.

7.4 *Significant narrative failure*

Evidence was also found in this study that some people experience a *significant narrative failure* on their journey through life when over a significant time period they do not achieve *the good life* they desire from the narrative(s) they are orientating their subjectivity within. Because the good life people desire to achieve is highly valued, significant failure to achieve it - in terms of meeting educational, housing, employment or relationship goals - produces strong moral emotions, for example, guilt, shame, envy, resentments and negative self-estimations. Significant narrative failures such as becoming unemployed, failing educationally or habitual misuse of substances also attract negative judgements from others. Evidence to support this view was also found and discussed in chapters 5 and 6.

During a period of *significant narrative failure* this study found people often remain in a failing narrative for several years despite not achieving the narrative's valued goals. Evidence was also found within autobiographical accounts that during a period of significant narrative failure people form further powerful habits such as self-harming or intoxication, often to suppress uncomfortable emotions such as habitual guilt, shame or resentment which are partly formed in reaction earlier trauma, but also reacting to their consistently not achieving the 'good life' they desire.

7.5 *Searching for a believable new narrative to re-orientate within*

However for some people it was found that the strong moral emotions provoked by a persistent *significant narrative failure* created the motivation for them to undertake *a dialogical search, or quest, for a new narrative* within which to re-orientate their life. Chapters 5 and 6 outlined evidence showing that people experiencing a significant narrative failure begin to doubt and disbelieve their current narrative and go through a period of searching for a new believable narrative within which to re-orientate themselves. The narrative analysis of auto-biographical accounts demonstrated that getting better within a new narrative was not an intellectual or purely cognitive process but involved emotional and social contact with others who believed in the new narrative (e.g. mutual aid groups, faith communities, survivor groups, etc.) and the *practice of new habits* which are morally valued both within the new narrative and social network, such as helping others, forgiving unjust hurts, abstaining from drugs, meditation or increasing compassion.

This study also found that a factor within someone's journey was the variety and type of narratives an individual is exposed to during the time they are experiencing a *significant narrative failure*. If people have become socially isolated with little social contact, often they are exposed to very few dialogues containing potentially helpful alternative narratives. However, it is important to note some people experiencing a *significant narrative failure* chose to persevere within their currently believed narratives instead of searching for a new narrative. For example, someone orientating within an educational/employment narrative who desires to become a nurse may fail their final year of studies and thus fail to qualify. Although this may well be experienced as a significant narrative failure, someone, instead of searching for a new narrative to orientate within, may decide to retake their final year of studies and carry on with their desired narrative goal of becoming a nurse. If they succeed their future narrative explanation to others would include how they did not give up on their dream when they failed their finals, but persevered with their desired goal and eventually became a nurse.

7.6 *Getting better:*

For those who do go in search of new narrative understandings for their mental and emotional distress, the range and variety of alternative narratives on offer to them is significant because these are all potential ways to re-orientate their life in order to *get better*. After analysing the autobiographies, *'getting better'* appears to be a more useful concept than 'recovery', as recovery often implies return to some former state of health which for many has simply never existed. Thus the concept of *getting better* allows for entry into previously unexplored

new territory within someone's narrative journey. This study found any new narrative may be a potential way to get better. These new pathways to getting better are formed through dialogical relationships with other people who always hold potential new narrative explanations for life's difficulties. However, as well as potentially helping someone get better, any new narrative may be something that an individual gets *'stuck'* in once again for several years on their journey through life. For example, in chapter 5 and 6 we saw examples where once someone believes they are seriously mentally ill they became 'stuck' for years as a patient within an illness-narrative understanding of their emotional and mental distress. Some people's autobiographical accounts reported that eventually they discovered an alternative to the narrative of being ill which allowed them to move on with their journey through life.

Chapter 6 also found evidence that the predominant response for people experiencing a significant narrative failure in Western countries in the early 21st century was to be directed by friends, family, colleagues and professionals towards mental health services that acted within a health/illness narrative. For example, this study found people experiencing a significant narrative failure were often directed to a professional mental health assessment, which usually led to a diagnosis within a classificatory model and treatments being prescribed (medication, hospitalisation, talking therapies, etc.).

7.7 *The Authoritative Narrator*

Chapter 6 found some evidence that whist people are experiencing a significant narrative failure and are in search of a new narrative they dialogue

with other people, some of whom are in the role of an "*authoritative narrator*". For example, a psychiatrist or other mental health professional is in a relatively powerful position of authorising a medical/scientific narrative understanding of their emotional and mental distress. In the process of a psychiatrist diagnosing a patient they are giving authority to that category as a valid label for this subject, and they communicate this version of reality to their patient and their family. To a large degree, mental health professionals do believe in their professional training and in a medical/scientific categorical lens for looking at people and therefore are embodied as an *authoritative narrator* of one way of assessing and understanding emotional and mental distress. Chapter 6 found that currently, medical science and psychiatry is the predominant narrative people are signposted to when they experience a *significant narrative failure*. However the analysis of the autobiographies raises real doubts about psychiatry's usefulness because it takes moral problems around people's habitual excess and reframes them as medical issues in need of professional medical treatment. However this analysis of narratives that aid recovery showed a wide spectrum of subject positions in recovery relationships with authoritative mental health discourses. This moral/medical spectrum in recovery space-time ranged from holding mental health discourses morally responsible for causing emotional distress/trauma and trapping the subjectivity in a pathological *pre-recovery chronotope* to those that varied in degree of allowing medical discourses in to shape their subjectivity. My own data analysis on chapter 5 could then be seen on this wide moral/medical spectrum as a subjectivity that felt trapped/held back by medical discourses shaping subjectivity with a pre-recovery chronotope.

Human beings constantly want to make sense of their everyday experiences and a significant way in which people do this is by telling each other moral narratives about themselves and other people who appear in their day to day journey through life (Taylor, 1989). Chapters 5 and 6 did find people attributing strong positive and negative ethical evaluations to their own and other people's habitual ways of thinking, feeling emotions and/or acting in pursuit of life-goals.

7.8 Weakening centripetal forces?

This study found some evidence in the autobiographical accounts in chapter 6 that medical science's centripetal forces may be weakening (but also strengthening) as alternative centrifugal forces within the heteroglossia may be increasing at the start of the 21st century. This would begin to open up new discursive spaces to think about mental and emotional distress. For example, post-psychiatry represents one attempt to open up new spaces for a polyphony of understandings of madness to be valued and given a voice, particularly the voices of service users and 'experts by experience' who have had, or are having, very troubled journeys through life.

The findings of this study suggest there is a case for considering a new approach, or the creation of a new genre, for ways of trying to help people experiencing significant narrative failures who have difficulties with moral habitual excess and insufficiency. It would be useful for paid staff to include reflecting on themselves in any ethical dialogical approach which is trying to help people co-produce better journeys through life because they too have

habits of excess and insufficiency (combined with their habitual skills) due to staff being human beings also.

7.9 *Journeying Ethical Dialogue:*

Part of my personal motivation for undertaking this study was a curiosity I had in experiencing resentment and unforgiveness at being sexually abused as a child, and this habit being taken as a symptom by a psychiatrist as part of their reasons for diagnosing me as having “Personality Disorder” during the 1990’s. When I heard this I began to have doubts about the usefulness of medical diagnosis and treatments in helping me *get better* because I had received seven different diagnoses from seven different psychiatrists during seven separate inpatient admissions to the psychiatric hospital. I was curious about how one profession could be so divided and *‘split’* to come to seven different conclusions about the same individual. As I found ways to get better, my biographical trajectory of coordinates in time and social space changed. I gained employment as a mental health housing support worker and eventually became a manager of Personality Disorder services, before becoming a senior care co-ordinator in an Early Intervention in Psychosis (EIP) service, and then Work Force Development Lead/System Broker at a non-profit programme in the North East of England, Fulfilling Lives, working with people with multiple and complex needs combining mental health, substance misuse, homelessness and criminal justice issues, who other services find difficult to engage.

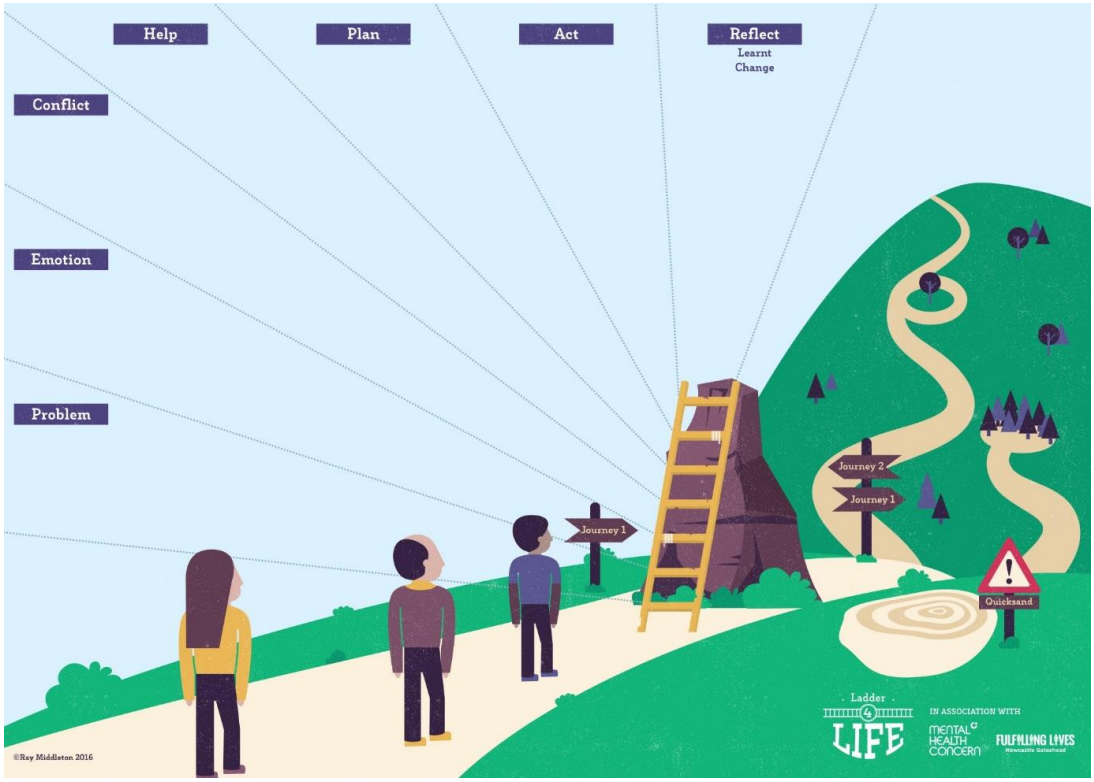
Whilst my journey was *getting better,* including getting married and raising children, these employment experiences exposed me to many different ways of thinking about people with very troubled journeys through life, both from people with lived experience and a variety of interesting professional approaches and attitudes. The group of people who are experiencing complex needs on very troubled journeys do not fit easily into current statutory mental health provision and continue to have very poor outcomes circulating around homeless hostels, hospitals, prisons and addiction services. Contact with traditionally offered services often has little positive effect on the narrative of their biographical trajectory through time and social space.

My frustration with traditionally offered services and their poor outcomes for this group of people motivated me to start this study. This has led me to conclude that a dialogical, ethical epistemological approach may be useful where all people in a dialogue reflect on their own moral habits, both positively valued ones and those ascribed negative ethical value. This would go some way towards addressing the power imbalance of a professional judging a patient's excessive habits without disclosing their own relative habitual excesses and insufficiencies. Any assessment by one human being of another human being's habits has a dialogical relationship influenced by the assessor's practice of that habit. This is because the process of assessment involves a unique meeting of two unfinalised personalities, who to some extent hold differing ethical ideas around habitual excess and insufficiency. In addition to the dialogue between two individuals there is also a polyphony of different genres and voiced narratives in dialogue within each individual about how any

habit may be judged ethically, and at what level to judge habits having reached problematic excess/insufficiency. Thus problematic habits could be explored dialogically within the *relatively remote contexts of understanding* amongst someone's social network, including staff in services, friends and family members. As each person in a dialogue is potentially a *remote context of understanding* for someone else within the social network any group reflection could create a micro heteroglossia of narratives which would be resonating with the wider social heteroglossia at that time.

There may be value in engaging someone's social networks in reflective dialogue about issues this study has found to be important, such as: significant narrative failure, moral habits (both as positively valued skills or ethically problematic excess and insufficiency), the desired 'good life' someone want to live, and the range of possible alternative narratives they could re-orientate themselves within. This could include sharing the dialogical view that medical science is historically and socially contingent. An ethical dialogical approach would involve contextualising medical science as one of several narratives within which emotional and mental distress could be understood.

In my current role I have applied some of the findings from this study by writing a social/psychological framework called Ladder4Life (Middleton, 2016) which visualises someone on a journey:



The ‘top of the hill’ in this picture visually represents the “good life” someone desires, or any way in which they would like their life to get better in future. The ‘dead end’ with a blue forest visually represents any narrative understanding within which someone feels they have become side-tracked, lost or experienced a *significant narrative failure* in achieving their desired good life. The ‘quick sand’ visually represents any habits of excess or insufficiency someone considers they express which habitually get them ‘stuck’ on their life journey, such as self-harming, guilt and shame, substance misuse, etc. Journey 1 and 2 could represent different narratives being considered for journeying along. Within my current work role I have opened up an ethical dialogue with people who are experiencing a very troubled journey and with their social network by listening to how they would organise their experience

into this new narrative genre of a journey with quicksand, dead-ends, rocks blocking their journey and ‘a ladder’.

The ‘rock’ on their path visually represents any problem they think is blocking their way to achieving the better life they desire at the top of the hill. The ‘ladder’ represents the habitual skills people practice to overcome their perceived problems. The first ‘rung’ of the ladder represents how they describe a problem, the second rung represents the habitual emotions they feel on life’s journey, the next rung represents the habitual ways they deal with conflict of wills with other people on their journey. The next rung represents habits around *co-operating* and asking for help with problems, while the next rung represents habitual skills around *planning*. The next rung represents any actions people have taken to put their plans in to action and the final rung of the ladder visually represents reflecting on the whole journey within this new narrative genre and consideration of what they have learnt or what they may change in their approach to life.

I have used this Ladder4Life social/psychological framework to develop dialogically informed version of Psychologically Informed Environments (P.I.E.) (see Johnson, 2018) which develop reflective practice amongst staff within frontline services engaging with clients with complex needs. This has included a day centre for people who are homeless and mental health residential rehab services in Gateshead, England. The effect of developing these ethical dialogical approaches has been researched and a positive evaluation published which found staff improved relationships with clients and

became more reflective of their own practice through this approach (Boobis, 2016).

7.10 Co-production:

In my current employment role I have also recorded *ethical dialogue* interviews with people with complex needs experiencing very troubled journeys on this Ladder4Life framework and co-produced films with them (e.g. Middleton, 2017 a), making these films publically available on You Tube. I have also valued opening up a dialogue in group discussions with experts by experience with complex needs, on the Ladder4Life topics, and coproduced a series of five films with them (e.g. Middleton, 2016). I have made the films publically available on You Tube in order to amplify their 'voice' and use them in work force multi-agency training on reflective practice.

In addition I have developed and co-delivered with experts by experience training based in part on findings from this study to staff from multiple services such as probation, substance misuse, homeless services and statutory mental health services. The effect this ethical dialogue training has had on these staff is currently being evaluated. This involves co-delivering training with experts by experience where we introduce dialogical ideas and then show the multi-agency staff receiving the training (probation, mental health professionals, homeless staff, addiction workers, etc.) coproduced films around the Ladder4Life framework. We then open up a dialogue to discover the different ways professionals interpret what they hear experts by experience saying in the films and help staff reflect and appreciate alternative ways of interpreting

and responding to the lived experience shared in the films by people on very troubled journeys through life.

An illustration of how this approach works can be seen from my work as a system broker at Fulfilling Lives, where I opened up a dialogue on the Ladder4Life framework with one of our male clients and their key worker (called a 'navigator'). The client was able to reflect on his life-goal of running a burger van and for his Mum to become 'proud' of him. He had been trying to achieve this goal for several years without success and so this could be seen as a *significant narrative failure*. Through dialogue he identified the thought that part of the reason for this was he was in the habit of being "easily led" by others. He reflected that his tendency to do what others suggested led him to take drugs, which had also led to overdoses and to him committing crimes for which had been imprisoned. He recalled his mother had said he was in the habit of being "easily led" as a teenager and she thought it led him into getting into trouble. He was unsure exactly what being too easily led meant, so I offered my understanding of its meaning and on reflection he said he thought that was a problem habit for him. I then invited his key worker into the dialogue to share his thoughts, and his key worker shared how he had noticed his client would often be easily influenced by others to take drugs which had led to overdoses and the need to be resuscitated. He recalled he had helped his client move from a large homeless hostel to a smaller one and this change in social context appeared to have helped his client, as there were less people asking him to spend money on drugs. This is an example, in a small way, of opening up a dialogue *about a habit of being too submissive* in *interpersonal*

relationships and how this contributes to a significant narrative failure. The ethical dialogue involved his present social network (e.g. his key worker's shared opinion) and his memories of the local moral framework he grew up within (e.g. his mother's negative evaluation of his habit of being too easily led). He gave permission for the *ethical dialogue* about his life journey to be recorded and made publically available in a Film (Middleton, 2017 b) to help in our training programme to develop multi-agency staff understanding and skills.

This was an attempt to create of a safe but ethical dialogical space for someone to consider their narrative goals and reflect on any habits that may be making it difficult to achieve them. Each view on the problematic habit was held dialogically within the social network as having a history, a social context and possible futures. He reflected he could see one possible future where he may be able to resist being easily led by others. Each participant accepted they only partly knew about a habit within a narrative, but were able take responsibility within the social network for sharing their potential narrative understandings of; the desirable 'good life' (running a burger van), problematic habits and valued skilful habits (e.g. resisting unhelpful suggestions from others). Attempts were made for everyone to have their unique contribution valued within the safe dialogical space. The principle of always only *partly knowing* is based on Bakhtin's epistemology where the truth is constantly being created between unfinalised personalities in dialogue so any one individual can only every partly know the truth.

Applying Bakhtin's ideas to help people with mental health difficulties from a social network perspective has successfully been developed in Western Lapland since the 1980's through the "open dialogue" approach for those with the experience of psychosis, who often attract a diagnosis of "Schizophrenia" (Siekkula, 2006, 2011). In contrast to making sense of 'psychotic' experiences (Siekkula, 2006) I am suggesting, based on this study, that there may be value in applying an *ethical dialogue* approach with people experiencing very troubled journeys through life in their social networks. This would attempt to productively reflect, within the relatively remote contexts of understanding provided by someone's social network, on both the problematic habits and habitual skills expressed in the pursuit of narratively driven goals. Each participant in such an *ethical dialogue*, with others on an apparent *significant narrative failure*, would need to open themselves to being transformed through each contextually unique dialogical exchange. All participants as unfinalised personalities would be considered to have both skilful habits and problematic habits whose ethical evaluation can change within different narrative understandings and local moral frameworks.

It is my belief based on these findings that radical new approaches do need to be tried and new ways of journeying alongside people through very troubled periods in their life-journey. An ethical dialogical approach may co-produce *better journeys* for those who are very troubled by facilitating dialogue between experts by experience, family, friends and professionals within someone's social network. By ethically, dialogically journeying with people it may be possible to co-create new paths allowing someone's biographical trajectory to

travel into new, previously unexplored social spaces. It is my hope that this study can be in some small way a contribution to the growing sets of innovative ideas around what may be helpful. Ethical dialogical approaches and the co-production of innovative *getting better* journeys may provide a more fruitful approach than modern medical health narratives. The centripetal forces may be weakening enough to accept that modern medical genres have not helped this group of people get better, nor transported (‘healed’? or ‘cured’?) them in any significant numbers into better life journeys. *New work requires new genres.*

7.11 <u>How the findings of this study may be used by others:</u>

The ethical dialogical approach developed through this study could be applied in several different ways. People with lived experience may want to explore dialogically the different ways habits of thought, emotion and actions are morally problematised within narratives within different social networks during people’s journeys. The key concepts could be researched further to see how they resonate with a wider audience and explore if they are helpful in practice for people on very troubled journeys. This could include concepts developed throughout this study such as “*significant narrative failure”*, “*dialogical search for a new narrative*”, the dialogical ethics of “*habitual excess and insufficiency*” and the role of “*authoritative narrators”*. The idea of opening up ethical dialogue around habits in polyphony of narratives within social networks could be further explored. Often people on very troubled journeys become socially isolated, so ways of creating supportive social networks with which to dialogue could be explored. Co-facilitating ethical dialogues around journeying and habitual

excess and insufficiency in social networks could involve experts by experience and other staff in a joint endeavour to co-create better journeys alongside people. New narratives could be introduced and reflected upon that may enable a chronotopic genre shift into a new journey around ‘getting better/recovery’.

My reflections on the findings of this study have led me to believe an *ethical dialogical approach* to people’s life-journeys within the relatively remote contexts of understanding of their social networks could be beneficial for people experiencing significant narrative failure. Such an approach could help co-produce better journeys for people by reflecting on skilful habits and habitual excess and insufficiency as people pursue narrative goals. The dialogical principle of *only ever partly knowing* what is going on, drawn from Bakhtin’s epistemology, would hopefully provide some protection against any one perspective imposing a powerful monological narrative understanding on someone’s very troubled journey through life.

It is possible to have helpful conversations with people struggling with their life-journey without necessitating them to medicalise their moral habits into the narrative of being sick and disordered. I believe the ethical dialogue in social networks approach developed through this study allows our moral habits to be reflected on alongside people experiencing significant narrative failures. Such an approach is hopeful because it allows a quest for new narratives to be continually opened up until someone re-orientates their subjectivity within a narrative that actually helps them get better and live the ‘good life’ they desire.

7.12 The originality and limitations of this thesis

This thesis has gone into greater detail than previous authors in tracing the *moral* origins of personality disorder, through DSM, the military's Medical 203, psychopathic personalities and Moral Insanity. It has also demonstrated disorder in the Moral Faculty is a concept underlying Moral Insanity that has been transported into modern medical discourse from its origins in non-medical moral Christian discourse deployed in anti-modern texts. It has also explored the moral social context influencing current DSM 5 diagnosis of Personality Disorder.

The fine grained dialogical narrative analysis of clinical notes, diary entries and an autobiographic account has highlighted a significant difference between literary/moral and literal/medical understandings of severe mental and emotional distress during someone's life-journey. The dialogical narrative analysis of accounts of successful recovery demonstrated how different subjectivities are enabled to emerge as they negotiate their position within genre informed overlapping spectrums of moral and medical discourses. Whilst other studies have identified journey genres as important in recovery, this study has gone into detail to show a variety of ways in which *chronotopic genre shifts* are significant in transporting/transforming subjectivity.

However, this thesis has been limited in only analysing one individual's psychiatric notes (as commentaries on subjectivity) and only analysing excerpts from seven recovery narratives, although this limitation did allow the

analysis to go into some depth. Other limitations were that analysing publically available accounts of recovery excluded material that may have disclosed more personal information, for example, if I had undertaken anonymised interviews the participants may have disclosed different experiences than they would in accounts intended to be read by the public. Thus any conclusions drawn from this thesis would need to hold these limitations in mind, including that accounts from people currently experiencing emotional and mental distress (pre-recovery) were not sought or analysed.

References

Adler, J.M., Chin, E.D., Aiswarya P. Kolisetty, and Oltmanns, T. F. (2012) The Distinguishing Characteristics of Narrative Identity in Adults with Features of Borderline Personality Disorder: An Empirical Investigation. *Journal of Personality Disorders* **26** (4) (498-512)

Adler J., Olin, F., Turner A., Brookshier, K, Monahan C., Walder-Biesanz I., Harmeling L., Albaugh M., McAdams D., Oltmanns T. (2015) Variation in Narrative Identity is Associated with Trajectories of Mental Health Over Several Years. *Journal of Personality and Social Psychology* **108** (3) (476-496)

Allister et al., (2018) *The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder.* The British Psychological Society, MIND, Anna Freud, Royal College of Nursing, The British Association of Social Workers, Barnett, Enfield and Haringey NHS Mental Health Trust and the Royal College of General Practitioners

American Psychiatric Association (2017) [website] http://www.psychiatry.org/about-apa--psychiatry/mission-vision-and-values, accessed August 14th 2014.

Andrews, M., Squire, C. and Tamboukou, M. (2008) *Doing Narrative Research.* London: Sage

Atkinson, P. (1997) Narrative Turn or Blind Alley? *Qualitative Health Research*, 7(3), 325-344

Augstein, H.F. (1996) J C Prichard's concept of moral insanity – a medical theory of the corruption of human nature. *Medical History* **40**(3), 311-343.

Bakhtin, M.M., (1981) *The Dialogic Imagination: four essays.* Translation by Emerson C. and Holquist M. (editor) Austin, TX: The University of Texas Press

Bakhtin M.M. (1984 [1929]) *Problems of Dostoyevsky's poetics.* Translation by Emerson C. (editor) University of Minnesota Press

Bakhtin, M.M. (1986) *Speech Genres and Other Late Essays.* Translation by McGee, V.W. (ed.), C. Emerson C. and Holquist M., Austin, TX: University of Texas Press.

Bakhtin, M.M. (1990) *Art and Answerability: Early Philosophical Essays by M.M. Bakhtin.* Translation by V. Liapunov, ed. M. Holquist and V. Liapunov. Austin, TX: University of Texas Press.

Bakhtin, M.M. (1993) *Toward a Philosophy of the Act.* Translation by V. Liapunov (ed.) M. Holquist and V. Liapunov. Austin, TX: University of Texas Press.

Barthes, R. (1973) *Mythologies.* Translation by Lavers, A. (editor) London: Paladin

Bernstein D.P., Iscan C. and Maser F. (2007) Opinions of personality disorder experts regarding the DSM-IV personality disorders classification system. *Journal of Personality Disorders* **21** (536–551)

Berrios, G.E. (1993) European views on personality disorders: A conceptual history. *Comprehensive Psychiatry* **34** (14–30)

Billig, M. (1996) *Arguing and Thinking: A rhetorical approach to social psychology.* Second edition, Cambridge: Cambridge University Press

Black DW, Pfohl B, Blum N, McCormick B, Allen J, North CS, et al. (2011) Attitudes toward borderline personality disorder: a survey of 706 mental health clinicians. *CNS Spectrums* **16** (67–74)

Blackman, L. (2001) *Hearing Voices: Embodiment and Experience.* Free Association Books

Bodner, E, Cohen-Fridel, S., Mashiah, M., Segal, Grinshpoon, A., Fischel, T. Iancu, (2015) The attitudes of psychiatric hospital staff toward hospitalization and treatment of patients with borderline personality disorder. *BMC Psychiatry* **15** (2)

Bolton, D. (2008) *What is mental disorder?* Oxford, UK: Oxford University Press

Boobis, S. (2016) *Evaluation of a Dialogical Psychologically Informed Environment (PIE) Pilot.* New York: Loving Healing Press Inc.

Bourke, M. & Grenyer, B. (2010) Psychotherapists' response to borderline personality disorder: A core conflictual relationship theme analysis. *Psychotherapy Research* **20** (6) (680-691)

Bowers, L. (2003) Manipulation: description, identification and ambiguity. *Journal of Psychiatric and Mental Health Nursing* **10**(3) (323-328)

Bracken P. and Thomas, P. (2005) *Postpsychiatry: mental health in a postmodern world.* Oxford University Press

Brown, J. (13/09/2011) “Coming Home”, online autobiographic narrative account of *recovery* available in the public sphere hosted on www.scottishrecovery.net accessed 3rd – 10th August 2018

Brunner, J. (1986) *Actual Minds, Possible Worlds.* Harvard University Press.

Burkenkotter, C. (2001) Genre Systems at Work: DSM-IV and rhetorical recontextualisation in Psychotherapy Paperwork. *Written Communication* **18** (3) (326-349)

Burrows, G. M. (1828) *Commentaries on the causes, forms, symptoms, and*

treatment, moral and medical, of Insanity. London: Thomas and George Underwood

Charland, L.C. (2006) The moral character of the DSM IV cluster B personality disorders. *Journal of Personality Disorders* **20** (2) (116–125)

Churchill, W. (1945) "*History is written by the victors*" [quote attributed to Winston Churchill]

Clifford, J. S., Norcross, J. C., & Sommer, R. (1999). Autobiographies of mental health clients: Psychologists' uses and recommendations. *Professional Psychology: Research and Practice,* **30** (1) (56-59)

Cohen S. and Scull A. (editors) (1983) *Social Control and the State.* Palgrave Macmillan

Coifman, K.G., Berenson, K.R., & Downet, G. (2012) From negative to positive and back again: Polarized affective and relational experiences in borderline personality disorder. *Journal of Abnormal Psychology* **121**(3) 668-679

Collier, Andrew (1977) *R.D. Laing: The philosophy and politics of psychotherapy.* Hassocks: Harvester Press

Coolidge, F.L. & Segal, D. L. (1998) Evolution of personality disorder diagnosis in the Diagnostic and statistical manual of mental disorders. *Clinical Psychology Review* **18** (5) (585-599)

Copernicus, N., Hawking, S. (editor) (2004) *On the revolutions of the heavenly spheres.* Running Press

Cosgrove L. and Wheeler, E. E. (2013) Industry's colonisation of psychiatry: Ethical and practical implications of financial conflicts of interest in the DSM-5. *Feminism & Psychology* 23(1) 93-106

Cox, T.M. et al., (2003) King George III and porphyria: an elemental hypothesis and investigation. *The Lancet*, 366 (9482) 332 – 335

Crowe, M. (2000) Constructing normality: a discourse analysis of the DSM-IV. *Journal of Psychiatric and Mental Health Nursing* **7** (69–77)

Davies, B. and R. Harre (1990) Positioning: The Discursive Production of Selves. *Journal for the Theory of Social Behaviour* **20** (1) (43-63)

Denzin, E.A. (1998). The anonymous programme and ego functioning. *International Journal of Social Sciences* 1(7) 134- 145

Digby, A. (1985) *Madness, Morality and Medicine*. Cambridge University Press

Docherty, T. (1993) *Postmodernism: a reader.* Harvester Wheatsheaf

Drake, R, and Whitley, R (2014) Recovery and Severe Mental Illness: Description and Analysis. *The Canadian Journal of Psychiatry* **59**(5) (236–242)

DSM I (1952) *Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Association

DSM II (1968) *Diagnostic and statistical manual of mental disorders* (2nd ed.) Washington, DC: American Psychiatric Association

DSM III (1980) *Diagnostic and statistical manual of mental disorders* (3rd ed.) Washington, DC: American Psychiatric Association

DSM III-R (1987) *Diagnostic and statistical manual of mental disorders* (3rd ed., revised). Washington, DC: American Psychiatric Association

DSM IV (1994) *Diagnostic and statistical manual of mental disorders* (4th ed.) Washington, DC: American Psychiatric Association

DSM IV-TR (2000) *Diagnostic and statistical manual of mental disorders* (4th ed., revised). Washington, DC: American Psychiatric Association

DSM 5 (2013) *Diagnostic and statistical manual of mental disorders* (5th ed.) Arlington VA: American Psychiatric Association

Eadie, C. (2008) "Emerging from a Cocoon", online autobiographic narrative account of *recovery* available in the public sphere hosted on www.scottishrecovery.net accessed 3rd – 10th August 2018

Eaton, N.R., Krueger, R.F., South, S.C., Simms, L.J., Clark, L.A. (2011) Contrasting prototypes and dimension in the classification of personality pathology: Evidence that dimensions, but not prototypes, are robust. *Psychological Medicine* 41, 1151–1163.

Emergence (2018) website: https://www.emergenceplus.org.uk/services/ Accessed 1st February 2017

Feuchterslaben, E. (Baron) (1845) *The Principles of Medical Psychology.* Translation by Lloyd Evans, The Sydenham Society: Adlard Printers

Fonagy, P., Gergely, G., Jurist, E. & Target, M. (2002/2018) *Affect Regulation, Metalization, and the Development of the Self.* New York: Routledge

Foucault, M. (1979) *Discipline and Punish: The Birth of the Prison.* London, New York: Penguin Books

Foucault, M. (1988) *The History of Sexuality Volume 3: The care of the self.* Knopf Doubleday Publishing Group

Foucault, M., translated by Hurley, R., (1990) *The History of Sexuality Volume 2: The Use of Pleasure.* New York: Random House

Foucault, M. (2001) *Madness and Civilisation: A History of Insanity in the Age of Reason.* London, New York: Routledge Classics

Foucault M (2006) *History of Madness*. Translated by Murphy J. and Khalfa J. (editor), London and New York: Routledge

Foucault, M. (2012) *The History of Sexuality: An introduction* Knopf Doubleday Publishing Group

Foucault M. (2005) *The Order of Things* Routledge

Frances, A. (2013 a) *Saving Normal: an insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma, and the medicalization of ordinary life*, New York: William Morrow

Frances, A. (2013 b) *Essentials of psychiatric diagnosis: Responding to the challenge of DSM-5.* New York: Guilford.

Frank, A.W. (1991) *At the Will of the Body: reflections on illness* New York: Mariner Books

Frank, A.W. (1995) *The Wounded Storyteller: Body, illness and Ethics* Chicago: University of Chicago Press

Frank, A.W. (2006) What is Dialogical Research and Why Should We Do It? *Qualitative Health Research* 15(7) 964-74

Gadamer, H.G. (1975) *Truth and Method.* Second edition. New York: Continuum

Gee, J.P. (1999) *An introduction to discourse analysis: theory and method*. Routledge

Gergen, K.J. (2009) *An invitation to Social Construction.* Sage

Gilbert, K.R. (2001) *The Emotional Nature of Qualitative Research.* Florida: CRC Press

Goffman, E. (1990) *The Presentation of Self in Everyday Life.* London. Penguin

Good, P. (2001) *Language for those who have nothing: Mikhail Bakhtin and the Landscape of Psychiatry.* New York, Boston, Dordrecht, London, Moscow: Kluwer Academic Publishers

Gray, F (01/06/2012) “There was never a truer saying than life begins at 40”, online autobiographic narrative account of *recovery* available in the public sphere hosted on www.scottishrecovery.net accessed 3rd – 10th August 2018

Guilfoyle, M (2013) Client subversions of DSM knowledge. *Feminism and Psychology* 23 (1) 86-92

Guyer, P. (2006) *Kant.* Routledge

Hammack, P. L. (2008). Narrative and the cultural psychology of identity. *Personality and Social Psychology Review* **12** (222–247).

Hancock, T. (1824) *Essay on Instinct and its relation to the moral faculty.* London: William Philips

Harré R. (1993) *Social Being.* Oxford: Blackwell

Hodge, L. and Bryant, L. (2017) Masking the self: Understanding the link between eating disorders and child sexual abuse. *Qualitative Social Work: Research and Practice* (06/2017)

Holler, C. & Klepper, M (eds) (2013) *Rethinking Narrative Identity: Persona and Perspective.* Amsterdam: John Benjamins Company

Heidegger, M. (1927/1962) *Being and Time.* Translated by Macquarrie, J. and Robertson, E., Oxford: Blackwell

Holm, A. L. and Severinsson, E. (2011) Struggling to recover by changing suicidal behaviour: Narratives from women with borderline personality disorder. *International Journal of Mental Health Nursing* **20** (3) (165-173)

Holquist, M. (2003) *Dialogism: Bakhtin and his World.* Second Edition. London: Routledge

Horne, G. (2014) Is Borderline Personality Disorder a Moral or Clinical Condition? Assessing Charland's Argument from Treatment. *Neuroethics* **7** (2) (215-226)

Hornstein, G. (2013) Whose account matters? A challenge to feminist psychologists. *Feminism & Psychology* 23 (1)

Husserl, E. (1970) *The Crisis of European Sciences and Transcendental Phenomenology: An introduction to phenomenological philosophy.* Northwestern University Press

Insel, T. (2013), *Directors blog: Transforming diagnosis. April 29th 2013.* National Institute of Mental Health (NIMH), Retrieved from www.nimh.nih.gov/ about/ director/ 2013/ transforming-diagnosis.shtml. Accessed April 2016

Jaspers, K. (1963/1923). *General Psychopathology.* Translation by Hoenig J. & M. W. Hamilton, M.W., Baltimore: Johns Hopkins University Press

Johnson, R. (2018) www.pielink.net accessed 10/06/2018

Kellert, S.H., Longino, H.E., & Waters, C.K. (Eds.). (2006). *Scientific Pluralism*. Minneapolis: University of Minnesota Press

King, M. & May, J. (2018) Moral Responsibility and Mental Illness: a Call for Nuance. *Neuroethics* **11** (1) (11-22)

Kirmayer, L. and Valaskakis, G.G. (editor) (2009) *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada.* UBC Press

Kuhn, T. S. (1962) *The structure of scientific revolutions.* Chicago: The University of Chicago Press

Kutchins, H. and Kirk, S. A. (1997) *Making us crazy: DSM: the psychiatric bible and the creation of mental disorders.* New York: Simon and Schuster, Free Press

Lash, S (2003) Reflexivity as non-linearity theory. *Culture and Society* **20** (2) (49–57)

Linehan, M. (1993) *Cognitive behavioural treatment of borderline personality disorder*. New York: Guilford Press.

Livesley, J. (2003) *Practical Management of Personality Disorder.* The Guilford Press

Livesley, J. (2012) Tradition versus empiricism in the current DSM-5 proposal for revising the classification of personality disorders. *Criminal Behaviour and Mental Health* 22 (2) 81-90

Livesley, W. J., & Clarkin, J. F. (2015) *Diagnosis and assessment* (51–79). In Livesley W. J., Dimaggio, G. & Clarkin J. F. (Eds.) (2015) *Integrated treatment for personality disorder: A modular approach* New York: Guilford Press

Livesley J. and Larstone, R. (2018) *Handbook of Personality Disorders.* 2nd edition, London: The Guilford Press

Locke J. (1836) *Treatise concerning Human Understanding.* 27th edition. London: Balne Gracechurch

Loue, S. and Pike, E. (2007) *Case studies in ethics and HIV research.* Springer

MacIntyre, A. (1981) *After Virtue.* Bloomsbury Academic and University of Notre Dame Press

Macleod, A. (08/08/2006) “There Is No Rehearsal”, online autobiographic narrative account of *recovery* available in the public sphere hosted on www.scottishrecovery.net accessed 3rd – 10th August 2018

McGrath, L. and Reavey, P. (2015) Seeking fluid possibility and solid ground: Space and movement in mental health service users' experiences of ‘crisis’. *Social Science & Medicine* **128** (115-125)

Manning, P. K. (1987) *Semiotics and fieldwork: Qualitative Research Methods Volume seven.* London: Sage

Matravers M (2011) Classification, morality and the DSM. *Personality and Mental Health* **5** (2) (152–158)

Medical 203 (1946/2000) War Department Technical Bulletin: Nomenclature of Psychiatric Disorders and Reactions. *Journal of Clinical Psychology* **56** (925–934)

Micale, M. and Porter, R. (editors) (1994) *Discovering the History of Psychiatry.* New York and Oxford: O.U.P.

Middleton, R. (2016) Ladder4Life [graphic] *Narrative social-psychological framework* Newcastle, England: JUMP

Middleton R. (2017 a) *Learning from Georgia’s journey through homelessness, mental health & addiction* [video] https://youtu.be/J6MHidZCAmI accessed 01/04/2017

Middleton, R. (2017 b) Learning from James’s Journey through homelessness, mental health, addiction and prison [video] https://youtu.be/Ac60S0OS8XY accessed 01/04/2017

Middleton, R. (2016) *Discussion with experts by experience with complex needs: Why is asking for Help hard?* [Video] https://youtu.be/XTDAbF6qLac accessed 01/04/2017

Mishler, E. G. (1995) Models of Narrative Analysis, *Journal of Narrative and Life History.* 5(2) 87-123.

Morris C, Simpson J, Sampson M, and Beesley F. (2015) Emotion and Self-Cutting: Narratives of Service Users Referred to a Personality Disorder Service. *Clinical Psychology and Psychotherapy* **22** (2) (125-132)

Morson, G. S. and Emmerson, C. (1990) *Mikhail Bakhtin, Creation of a Prosaics* California: Stanford University Press

National Institute for Mental Health England (NIMH(E)) (2003) *Personality Disorder: No Longer a Diagnosis of Exclusion: Policy Implementation Guidance for the development of services for people with personality disorder* http://personalitydisorder.org.uk/wp-content/uploads/2015/04/PD-No-longer-a-diagnosis-of-exclusion.pdf NIMH(E)

National Institute for Health and Clinical Excellence (NICE) (January, 2009) *Guideline 78: Borderline personality disorder: treatment and management* England: National Institute for Health and Clinical Excellence

Nebelkopf, E., Phillips, M. (2004) *Healing and mental health for Native Americans: speaking in red.* Altamira Press

Newton, I., translation by Motte B., (1729) *The Mathematical Principles of Natural Philosophy: Volume 1* Oxford University Press

Peters, M., & Appel, S. (1996). POSITIONING THEORY: Discourse, the Subject and the Problem of Desire. *Social Analysis: The International Journal of Social and Cultural Practice* **40** (120-141)

Pelmann, C. (1893): Recent attacks on alienists and asylums. Allg. Z. Psychiatry **49** (693) [Referenced in Schneider, 1923/1950]

Pickersgill, D. M. (2014) *Journal of Medical Ethics* 40 521-525

Plummer, K. (2001) *Documents of Life 2: An invitation to a critical humanism.* London: Sage Publications

Polkinghorne, D. E. (1995) *Narrative Configuration in Qualitative Analysis*, in Hatch, J. A. and Wiseniewski, R. (editors) *Life History and Narrative.* (1995) The Falmer Press (p. 5-24)

Porter, A. H. (2008) *The Cambridge introduction to narrative.* Cambridge University Press

Porter, R. (2002) *Madness: A Brief History.* Oxford University Press

Potter, N. (2011) Mad, bad, or virtuous? The moral, cultural, and pathologizing features of defiance *Theory & Psychology* **22**(1) (23–45)

Prichard. J.C. (1835) *A treatise on Insanity and other disorders affecting the mind.* London: Sherwood, Gilbert and Piper

Reik, T. (1932/1959) *The Compulsion to Confess: On the Psychoanalysis of Crime and Punishment* New York: Farrar, Straus and Cudahy

Reissman, C.K. (1993) *Narrative Analysis.* London: Sage Publications

Roth M. and Kroll J. (1986) *The Reality of Mental Illness.* Oxford University Press

Romme, M., Escher, S., Dillon, J., Corstens, D.& Morris, M. (2009) *Living with voices: 50 stories of recovery*. Ross-on-Wye: PCCS Books

Romme M. & Morris M. (2013) The recovery process with hearing voices: accepting as well as exploring their emotional background through a supported process. *Psychosis* **5** (3) (259-269)

Rosen, A., Mueser, K. & Teeson, M. (2007) Assertive community treatment – issues from scientific and clinical literature with implications for practice. *Journal of Rehabilitation Research and Development* **44** (6) (813-825)

Ross, C.A. and Goldner, E.M. (2009) Stigma: negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature. *Journal of Psychiatric Mental Health Nursing* **16** (6) (558–67)

Sansone R.A. and Sansone L.A. (2013) Responses of mental health clinicians to patients with borderline personality disorder. *Innovations in Clinical Neuroscience* **10** (5-6) (39–43)

Scheff, T. (1974). The Labelling Theory of Mental Illness. *American Sociological Review* **39** (3) (444-452)

Schneider, K. (1923/1950) *Psychopathic Personalities* (9th ed., English trans.) London: Cassell

Scull, A. (1991) Psychiatry and Social Control in the Nineteenth and Twentieth Centuries. *History of Psychiatry* 2 (6) 149-169

Scull, A. (1993) *The most solitary of afflictions: madness and society in Britain 1700-1900.* Yale University Press

Seebohm T. M. (2004) *Hermeneutics: method and methodology*. The Netherlands: Kluwer Academic Publishers

Seikkula, J. (2011) Becoming Dialogical: Psychotherapy or a way of Life? *The Australian and New Zealand Journal of Family Therapy*. 32 (3) 179-193

Seikkula, J. and Arnkill, T.E. (2006) *Dialogical Meetings in Social Networks.* Karnac (Books) Ltd.

Shaw, C. and Proctor, G. (2005) Women at the Margins: A Critique of the Diagnosis of Borderline Personality Disorder. *Feminism & Psychology* **15** (4) (483-490)

Shean G. D. (2004) *Understanding and treating schizophrenia: contemporary research, theory, and practice.* New York: The Howarth Press

Shorter, E. (1997) *A History of Psychiatry.* New York: Wiley

Skodol, A. et al (2013) Personality disorders in the DSM-5: Current status, lessons learned, and future challenges. *Personality Disorders: Theory, Research and Treatment* 4 (4) 342-349

Smith, D. S. (2007) *Husserl.* Routledge

Spence, D.P. (1982) *Narrative Truth and Historical Truth: Meaning and Interpretation in Psychoanalysis.* New York and London: W.W. Norton and Company

Spillman, C. (2008) "You don't have to suffer to feel good", online autobiographic narrative account of *recovery* available in the public sphere hosted on www.scottishrecovery.net accessed 3rd – 10th August 2018

Stanley, L. (1994) Sister under the skin? Oral Histories and Auto/biography. *Oral History.* 22 (2) 88-89. Cited in Roberts, B. (2001) *Biographical Research*. Open University Press, p. 74.

Stevenson, T. (2013) Mind Field. *The Financial Times*, (25 May 2013) p. 8

Stickley, T. and Bassett T. (Editor) (2008) *Learning About Mental Health Practice.* Wiley

Stroma (pseudonym) (13/01/2010) “Twelve Steps to Recovery”, online autobiographic narrative account of *recovery* available in the public sphere hosted on www.scottishrecovery.net accessed 3rd – 10th August 2018

Sullivan, P. (2012) *Qualitative Data Analysis Using a Dialogical Approach.* Sage Publications Ltd

Szasz, T. (1970) *The Manufacture of Madness.* Harper and Row

Szasz T. (1994) *The Therapeutic State: Psychiatry in the Mirror of Current Events.* Prometheus Books

Szasz, T. (2009) *Antipsychiatry : Quackery Squared.* Syracuse University Press

Tamboukou, M. (2003) *Women, education, and the self: a Foucauldian perspective.* Palgrave. Macmillan

Taylor C. (1989) *Sources of the Self: The making of modern identity.* Cambridge University Press

The British Psychological Society (2017) *Ethics Guidelines for Internet-Mediated Research*

The Scottish Recovery Network (2018) [website] www.scottishrecovery.net accessed December 2012 and August 2018

Thiselton A. C. (2009) *Hermeneutics: an introduction.* Michigan: Wm B. Eerdmans Publishing Company

Torn, A. (2009) *Madness and Narrative Understanding.* Unpublished PhD Thesis. School of Health Studies, University of Bradford

Tuke (1813) *A Description of the Retreat, an Institution near York for Insane. Persons of the Society of Friends.* Dalton, Harvey and Co.

Tuke, S. (1846) *Review of the early history of the Retreat, near York.* The Retreat Yorkshire Hospital

Turner, B. S. (1995) *Medical Power and Social Knowledg.e* Sage

Tyrer, P. (2015) Classification, assessment, prevalence, and effect of personality disorder. *The Lancet* 385 (9969) 717-726

Warner S. (2009) *Understanding the Effects of Child Sexual Abuse: Feminist Revolutions in Theory, Research and Practice*. London: Routledge

Wengraf (2001) *Qualitative Research Interviewing: Biographic Narrative and Semi-Structured Method.* London: Sage

Whitaker, R. (2010) *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs and the rise of Mental Illness in America.* New York: Broadway Books Crown Publishing Group

Whitaker, R. (2017) *Mad in America: Science, Society and Social Justice* [website] https://www.madinamerica.com/ accessed 03/01/2017

White M. (2000) *Reflections on Narrative Practice: Essays and Interviews.* Adelaide: Dulwich Centre Publications

Widiger, T.A. (1993) The DSM-III-R categorical personality disorder diagnoses: A critique and alternative. *Psychological Inquiry* **4** (75–90)

Wilkins, T.M. and Warner, S. (2001) Women in Special Hospitals: Understanding the Presenting Behaviour of Women Diagnosed with Borderline Personality Disorder. *Journal of Psychiatric and Mental Health Nursing* **8** (4) (289–97)

Appendix I

Data for Analysis:

A short auto-biographical narrative account from 2012 (age 41)

My mother had left Dublin, Ireland, in the late 1960's to study, and met my father, who was from England, at Leeds University. They both became teachers, and I was born in Leeds, in 1971. Family life was stable, routine and predicable. There were no dramatic big issues in the family (such as domestic violence, or drink and drug problems). I don't recall hearing my parents argue. My parents seemed active helping out in the running of Catholic Church, or school fairs, and my Dad, although he did not say much always seemed to be active with DIY, making craft items or digging, building and growing things. I don't really know why, but I didn't feel I 'naturally' fitted in to social life. I felt a bit of an outsider trying to work out what "family life" was all about. My parents seemed a bit distant to me. Family holidays seemed to alternate between large extended families; grandparents, aunts, uncles and cousins, in Ireland and in Britain or seeing the families of friends my parents had made at Leeds University. I remember enjoying playing with children my age when we visited other families. My earliest memories are of going to junior school age 4. I remember going up seven stone steps with a metal railing and entering in through a large wooden door. It just happened one day out of the blue – off to junior school, as if that was the natural thing and everyone did this, although it felt very unnatural to me and a challenge to learn how this world ran with bells and lessons and playtimes and teachers and wooden desks with holes in the corner for ink wells which were empty as that technology was not used any more. We were given a miniature bottle of milk every day.

Junior school seemed to me to be a very, very strange world. I set about trying to understand it. The other children / pupils my age appeared to know all about school, know each other and somehow naturally fit into school life. I felt like an alien in a strange world. I had a strong sense that I did not fit in here, and that most of the other pupils did seem to me to 'fit in' and belong and naturally know things I did not. They knew the rules and names for games played in the playground, like "kiss catch" and "football". They knew the lyrics to rhymes people would link arms and chant as they marched around the playground, like

“We won the war, in nineteen forty four!” Why were we chanting about winning the war as this was 1976? They knew which football team they supported, and this seemed important as a gang of lads surrounded me and demanded to know “what team I supported?”, I recall anxiously wondering what the right answer was? Later I discovered the ‘right’ answer would have been “Leeds United”!. Anyway, I thought of a football and it seemed in my mind to link to a flag of Japan, so I said “Japan”. There was a stunned silence as they were not sure how to react to...“do you watch them play?” one of my incredulous inquisitor asked me, “every weekend” I lied, anxiously wondering what would happen next. They just walked away looking for someone else to interrogate about their sporting allegiances. I do not recall being bullied at school at all, but do remember trying to work out what the “right thing” to do in social situations was. I remember being asked if I wanted an ice cream outside of school by a family friend and I really felt like I wanted one but said “no” as I thought that was “the right” think to say.

Apart from trying to puzzle out the social rules of school for ‘fitting in’ before anyone realised I did not know them, the emotion I remember most is being overwhelmingly bored by the experience of school. I remember seeing a black boy and thinking I was “the only other black kid in the school”, which looking back now, was a strange thought as ethnically I am white British. May be he looked as out of place as I felt. Looking out the window aged 6 or 7 I saw three lads from my class mates climbing over the fence to ‘play truant’ from school. I was impressed that they knew the rules of how to ‘do’ school so well aged 7 that they were confident enough to break the rules, and escape from this world. I envied them as they seemed naturally at ease with the social rules and how to escape the constraints of compulsory education for some unknown better time outside on the streets of Leeds that afternoon. Playtimes I remember as cold and wet. I tried playing “football” – I was chosen last and put in goal as they could tell I did not know how to play. Football seemed very important topic of conversation but I could not work out why, or even start to join in a conversation.

I was always very well behaved at school as this seemed an important expectation of the teachers and I wanted to fit in. I seemed to get into lots of trouble for spelling mistakes. This was 1976 and word like “dyslexia” was not

commonly used. Spelling things correctly seemed very important to teachers and try as I might this was not something I seemed able to do. Instead I seemed to amaze my teachers with the number of variations I could produce on spelling simple words like “thyre, there, thear, their,,,, and so on!”.

Singing “times tables” in class appeared to be just as important as spelling and standing up when another teacher entered the classroom. We would chant: “2 times two is four”, three times two is....six, etc.”. I found it hard to convert the song quickly in the class maths tests. I recall falling over a lot at school and banging my head – and having to go to A&E a few times. The standard test for concussion in A&E appeared to be “what is eight times seven?” – If you did not know the answer you were probably suffering from concussion. I did not know the answer, so my Mum pointed out to the doctor that I did not know the answer to “7 times 8” that even when I’d not fallen over. Anyway I decided to memorise “fifty six” as being an important answer to pass the process when A&E doctors assess you for head trauma.

Reading books seemed important in this junior school world as well. I recall a picture of an African woman grounding tapioca and thinking that there was a very different world out there, somewhere, where this woman was doing something different to rote learning times tables and learning the correct spelling of “Their” (“i before e except after c”). I felt extremely bored. What was this world I was in? – I began to feel like I from another planet? A lot of the rules seemed not to make a lot of sense but seemed more about being in a big gang together, like the people who can spell and play football and knew their times table. I knew other worlds existed out there like Africa where a black woman was grinding corn with a pestle and mortar because I’d seen a picture of it in a book I’d read at school.

I would get terrible ‘pins and needles’ and a ‘dead leg’ when I sat down and crossed my legs - as instructed, for school assemblies - when I told a teacher they did not believe me and insisted I do what everyone else was doing. I thought it unfair that they did not believe me as it was true. Some food tasted awful to me but this seemed not to be believed by adults who said it tasted fine and I should just eat it up, but it really did taste awful.

At playtime we went outside. How to not be outside at playtime, in the cold, became a problem I wanted to solve. I just felt so cold. I was about seven. I

studied the rules of junior school - rules about having to go out to play unless it was “raining”. I could not make it rain so the solution I thought up was to steal a razor blade and cut my hand with it when no one was looking and then present the injury to the teacher on playground duty. I would claim I had “fallen over”, and she would take me inside for first aid treatment and I would warm up. I carried out my plan, cutting my hand etc. - but after they bandaged my hand up the teacher sent me back outside and I remember being very disappointed my plan had not worked.

It was a catholic school, and so we had “Religious Education”, and in this lesson one day, aged about seven or eight, the teacher asked the class where human beings had come from? I put up my hand and when chosen, gave a short synopsis of “Darwin’s theory of evolution” to the class, which I hoped would impress my fellow pupils. The teacher immediately sent me out of the class to see the headmistress, who was a nun, and I was asked to repeat the theory to her. I was trying to work out if I was in trouble or not. She walked over to a cupboard and got out a Terry’s chocolate orange and gave it to me. I then recall walking over to the adjacent high school to meet my father, who was a teacher there, and told him the story. I could not work out if the school’s reaction was a good thing or a bad thing - as being sent to the headmistress (who seemed friendly) tended to be for pupils in trouble, but a chocolate orange appeared to me to be a reward, or some kind of encouragement.

I was taught about the Catholic faith’s beliefs in school and attended church on Sundays with my parents. Church seemed very boring to me, full of rituals to work out and lots of rules to learn about standing, sitting and kneeling and saying thigs together at the same time. I remember believing in a God of some kind but having some doubts about what I was being taught about God in religious education lessons. Some of it seemed like lots of rules and regulations to pass a test and get to heaven – which seemed to be the most important thing and avoid going to hell or getting stuck in a place catholic teaching called “limbo” which was neither heaven nor hell but a kind of post death waiting area of some kind. I remember thinking “Limbo” did not sound like a good place to end up. There were bits of the teaching I liked though, like stories of “saints” doing things that the rest of society thought was very odd or different – like Francis of Assisi who rejected the rich life to live with the poor.

I thought these saints were great as they did not seem to fit into society whichever century they were born in and I did seem to fit into my society so I started thinking about how I might become “a saint” – whatever that was. I also liked the stories about Jesus because he seemed to be against the religious authorities and against the rich and powerful of his day. I also recall liking the stories Jesus told, like the “Good Samaritan”. But I could not see how these stories connected to the rules and rituals of church life and all that sitting and standing.

I thought logically about some of the catholic teaching. I got the impression God was on the side of the poor and interested in social justice issues. I also thought that if it were true that going to “confession” and confessing one’s sins to a priest meant you were forgiven then technically as you stepped out of the confessional box you would be free from “sin” and so this would be a good time to die, and so I wondered about aged seven, would it be a morally “good” thing to do to stab and kill my school colleague as they stepped out of the confessional as they would then “go to heaven”, which seemed the most important place to end up going to. I would then be guilty of murder though, so would have to confess and repent and get forgiven, but would have helped transport someone to heaven. I was not feeling close to acting this out in any way – it was just a logical thinking through of the moral implications of what I was being taught and wondering if it was true or not?

I recall reading a secular child’s book - “The road to Oz” - and it had a picture of a tramp at a cross roads and people were nice to him because he had a magical magnet wrapped in brown paper and tied with string secretly hidden in his pocket. I remember being affected by this story, aged about six, and wondering what the magic magnet was?. He gave it away to someone else and I wondered whether he got beaten up as he wondered off down the street.

I have no idea how much of my memory corresponds to the actual chronological events of my lived life, but this is how I remember it. Most of my class seemed to play out on their streets at night with each other, but I lived about five miles away and no one from my primary school lived where I lived so some of their conversational content was hard to follow.

There was a way to escape the madness, boredom and confusion of junior school though and that was by attending appointments with my mother to have

my hearing tested as there was some concern I might be partially deaf. I recall this experience had its own rules and routines such as waiting rooms, headsets and questions about hearing “beeps”. I assessed what the adults were doing around me and guessed if I scored well on the hearing test I’d “pass” and be sent back to boring junior school. So I decided to fake the test and pretend not to hear some of the test material so I could keep getting out of some boring school stuff. It worked and I was sent off for a routine operation to have “grommets” put in my ears on repeated occasions, which meant I could not take part in swimming lessons and had to have more tests for my hearing problem. I do not recall being unhappy at school, just not belonging, not fitting in and being bored and envious of my classmates ‘natural’ social skills and ease with how to “do life”.

I remember wanting to belong and fit in and feeling like an outsider learning the rules by observation and mimicking what people around me were doing ‘naturally’. I noticed other children called their parent “Mum” and “Dad” and then felt very self-consciously aware that I called my parents by their first name, so with great emotional awkward feeling subjectively for me, one day I started calling them “Mum and “Dad” so as I could blend in more easily with other children my age.

My Dad took me to play rugby at weekends and taught me how to fish at sea and by rivers. Sea fishing seemed exciting as I might catch a fish and the rocking of the boat on the sea seemed to imply some danger, and it was a world away from boring junior school with its strange rituals and its rules regulating its pupils for the purpose of something called “education”.

Interestingly, before I went to high school, when I was aged around ten, an older female started to initiate sexual encounters with me. This then continued in a cycle of off and on for approximately seven years and it was a secret that nobody else knew about at the time, including my parents, until I decided to disclose that I had been sexually abused to my parents when I was aged about 20 (in 1991) who believed me which was a great relief. This also helped them make more sense of why I had ended up in a residential alcohol rehabilitation unit aged 19.

I developed mixed, and often conflicting thoughts and feelings about the sexual encounters with this older woman. Part of me found them exciting and I liked

the attention and I had sexual desires to have the experiences. At the same time I began to feel angry and resentful at the amount of power she developed over me, and that she went through repeated cycles of telling me it was wrong and had to stop and then she would initiate the encounters all over again. I developed feelings of guilt and shame about myself and my sexual encounters and anger towards her and the power she held over me. I experienced my sexual desires as a vulnerability I had - where someone could have power over me and I did not seem to have the power or self-control to resist their advances and offers. After a couple of years of this, aged about 12, I started a process that I would repeat many times over the next few years, of me deciding sex with this woman was causing me too much emotional distress and so I would not engage in it any more. But then when it was initiated / offered by her again then I seemed to lack the power to say “no”. Then I would hate myself for my lack of self-control.

Sometimes she said it had to stop, but on these occasions I would have no choice in the matter and would feel hurt and rejected and not in control of the situation. I also developed a high level of fear of discovery – that we would be caught and discovered by someone engaged in sex which I thought was both illegal and morally wrong to be having sex at ten. She also seemed clear that it was wrong to be having sex with me at such a young age (10+) and would tell me “what we are doing is wrong, we will go to hell for this you know”. This went on roughly from the age of ten to seventeen. During that time I developed strong feelings of guilt and shame about myself in relation to my sexuality and sexual encounters. I also began to form a relationship with myself where I was angry at my lack of self-control to not stop engaging with sex with this older female. As a teenager I noticed I was attracted to other females - but this also made me very anxious and frightened as I felt threatened by them. Later I wondered if I could be gay to avoid relations with women but eventually realised I was sexually attracted to women, not men. I desired a sexual relations, as in as in having “a girlfriend”, as a teenager but felt very threatened by the prospect and overwhelmed with anxiety that they would destroy me or else that I would not be able to leave them if I did not like them because it would cause them too much pain and emotional upset for me to “split up with them”. If I dated someone I feared I might be stuck with them, or they might

humiliate and hurt me. I also felt angry with the older woman initiating sex with me from the age of ten onwards - but also enjoyed some parts of these sexual encounters and so felt guilty about enjoying myself having sex. Sometimes I would start these encounters when I was 13 or 14 years old, so I felt guilty about my part in the sexual relations with this older woman. Sometimes I liked how it made me feel.

I found living with these very strong feelings of guilt, shame, anger, fear and lack of self-control around enjoying myself very uncomfortable to deal with. Ironically I found that thinking about, or having sexual encounters with this older woman would temporarily lift me out of my difficult thoughts and feelings. Sometimes I started to initiate the sexual encounters when I felt particularly bad, but afterwards would feel more guilt and shame in that I had started it this time. Sometimes she would initiate it. I also felt very confused about the whole process and rejected many times. After about three years of this, about the age of 13, I discovered that if I drank enough alcohol it had a very significant impact on my inner turmoil of tense thoughts and feelings. Basically if I got drunk then my inner tension of guilt, shame, fear and anger tended to dissolve and go away and I went into another world away from all the emotional pain and guilt. Guilt appeared to dissolve in alcohol for me. I would feel “great” for about four or five hours. Then I would feel terrible suffering from a hangover the next day, but as time went on I noticed the hangovers gave me a kind of satisfied feeling. It was almost like I felt strongly that in all fairness and in the interests of justice I ought to be punished for being involved in these secret sexual encounters and the physical suffering of a bad hangover felt like my just punishment for all my wrongdoing. Thus I drank alcohol repeatedly to excess and gradually increased the number of nights a week to five or six by the time I was sixteen.

I also found that entering the doors of arcades and gambling on fruit machines had a similar effect of lifting me out of the mixture of guilt, shame, anger and fear temporarily whilst I enjoyed gambling and playing slot machines whilst I was doing it for an hour or two until my money was gone, which again felt like a just punishment for my wayward behaviour.

I would say I enjoyed high school while i was at school (i.e. 9 – 4.30 p.m. Monday to Friday) as it seemed to be a separate world I would enter and

perform well in having friends and “having a laugh” and I enjoyed some of the academic study also. At high school seemed to be able to make friends and would meet up out of school to play computer games or try to get hold of alcohol to get drunk, but I would also get drunk on my own to relieve the feelings of guilt, fear etc. Mainly I was well behaved at school, except for a brief time aged 15 where I was caught truanting to be in gambling arcades and was given “The Cain” (corporal punishment) as a penalty for this (before it was made illegal in England). I just found being given corporal punishment a very interesting process as I could not see how this would make me change my behaviour? Secretly I was proud to have got the Cain before it was made illegal as I could brag about it to friends as a status symbol. Academically I fluctuated a lot depending on how distracted I was and how hard I tried. I went from the top to the bottom set in maths and then back up again, sitting my ‘o’ level a year early and getting an ‘A’. I ended up with eleven ‘O’ levels and went on to do ‘A’ levels, but got significantly lower grades than predicted aged 18 and failed to get good enough grades to get into University.

I then got a paid job washing up in a pub restraint 70 hours a week and found I could drink alcohol while working, and then get drunk in the bar when my shift finished. My work colleagues seemed friendly enough. I thought I’d entered a new world of full time employment, but found some of the “banter” with my work colleagues difficult to join in with, which I put down partly to it being working class culture which I found difficult to fit in with and some of the banter was about sexual conquests which just made me feel very anxious inside. After three months I was drinking excessively every day and not having any money saved. I remember feeling incredibly angry about the situation I was in. When I felt attracted to a woman I also felt very anxious and threatened. I would try to manage these feelings by drinking alcohol but then would drink too much before, for example, being able to “chat up” a waitress at the restaurant that I felt attracted to. I also recall hating myself for this and feeling very angry with myself at not having the power to organise myself any better than being a “celibate drunk washer upper” in a restaurant. Was this going to be the life I would be stuck in? I felt desperate and could not see a way out of my situation. I tried to ask a waitress out on a date, but felt overwhelmed with anxiety and images of me dying violently (e.g. falling off a bridge, hanging myself). I recall

going out for a cigarette break and drinking a bottle of spirits and then being picked up by the police for “drunk and disorderly”, who brought back to my employer, who said he thought I’d been a long time on my break. Incredibly he let me keep my job – as long as I could wash up for his business, he said, he “did not care what problems I had”.

I went to my G.P. and told him virtually nothing - apart from that I seemed to be very anxious and he prescribed me “beta-blocker” saying I was “getting panic attacks”, the medication he said would slow my heart rate down. I recall being pleased that the prescription seemed to me to be a small symbolic recognition by my GP that there was something “wrong” with me, though I had not told him what exactly. I gave up gambling as it cost me too much money, but carried on drinking to repetitive excess. I kept wondering how to solve my problems.

I would think through my problems on my own, in my head. I felt too frightened to tell anyone about why I had these problems with my thoughts and feelings. I felt as though if I told anyone I’d been sexually abused as a child then the world would end in some kind of catastrophe and the sky would fall in on me and terrible things would happen. My abuser had said that if I ever told anyone what she did then “I would go to Hell” and I guess at some level I believed this, though at another level I remember thinking that’s not true, I don’t even believe in Hell.

After lots of trying to “think it through” - I decided the solution to my problems was to emigrate to another country and “get away” from all my problems in England. I could then make a fresh start on a new chapter of my life away from all these difficulties. I bought a flight to Canada and went there with £50 in my pocket. I worked there and stayed with my aunt for a while, who was kind enough to put me up. I remember thinking as the plane landed in Canada, “no one knows I am an alcoholic in this country, I’ll be able to enjoy a few drinks”. To my surprise I found far from “leaving all my troubles behind” in England, they had somehow followed me to Canada on the plane, which I thought was strange.

I got a paid job and when I thought about asking a woman out whom I felt sexually attracted to again I felt overwhelming fear that she would attack and hurt me, I felt guilt and shame about wanting a sexual relationship and felt

angry at my lack of self-control over my internal life of thoughts and feelings. I started to drink alcohol to steady my inner turmoil, but did not seem able to control the amount I drank. I drank repeatedly to excess and ended up picked up by the police in Canada one night for “drunk and disorderly”. I then decided to sort my problems out by hitch hiking across the trans-Canada highway which took about six weeks, to cover 3000 miles. I liked hitch hiking as I was always heading away from something behind me in the last town, I was putting all my problems behind me and had some forward direction in my life - which was getting to the next town, so to speak. I liked having the purpose and direction of trying to get to the next town and the excitement of not knowing what adventures I might end up involved in. I met some very interesting people along the way who gave me lifts in their car. I would make myself little signs about where I wanted to get to next, and listen to music while waiting at the side of the road for a lift.

I liked the excitement of not knowing who would pick me up or what might happen next, and that I had never been to the next town I was heading towards. At the end of the road I got to Vancouver and suddenly felt very depressed and desperate, bit sure what to do with my life or what direction to go in. I tried to get the authorities to deport me but they refused, so I went into America. I carried on hitchhiking and ended up living above a pub in Chicago temporarily and got a job moving furniture with a group of American men. At first I thought this was very interesting and a chance to find out more about American culture. However in the course of working and drinking with these men I remember thinking this is a very different world I have ended up in here. Their lives appeared to involve legal and illegal ways of getting hold of money for alcohol and cocaine fuelled adventures at night which often ended in extreme violence. They did not seem bothered about going to prison. Their values seemed very different from mine. I felt quite frightened whilst with one of my associates in the furniture removal business described his delight at sneaking into his cousins barbecue the previous evening and stabbing him. Everyone in the group appeared to find his story very amusing and laughing, partly because they knew the victim, had “got it coming” and “deserved a bit of a stab”. I felt scarred for my own safety and started to think I needed to escape this world of drink, drugs and violence. I also met Americans who seemed

regular people with regular jobs, but my work colleagues scared me, and I worried they might turn on me or I might get caught up in something with them and I did not fancy that. I went out for a few drinks with a colleague whilst I thought up a plan to get away from my situation as I thought I was definitely out of my depth and did not know how to relate to people here. I got offered some crack cocaine and asked if I'd like to get involved with "a job" that would earn "enough money to buy a month's worth of coke". I thought this sounded like a movie, but the guy asking me looked genuine enough and had the look of someone who had been to prison and was on crack. I was frightened I'd end up dead or in prison. I thought of a character from a novel I'd read called "Decline and Fall" who kept ending up "in the soup" – that where I was I thought. I thanked him for his offer of employment but said I was "too busy". I went drinking by myself and ended up being picked up for "drunk and disorderly" by the American police. I complained that this was the third country where the police had done this to me and this had to more than a coincidence? I remember telling the police in the fourteenth century this would not be happening as we would both be native Indians catching trout in a river and we would have no access to alcohol or the modern criminal justice system. The police said it was nothing to do with the 'crap' I was talking about, it was just happening to me because I was 'a drunk'.

I decided to get out of America as quick as I could, it seemed like two worlds in one to me – America of the rich and the poor – and I had visited without any money. I escaped on a plane back to England, about 12 months after leaving it. I then got a job working on the Channel Tunnel as a labourer for a few months before heading off to do a politics degree at Newcastle University. However by this time my drinking was so excessive that I dropped out after a few weeks, feeling very desperate and defeated, with some suicidal thoughts and a desire to do something about my drink problem. I went to an alcohol service in Newcastle and recall telling them I needed to stop drinking and the councillor telling me I was "too young" to do something excessive like stopping drinking entirely, and he advised me to try "drinking with moderation" and keeping a "drink diary". His theories did not seem to connect to my experience and what I felt I needed, which was abstinence. I returned to Leeds with the help of my parents and explained to them the extent of my problem with

alcohol, and they helped arrange the offer of a place in a 12 step abstinence based alcohol rehabilitation centre. I felt guilty about this as it was a private facility and my parents did not have savings so they were going to borrow the money to send me to this rehab.

I accepted their offer and after 28 days treatment there, which involved working through a 12 step programme, I was advised I had “more serious problems” than the average patient who routinely went home at the end, and that I should go to a further rehab for more extended work in Lincolnshire, which I did. I remember thinking what are these more serious problems? - but was afraid to ask directly. I felt guilty that I had been such a failure at “doing life” that I’d ended up in rehab when my peers were getting on with education, careers and relationships. I felt very envious of people who seemed to be able to “do life” without too much bother. I tended to idealise other people I saw and think they did not have big problems or difficult emotions to struggle with and so was jealous of the life i thought they had and envied and resented them. I wanted to “get a life”, which to me meant a job and a relationship. I was puzzled why this seemed so difficult for me.

For the next four or five years I saw myself a “recovering addict / alcoholic” and worked at a “12 step” programme which involved attending Alcoholics Anonymous meetings and being completely abstinent from alcohol and illegal drugs. There were some basic ‘steps’ or techniques that I practiced such as admitting what I had done wrong in my past, making amends, looking at my character defects and trying to be honest. I took responsibility for my alcoholism and what I was going to do about staying in recovery. I met with other people in recovery and saw part of the process as using some of my experiences to help others get into recovery and stay sober also. As part of putting the programme into practice I tried to direct my life towards some “higher power”, in a spiritual sense, which would give me the power and direction not to drink alcohol (a power I thought had evidently previously lacked, demonstrated by several attempts to stop drinking on my own ‘will power’).

I was not a Christian at this time so my “higher power” was a vague undefined notion, which a 12 step approach considers to be sufficient for its stated purpose - of helping members stay sober. On some levels this worked for me,

for example, I stopped drinking alcohol self destructively for the next five years. During this time I went to University and got a first class honours in Sociology and Social Psychology.

However, despite academic success I found I had some serious underlying emotional conflicts and turmoil once I got sober – For example, I experienced repeated severe depressive episodes where I felt suicidal. I had thoughts of harming others which upset me and thoughts of harming myself. I was never actually violent. I also had problems being highly anxious around other people, especially women I felt attracted to, to the extent that I did not date anyone despite wanting to. I felt resentful about having been sexually and emotionally abused and resented the person who had done this as I thought it was unfair that they had and I seemed stuck with the consequences in terms of inner turmoil of guilt, fear, anger etc. I felt emotionally damaged and searched for solutions in lots of things such as self-help books, Hindu texts, the Koran, Buddhist texts, the Bible, popular psychology texts and attended confidence building courses. I tried applying techniques in books like “Feel the Fear and do it anyway.” - popular at the time.

My self-esteem seemed negative as I hated myself and high academic achievement did not seem to make me feel good about myself. I felt driven to work hard, which has been a habit all my life, and would study for 12 or more hours a day. I recall daily life being a real struggle - in terms of looking for some meaning in my life and trying to avoid feeling guilt, shame, fear, anger and depression. I recall reading philosophical text looking for some meaning and direction in my life that I could really believe in and not just see as human constructed projects with rules and regulations. I recall seeing my GP often and getting some anti-depressants. These seemed to lift me for a while so I could function again and feel less suicidal.

Then I remember getting some counselling from relate in my search for ways to get better, now I was not drinking self destructively. They thought my problems were ‘more serious’ than they were trained to deal with, and referred me via my GP to a psychiatrist who offered me psycho-therapy. She warned me that it might make me worse and it might not work for me, but I was desperate to get better and had heard a lot in the media about psycho-therapy supposedly being helpful. I remember thinking that Woody Allen had been

going to psychotherapy for years and his movies were very funny. I went to psychotherapy every week for about 2 years and talked about my problems. I did get much worse – psycho-therapy seemed to help me get more articulate about me problems and their causes without this leading to me getting better. I wondered how the process was supposed to work in people who found it helped them get better rather than in my case where it seemed to unravel me even further and expose all my pain and fear without offering a solution. I remember thinking the psychiatrist referring me had warned me that it might make me worse and so she had been fair in warning me. I recall being very suspicious about my therapist and thinking he might steal some of my ideas. Eventually I told him I was thinking of going back into the adventurous world of drink and drugs because I had got much worse and the inner pain was unbearable and i needed some kind of painkiller unless he had any bright idea about how to get better that he had been holding back to do with his therapeutic stance? When he repeated what I said back to me in a 'client centred' style I felt really angry and left, not to return again. On reflection, it must have been difficult for him to listen to me describe my problems and pain every week for 2 years, and witness my deterioration.

Anyway, at this point in my life journey some of my friends in AA had 'relapsed' and gone back to drink and drugs. This contributed to me thinking about that way out of my increasingly desperate emotional state. I decided AA and psychotherapy were not working for me and went to the pub on the way home from my last therapy session. I was in a desperate state of inner tension where I just wanted to change how I felt as the pain seemed unbearable so I ordered a pint of Guinness. After a few more pints I found my bad mood started to lift. Then I drank excessively until I 'blacked out' (memory loss). I started drinking every day as an attempt to manage my mood and I was determined to "have some fun", which i had always found hard to do. A friend of mine offered me some amphetamine and I thought "why not, it must be better option than suicide, homicide or being desperately miserable". I then took amphetamine, cannabis, ecstasy (MDMA) or excessive alcohol every day for about six months. I thought it was great at first as the chemicals produced large shifts in my mood, such as myself confidence on amphetamine was suddenly fantastic and on ecstasy I enjoyed myself and felt good for the first time in years, but

the chemical management of my moods only lasted temporarily before depression or anxiety or guilt started to influence me again. The side effects appeared to be increased paranoia, low mood, panic attacks. I tended to treat the side effect with more drugs. I worked on a PhD at this time, after I graduated. My alcohol and drug use quickly escalated to the point where I felt out of control and desperate to get 'clean and sober' again, as I thought I'd end up dead soon if I did not, probably from an accidental overdose.

I decided to tell my parents I'd "messed up" my life again. I felt very guilty about the repeated distress I caused my parents due I believed to my failure to organise my life in a more manageable and orderly way and bad choices such as taking drugs to relieve emotional problems I had. I felt guilty that I might affect my younger siblings with the example of my self-destructive lifestyle. Sometimes told others I would kill myself which understandably stressed them out. My parent's attention tended to drift towards me and my problems rather than being balanced amongst my younger siblings at the time. I was quite selfishly caught up in my own world and my own problems and did not think about others much at this time of my life.

My patents helped me get to see my GP. I was asking for a referral to rehab again, but this was not routinely funded on the NHS. I described what was going on with my thoughts and feelings to my GP, whom I remember appeared to be genuinely concerned about me. He referred me to the psychiatric hospital for an assessment, with a letter from him. So I went up there and had a long interview with a psychiatrist, at the end of which they said I needed to be admitted to the psychiatric hospital. I felt relieved given I was quite desperate and suicidal at the time.

They prescribed some medication which I had high hopes would make me better, after all why else would they prescribe me medication, if not to make me better?

I remember feeling a great relief that the psychiatrist felt there was something wrong with me. I did not feel guilty for messing my life up any more. I recall thinking; "I knew there was something wrong with me."

It seemed very validating to me to be admitted to the hospital, like a professional endorsement saying that I did have some serious problems, I was not just a failure at life through bad choices. I was not guilty because I was ill

– what a relief I felt. I could explain this to others now as a way to explain how badly my life had gone so far. I also felt less guilty as I entered the psychiatric hospital as an inpatient about the fact that psychotherapy and AA appeared not to have worked. I had felt that it was my fault these approaches had not made me better, but if I was mentally ill in some way then maybe it was not my fault, or it was not due to some lack of effort on my part, but because I was mentally ill in some way. I hoped the professionals would know what was wrong with me from my description of my problem and hoped the anti-psychotic medication would make me get better so I could enjoy my life and get back to my PhD. It was 1996.

After being admitted to hospital, the next thing I remember is my body starting to get stiff and freeze whilst I was having a wash and shave, I then had difficulty breathing and tried to get down the corridor to the nurses in their office, but I could not move my legs and fell over in the corridor and then I stopped breathing. I was terrified and thought I was going to die. Then a nurse ran down the corridor and some more and they injected me with something in a hurry and after a few seconds my throat muscles relaxed and I took in a deep breath. I had had some kind of reaction to the anti-psychotic drug, “haloperidol”. I wondered if these doctors knew what they were doing and started to doubt if these medications would make me better - or just kill me? They prescribed a different anti-psychotic, chlorpromazine, and I took that to see how it would alter my thoughts and feelings. I was very curious about the whole process. I recall wondering why as part of the admission process they were weighing me and checking my reflexes, why was this important I wondered, as my problems were not physical but inside “my head”, so I thought.

Through this process I started to see myself in a new light - as someone with “mental health problems”. Someone had mentioned “Bi-polar affective disorder”. I was hopeful that the professionals would diagnose and treat me and I would get better.

Surprisingly to me the opposite happened - I seemed to get considerably worse and deteriorate in my mental health. Professionals kept asking and I kept answering their questions about my problematic thoughts, emotions and self-destructive behaviours. I spent the next five years in and out of the psychiatric hospital. Chemically I was prescribed a combination of anti-depressants, anti-

psychotics and/or mood stabilisers for that time. I seemed to attract lots of different kinds of diagnosis from professionals and I noticed professional opinions were divided about me and my “case”.

As I continued to deteriorate under psychiatric care they appeared to increase the dose of my medication rather than notice psychopharmacology was not working to make me get better. I became a long – term unemployed, chronic ‘mental health service user’ for the next five years. I felt like I had entered some terrible nightmare, or I was in some kind of living hell where I was suffering torment without an escape or a way out. I remember being diagnosed with bipolar affective disorder, which I thought was ok because some celebrities had this, so it must be ok. Then it got changed to “psychotic depression”, and I was not sure about this as I had not heard any media celebrities saying they were psychotic, unlike Bi-polar which seemed more fashionable and therefore more acceptable and understandable my other people. Depression, recurrent depression, obsessive compulsive disorder (OCD) and anxiety were also diagnosis I was given during the next five years.

I remember thinking at one point that the 1000 mg a day of chlorpromazine was “a bit like having ten pints of bitter”. I remember thinking that I had in common with the doctor that we both thought a chemical solution would be the best way to sort out my troubles and afford a cure, we just could not find the right combination of chemicals to make me better. One day after about five years and six or seven inpatients admissions I got very depressed and started to despair that my life would ever improve. I had no job, felt very lonely, had no role in society, no relationship and no prospects of finding a way to get better. I was starting to realise that this dance of seeing professionals such as doctors and them diagnosing me and prescribing medication was clearly not only not working but I was somehow getting much worse in the process, although I did not think anyone was intending this to be the outcome as most staff treated me very well and were very friendly and seemed to genuinely care about my welfare. My memory now is that over these years my story told to mental health professionals was fairly consistent in complaining of anxiety, depression, guilt, shame, and anger linked to sexual abuse in my childhood which I felt had been unfair and consequently I lacked “a life” now, in terms of I had no job and no relationship despite wanting these things. Although some

professionals varied slightly with their personality or their professional role, in general I found the response of services pivoted around changing diagnosis or medication. Professionals appeared to me to be more at ease emotionally talking about anxiety and depression and appeared less emotionally comfortable talking with me about guilt and shame issues. The anger issue tended to be talked about in terms of an anti-psychotic might be able to reduce intrusive psychotic images of violence that were associated with me feeling angry about things I perceived as unfair, such as being sexually abused as a child. Things may have been different than I remember now as a forty one year old man, but that was my general impression. Sometimes it appeared that whatever the details of my story the answer was always “chlorpromazine”. Sometimes I secretly thought, well I could do that, listen to peoples sad stories of their lives and then say “chlorpromazine” at the end like a magical spell or panacea. Other things did happen in terms of treatment from services, but the weight of professional hope often seemed to me to fall on prescribed medication.

My life had no direction and I was caught in an endless cycle of admissions to hospital to “prevent harm to myself or others” followed by months of loneliness in my flat, unable to find a way out of my prison. Sometimes I tried things that failed, like buying and selling things or painting pictures to sell. Everything I seemed to try seemed to fail and be unsuccessful which lowered my self-esteem and depressed me. One day I recall asking my psychiatrists, “after all these years, what do you think is really wrong with me?”

To my surprise they said “the truth is you have a personality disorder, most likely a borderline personality disorder”.

They did not explain what that meant. I did not ask for an explanation either. I’d not heard of this diagnosis before. I left and started telling people that was why my life was a train crash of a failure, according to my psychiatrist it was because I had a “borderline personality disorder.” I’m amazed they did not explain or I did not research myself, and find out what this diagnosis meant. At the time it seemed enough that there was this explanation for my failure of a life, and it was not just my fault for making poor choices or not trying hard enough, but it was because I had a personality disorder.

Fed up with deteriorating I tried moving to another city and getting involved with direct political activism around 1996. This gave me a purpose and some direction. I was loosely associating with environmental campaigners trying to get issues of “global warming” into the mainstream media and political discussion by taking direct action. I was introduced to this through one of my brothers who seemed more ethically and politically minded than me around these issues and was very accepting of my mental health problems and he let me live with him for around a year. At the time warning people about global warming was portrayed in the mainstream media and by politicians as a “Mad” activity of a few fringe “tree hugging hippies”. When I studied the scientific data it seemed fairly straight forward and clear that the world was likely to end through climate change but the difficulty appeared to be the vested interests of the rich embodied in multi-national capitalism, international banking and dictatorships by small elites in countries such as Britain in so called “democracies”. At the time I thought there was not much difference between Labour and the Conservatives in terms of distance on the political spectrum and anyway I thought they were run by a small rich elite who reproduced themselves via the public school system (including the press) so little could be expected there except protecting the already established vested interests of the rich and powerful.

So the social world appeared to me to be disordered like I was, and intent on self-harming through consumer capitalist fuelled climate change. Instead of harming myself I thought I’d try political action to try to stop capitalist society harming itself. I got involved with the direct action environmental groups like “Earth First!” Actions were divided into “fluffy” (legal) and spiky (illegal). I got involved with actions strategically targeted against genetic engineering experiments, nuclear facilities, stopping a wood being knocked down, open cast mining, anti-capitalist actions and pro-squatting actions. I got arrested for “obstructing the undersheriff” when I was locked into a concrete block buried in the ground when the authorities wanted to fell a wood. The reason I was locked in down on the ground was that I was too frightened by heights when I tried sleeping up in the trees with everyone else, so I volunteered to be “the first line of defence” when the police invaded the site to avoid losing credibility with my fellow environmental activists.

I was impressed by most of the people I met (apart from the animal rights activists, as they seemed not to like people). For a time I felt part of a group of people who were trying to raise the issue of global warming and the threats from multi-national capitalism. However most of the other people I met seemed more ethically motivated and had a more stable identity than I had. I felt acutely aware that I had problems with anxiety and depression and other emotional difficulties and the other environmentalists did not appear to have these problems. I seemed to be looking for an identity and a sense of belonging more through my involvement more than other people were. Morally we were locating problems with the behaviour of powerful capitalist organisations as 'unethical' and the limitations of Western "democracy" to tackle the problems of global warming. This process of direct political action against wrongdoings of multi-national companies did not appear to resolve my own problems with guilt, fear of sex, anger at personal injustices and my re-ignited drink problem. After about a year I returned to Leeds following a particularly 'bad patch' where I got low in mood and lost some memory through drinking. The press were reporting environmental activists as "crazy" for suggesting climate change was a threat from capitalist materialist obsession with growth. Nowadays mainstream politicians think climate change is a legitimate subject to be concerned about and not "crazy" at all to be concerned about.

Back in Bradford in the late 1990's I sank into another couple of years of unemployment and repeated admissions to the psychiatric hospital. I thought it likely I'd be dead by thirty. I kept looking for a way out of my situation, which I hated. Sometimes I got so desperate to change an intolerable feeling of guilt, shame and anger that I self-harmed by taking overdoses or cutting myself. I did not want to die as I thought suicide morally wrong, but I was "half in love with easeful death" as some poet once said, and was in two minds as to whether I wanted to carry on struggling with an unsuccessful life after feeling like this for the best part of twenty years (between the ages of ten and thirty).

Then I decided to have another go at staying to stay off the drink again by washing up voluntarily in a fair trade cafe in Bradford and going to a few AA meetings again. While washing up I heard someone telling an ex-heroin addict (fresh out of prison) that "Jesus had died on the cross and risen again to set him free from the ways that bound him." I was interested intellectually,

analysing the interaction and thinking “This guy must be a ‘born again’ Christian.” What surprised me was that he genuinely seemed to care for the welfare of the other person and this challenged my idea of ‘born again’ Christians which I thought were deluded gullible victims of right wing American evangelicals, or so I thought, based on what I’d seen on the B.B.C.

This guy talked about Jesus being able to emotionally heal people through the Holy Spirit and I thought that sounded like something I needed. I had heard ‘the gospel’ before, but for some reason walking home I suddenly felt: “it’s true!”. I then joined the church in Bradford that this man went to and made a decision to ask Jesus to be the “Lord” of my life. Seeking God’s will in my life seemed to give me some much needed direction which helped. Psychologically this meant I was subjecting myself to the authority of Jesus (as in ‘Lord’). Practically I worked this out by practicing some of what it said in the Bible, for example, I shared the emotional damage done to me by my sexual abuse, and I forgave the perpetrator. This lifted a lot of anger and resentment from me. I also admitted the things I had done wrong in my life, in confidence, to another Christian, turned away from them and believed I was forgiven, which lifted the feeling of guilt from me. At the same time I felt accepted by other people in this church and felt they genuinely cared about and loved me. About 10% of the congregation were ex-addicts so I felt at home and not judged by them. They invited me round to their houses for meals and they appeared to care about and love me. They seemed to accept me as I was, and also seemed to believe I could get better at the same time. They did not care about my diagnosis or medication and I did not scare them off.

I was 29 years old. I stopped drinking and taking drugs (both illegal and prescribed. I did voluntary work for the church’s outreach to addicts in Bradford. I then got a job in a bookshop, then as a support worker in a mental health hostel, then I worked in a personality disorder accommodation service. I then applied for the manager’s job and managed the small personality disorder service for three years before changing jobs to work for an early intervention in psychosis service as a senior care co-ordinator. When I was about 29 I started dating a woman I met at church. Dating for me was for the first time in ten years, which was quite scary. I asked her to marry me and she said yes. I then became a step-dad to her two children who were aged 6 and

eight which I found a big challenge. We've been happily married now for 11 years. My wife is very supportive and I think it helps that she has a fairly stable identity and that she did not have any addiction or mental health problems in her past. Now I feel I have a good life which I enjoy and have roles in terms of being a Dad and husband as well as paid employment. I also am active in my local church. I have problems today but I see them as the everyday problems that we get because we are human beings in relationships with other people, that is the normal problems of everyday life which I try to solve, more or less, with the help of others. I can also be helpful to others. As a forty one year old man I no longer have the set of problems I had between the ages of ten and thirty.

Appendix II

Data for analysis:

Contemporary Diary Entries [Age: 22 years old]

21st April 1993: I feel often these days a frustration at my inarticulateness. The struggle to share, or attempt to share, the ambiguity, the unknown terror-tory that I'm entering these days, or am it, in. The struggle to attempt to depict that or to shed light on, even to myself often seems too much. I feel like not expressing it as it seems so incomplete, so inconclusive. Perhaps I like conclusions too much. Anyway when I want to give up and turn back from my truth I think of the Russian Harlequin in Heart of Darkness. When his self was prodded, when the questions became too awkward, he gave up. He resorted to "I'm just a little man" and turned to his idol for comfort. Cold, false comfort.
Last night I dreamt I struggled with a demon. Such a model of existence is not very popular in the West now. It's not too popular with me either! I can see why other models are more appealing. Science reassures us via its distance and complexity, it has become the dominant model. Psychology contributes much but it denies evil as a force, which is great, unless there is an evil force that influences us. Then the fact that a model does not account for it does not eliminate it. Labelling theory sounds great, - but once you throw away the label, what do you do? Do you act like the Harlequin and say 'this no longer exists – I threw away its name'. Such could be said of the devil. If modern theories throw away its label it still exists. And what of God? I'm not such a pessimist to acknowledge only a malevolent, destructive force in the world, though I have been there. No, God must exist. I have difficulties in my relationship with God. I know Hell exists because I've been there. To some extent I'm still there. This talk of post-mortem journeys misses the point slightly for me. What about now? The strange thing is I didn't go to Hell for what I did wrong. I don't think so anyway. I may change my mind. Anyway strangely enough someone else sent me to Hell. Yeh, whackked my soul so badly with a bat that it nearly bled to death. But it didn't. It just crawled off to Hell. My fall, the fall, the fall, wasn't so much a fall, a fall, as I was tripped, tricked, pushed. I had part of my soul, yeh, my soul ripped out of me by some evil bitch of a she devil, yeh, strong language, but oh so true. Sometimes the truth hurts (it hurts the good though,

or not?) Anyway this she-bitch-devil was the nicest, sweetest, most respectable, alright person, they just had an evil streak or something. I can't deny that she beat, broke and scratched my soul. How's your moral decision making at eleven – hey, yeh, you – at fucking eleven. With some bitch-eve-devil standing with an apple for you to bite. Well I took a bite. The poisoned fruit seemed so sweet. I bit and i was struck. I bit into the offered fruit. I bit and was bitten. Once bitten (and scratched) forever smitten. Or maybe not.
Anyway I always wanted more of that fruit and didn't she know it. I was hooked. A real addiction to that fruit I had. And she'd offer it and then take it away and I'd cry and then she'd offer it and away then away gone away offered away smash bang wallop bang offered away bang, fuck off, fuck me, fuck off, fuck me, fuck off, fuck me, haha ha your hooked on me good and proper!! Oh how it hurt. And the sad thing is I thought my cure lay in more of the same. I didn't know it was pagan idolatory, a heavy word again to use. Did she know?
Forgiveness is what???? God will have to show me coz no one else has yet. The bitch. I'm angry. She fucking sent me to Hell, how do you forgive an unrepentant child molester for sending you to an emotional and mental Hell?
Obsession/Compulsion/addiction/Idolotary of: Gambling / money making / alcohol and first and foremost "sex". Thanks for that present. Anyway I have to deal with this, no it doesn't sound fair. The good go to Hell. The sinned upon go to Hell. It doesn't make sense. I don't know. Maybe the next world rights these wrongs.

22nd April 1993: Sent away for Richard Hamilton Print (+ve and fun).Sorted out next stage of my house purchase. Attended lectures. +ve. Avoided essay – not so good. Went to Manchester and attended my first Sex Addicts Anonymous meeting. A nice group of honest and brave individuals. I felt I could share freely. My desire for sex seems to me to be more powerful / in control of me. A kind of higher power. I don't know where this will lead me, but I am prepared to find out. 20 days since I acted out in my sex addiction. This time solving my problem I have strength of fellowship and willingness to work at it from me.

23rd April 1993: I can see/say that a good, Godforce / +ve force in the universe has helped me through other people. Also I can say/see that the Devil, evilforce, negative force in the universe has harmed/damaged me through other people. Therefore I can see/say conclude that God or the Devil can work through me to help or damage other people in this world in my lifetime.
Struggled to not act out my sex addiction. Not acting out an addiction means difficult thoughts/feelings start to surface that addictive acts work to avoid/hide/distract. Thus not acting addictively means difficult feelings surface. Unsure / a bit confused. 5 p.m. – 5.30 felt emotional pain about letting go of my obsession. Felt much greater grief later. 11.45: in tears with grief of letting go but feel it is healthy move. Excellent meeting in Armley Prison. One man got 10 years for what appeared to be sexual obsession mixed with alcohol. Sobering thought.

24th April 1993: Very painful day. I experienced a stream of involuntary, compulsive sado-masochistic thoughts/flashes/fantasies. Some thoughts involved me harming women. Felt guilty about these thoughts. I prayed to some 'higher power' for them to stop. They did not straight away but persisted for about nine hours constantly. I felt wretched, awful. Looking into my creepy thoughts was very unpleasant! Anyway I also felt 'this to shall pass' and I was 'doing the right thing'. I voluntarily welcomed the pain of looking into myself now I have stopped acting out 'issues' and stuff are going to surface. I have a gut feeling the only way to progress is through the pain to the 'promised land', the other side. I resisted the temptation to 'act out' and deny my disturbing thoughts. I allowed myself to be disturbed. Shared with R at earliest opportunity as he was working all day. That helped. Also shared my pain at a Narcotics Anonymous meeting. Not ideal environment but I chose my words carefully. The pain was almost unbearable and I felt worse than my withdrawal from alcohol dependency. These thoughts of violence to women, violence to myself, or women being violent to me are not right or fair! There is no-where to talk about these things without others judging me as 'bad'.

25th April 1993: No sado-masochistic compulsive fantasies today, (either as perpetrator or the victim). Read some Sex addicts anonymous literature. Talked with R., who is having a hard time.

26th April 1993: morning dominated for me by sexual fantasy (SF). Wondered aimlessly around. Phoned R. Avoided writing my essay. Afternoon dominated by SF. Felt I was restraining myself from acting out some of this stuff. Came home. Went over to R's and shared for about four hours. Feel returned to sanity for the time being. I am powerless over my sexual fantasies. Lack of power over myself seems to be the main problem. I hope I can be freed from this powerful controlling compulsion in my life. Surely anything is capable of God if I am entirely willing. Samuel Johnson (1759) had same thing from sounds of things. My pursuit of sex interferes with my spiritual development. My sexual fantasies lead me to feeling hopeless, inadequate and suicidal (not good).

27th April 1993: Felt a lot of pain today. Went to therapy. Lot of pain. Wondered why I am in Hell for what someone else did to me, it does not seem fair/just. If God is good, and just, as some commentators suggest then one would think the next life would redress the balance.

I felt inner turmoil and chaos. I felt strongly that I was possessed by an evil spirit and it was winning it's struggle for my soul. Went to bed. Shook uncontrollably. Prayed a lot. Asked God why God did not respond to my pleas for help. Said the word "God" seven times as I thought I was dying – said I rejected Satan and all his evil work several times. Felt glimmer of hope for about 5 seconds. Inner chaos, feeling possessed, shaking, self destructive behaviour.

11 p.m, at 7 p.m. I felt at point of mental collapse. As if I was about to be possessed by the evil spirits that were raging battle within my soul. I felt I had held out to the last and refused to make a pact with the devil for some light relief from the pain of the psychotic episode. I ended up saying the word "God" seven times and holding my hand up. Since then i have returned to a fairly sane state of mind after having a bath and a herbal tea. Strange how one's inner moods and experiences can swing so in a brief snatch of time, but a few

hours. Anyway tomorrow is another day. Perchance that was some kind of test. I don't know but I did the right thing. I did wonder if I had been taken over afterwards but one look in the mirror at my eyes – they were clear and bright as they have ever been, told me about the healthy and positive state of my soul now than any priest could have done.

28th April 1993: A good morning free from the tyranny of unwanted thoughts. I faced essay at two and felt unable to write, a huge resistance, as if I'd been asked to work down a sewer or something. Anyway, from 3 pm to 9 pm the sense of dread returned. I felt uneasy, uncomfortable. I thought reality was an illusion and I was starting to see that in fact I was in Hell as my illusion vanished (reality). Heard a voice saying "I am the new Jerusalem". Wondered what that meant. No one to talk to about these experiences. What does it mean? – "I am the new Jerusalem"? Saw some angels and trumpet in the sky about a book I would write, what does that mean?. Seems a bit weird. Thought "this will pass". Mother asked me how I was, so I told her. She was o.k. about it and I felt better for sharing my thoughts of possession. Wrote end of my essay. Feel "sane" now, but not happy with life at all. Manchester tomorrow. As Jung says, "Neurosis is always an alternative to legitimate suffering.". Me delusions may be alternative to remembering how she abused me. I remembered being bitten by her today. Uhhhh!

29th April 1993: I dreamt I rescued myself, Rapunzel, from a tower in a forest. Today was an o.k. day. Attended lectures. Did some study free of obsessional thoughts. Went to Manchester Sex Addicts Anonymous. Good fellowship. Honest. Got some phone numbers. When I think of society I think "Arhhchnknknk Ah Ah *! Huh ! Arrrr! Oh Waht!? Ahrr! Helhelhelhel"Hell?"

30th April 1993: Very good Day today. Finished my essay. Shared at Young Person's A.A. group. Felt I had integrity. Shared my experiences with C. About benefits of SAA. They want to come to next meeting. Felt attack of obsessional thoughts, handed it over, prayed and it was gone – just like that. Felt strong sense of what it means to be "fishers of men." Interest in Christianity.

1st May 1993: Very good day. Felt freedom from: a) compulsive objectification of women.

b) involuntary sexual fantasies.

c) Felt spiritual strength and integrity as a result.

2nd May 1993: My day was virtually free of sexual thraldom. Worked in Gallery with bad cold. Felt very 'needy' of something when I got home. Phoned L, drove over to share with R. Felt genuine, centred and honest after that.

3rd May 1993: 10:30 Woke. Bath. General reading. Now 3 p.m. Feel a bit melancholic. Still free of sex obsession. I do feel an underlying uneasiness, restlessness, uncomfortable dis-ease within. Intend on finding out what it is and appropriate way of addressing it.

I have felt much that "what now" feeling now my sexual pre-occupation has gone. What is my motivating / driving force now? In theory 'God', in practice I feel no motivation. Maybe this will come. Also practice of the 12 steps.

Freed from thraldom
My soul blinks at the light
It knows not what to do
Stood at the gate, it wants to turn back
Light dawned on me
Dwelling in the shadows
What 2 do now?
Shall I return to the familiar darkness
Is it enough to be free from false gods?
What motivates me now? A vague woolly positivity?
Which direction should I go leaving the pit?????????
What would I choose as my motivation (direction) in life?
My self esteem has reached the new dizzy heights of neutrality.
If one pursues happiness one has lost the chase,
Give up and it will reward the insight
Decision made: to change direction, to turn my 'will' over to ????
What/who could I trust to lead me away from the pit's edge?
I'm bound to fall back in.

Looking for a means of escape from the pit. Voyaging to? We must prepare for death. Human soul. Weather forecast for my soul. Storms on the way. To be prepared to calmly meet danger and risk death.
The problem with soul searchingly testing, defining, rejecting, affirming what one believes, what one's values are through intellectual debate and bookish truth chatter, rational debate and the rest is that it creates in me a quiet consistent accusation that I am a hypocrite, as I have beliefs I temporary hold to but do not put into action (lack of power?) This is the root of my unease considering the ethical or moral dimension, the contradiction between holding moral values for ways of being and me acting opposite to them. Am I just a thrill junkie? Searching for a sense of self worth and value? Does this obsession direct my life?

4th May 1993: Apathy and depression. No motivation in life? What is it all about? Exams in three weeks?
5th May 1993: Natural morning. Thoughts of acting out started to creep in. Phoned L. Phoned R. Phoned A. Tried to fix car. Wrote out a practical programme of action rooted in the 12 steps. Feel ok now. Exams in 14 days!

6th May 1993: Drove five people to Manchester S.A.A. Good share with R. Want to start West Yorkshire S.A.A. meeting. All ok day. I feel I have a problem doing what is right for me (such as study). And also a problem enjoying myself.

7th may 1993: Woke. 2 hour bath. Read SAA literature. Went to A.A. meeting and shared. Felt centred and ok about myself. My relationship with reality, that "clingy thing", is improving.

8th May 1993: Felt free of compulsive sexual fantasies. Felt centred and spiritually sound. 2.15 pm: Eye contact with young female waitress caused feeling of "total well being" – "total serenity" and euphoric feeling beyond belief. This lasted for 10 hours (until now). Shared about this. Suppose this is what people mean by "love at first sight" or "falling in love"? Will keep honesty and 'God-centeredness' as two guiding principle, as I did today. Also saw G and booked venue for Sex Addicts Anonymous meeting in Bradford tomorrow

night. Lot of stigma about the sex stuff – people want to present a front that they are ok. May be they are ok, may be its just me? People judge me, but by whose moral standards are they judging me, their own? Have they experienced what I have experienced?
9th May 1993: held first SAA meeting in Bradford. Me R, C, and J. I do not know where this is leading.

10th May 1993: Started day with a prayer. Sat next to attractive woman as I was late for lecture. Felt nervous. Away with sex fantasies. I got increasingly depressed. Violent thoughts towards women crowded in. Felt more depressed. Numbed out feeling to cope with it. Felt angry. I dreamt last night I was sat on a ledge watching people bellow and suddenly I felt the compulsion to jump off the ledge, lacking power to control my desire, so I grabbed my bags and went back inside.

11th May 1993: A difficult day. Compulsive visual cruzing to lift me out of emotional pain. I was in painful Therapy session today. Did not like what therapist wanted me to address. Is therapy abusive I wonder? Certainly I feel much more pain now and no pay off since starting therapy. Anyway I can always share that it was abusive if that was the case? Phoned L. Thought about buying pornography to get out of the pain pit. Felt guilty about this, doesn't seem the right. Conflict. Tension. Did not act out. Yearned for death. Resisted quick addictive lift out of the pain. Struggled with my self. Fell on the floor crying at 11 pm saying I could not take any more of this pain. Thought I was having a nervous breakdown. Got up again and went to bed. Tried to kill myself. Obviously failed at the task, else I would not be scribing away at my "notes on a failing life". I usually pass things but they tend to be intellectual exercises in head knowledge. Killing yourself is a different enterprise. It is very organic. Not as easy as you would imagine. Big hurdle is I believe it is morally wrong and not fair on those I am related to as it would cause them pain etc. Another problem with attacking yourself violently in attempt to murder your self is that their is always a spy in the camp. I always know what I am plotting against my self and so I also plot against the plan to assassinate myself. "Half in love with easeful death" I am, I think that is from an Elliot poem. I kind of

want it to look like an accident to avoid the guilt and inevitable emotional damage to others. With cutting I'm a bit of a coward and never get very far. With an overdose I think of Caesar crossing the Rubicon and saying "Lets role the Dice!". Obviously I hate myself to try to kill my self. Surely better to kill myself than kill someone else, that would be morally worse.

12th May 1993: I felt very clever today, intellectually. I thought of killing someone. I thought of death. Are my problems normal? What measure should we use? 'Man, the measure of all things"? What to do? What to do? Thought about seeing my G.P., he might have some bright ideas. Appointment the same day. I talked to Dr. C., disclosed a bit of the underlying structural problems with my identity and social relations. He talked in a kind of G.P. style. I felt he was a very good male role model, strong, assertive, reassuring, decisive. He gave the impression he knew what to do with suicidal/homicidal stuff. Anyway, he referred me to someone else – a psychiatrist – Dr. R. on Friday at 9.30. I suspect I have a lot to come to terms with about my past. I also do not like identifying with serial killers, but apparently I do. Very important you deal with this, Ray.

13th May 1993: Emotional pain. Talked with L. about this psychiatric referral – what did he think? What path might I go down?? They might have the answers?

14th May 1993: Psychiatrist asked me lots of questions. I told her the answers. Went back and forth like a game of ping pong. Ping pong. Ping pong. Ping pong. Ping pong. I was honest as she was a professional and I was desperate. The more I told the truth the better she could help me with my probleomos. After a while we stopped playing ping pong. I was desperately hoping she had some kind of solution. She said she could refer me to another service if I wanted, psychotherapy paid for by the N.H.S. – different from the one I go to now. But she warned me that it would get more painful, it might not get better, some theories think therapy is form of abuse and it was my responsibility to decide in the end. She was not exactly selling psychotherapy! Sounded like she had her doubts. Anyway, I thought about the choice, medicine was offering

me a slow painful potentially abusive treatment that might not even work or I could say no thank you to medical intervention and go back to my house and carry on in my dysfunctional hell – on earth way of going about life / painful way of being in the world.

15th May 1993: Started sex fantasy life again as a synthetic elevator out of my painful prison in the world. What about that great offer from the N.H.S.? Lets role the dice! Asked S out for a date. She said no. Panic attacks before and afterwards. Found it difficult to talk / breathe. Later, chaired second Bradford Sex addicts anonymous meeting. Good turn out. Shared with R. after. Very good.

16th May 1993: A profoundly painful and depressed state of mind was my lot today. Thought of having sex as an elevator out of my pain, but decided not to, as it is temporary escape and does not work as with all escapist repetitive excess. I do use sex as a psychological analgesic, an emotional pain killer. Kill bits of me? Kill all of me? Cut bits out of me? May be killing my self is a metaphor? Kill my self and start again? I don't know what the answer is. I went to bed five hours ago as I thought I'd do least harm there. Can't sleep as usual. Phoned L. But he was out. No sign of God yet. What does it mean when you abandon all your false gods, false powers I've been subjecting myself to, and, anticipating meeting God, one find oneself living in Hell???? Where are you God? A Quiet God I seem to have. Regular therapy / counselling tomorrow. Still not decided about psychotherapy offer from NHS. Be assertive and ask Questions about therapy being abusive. Stop people pleasing Raymond! You defer to almost anything, even your therapist!, you wont tolerate the excruciating pain of someone disapproving / judging you, not liking you, of being in conflict with them. You are a coward Ray. Be brave.

17th May 1993: Release at last. 22 years old. Saw therapist/counsellor (T) Shared the pain. Decided to disclose to Mum and Dad about my abuse, etc. Had to do something before I killed myself or someone else. Also shared about cutting self at 7. Lack of communication etc. Was worried my abuser might start on someone else aged 10 now I'm an adult and of no interest to them.

Thought if I do not share and they abuse 10 year old I'd be partly guilty for not saying what had happened to me. Mum and Dad believed me which was great relief. Must have been shock to them. Feel better already. Alcoholism and ending up in rehab at 19 makes more sense to them now they know I was sexually abused for years.

19th May 1993: Today I was less depressed than yesterday. I did not do much though. I was still powerless over sexual fantasy stuff though. Power over my subject seems to be the big issue? Where am I orbiting? My next move wants to be improving my re-alationship with reality. I am at a new beginning. Where is God?

20th May 1993: 22 years old. I felt some freedom today. I am not responsible for how the perpetrator of my abuse feels or thinks as a result of me speaking the TRUTH!

I read that in a self help book if I'm honest, I wonder if it is true or if I believe it. The CAPITALS make it sound dramatic – like a bold statement. Blah blah blah. The power of positive thinking. The power of positive drinking? Three years sober at 22. Some people appear to be 'natural' social human beings in their social world, like they absorbed all the rules young or something, soaking them up from the social sponge. I always felt like an alien from another planet, trying to work out what "primary school" was all about etc., 'how come everyone else knows the rules' I used to think. What was expected was a real puzzle. Rhymes in the playground, "we won the war, in 1944!" - It was like I was from another planet. I cut my hand with a razor aged seven to get in out of the cold playtime. At the time it made logical sense, but now it seems odd. Why did I not communicate my needs in a better way?

21st May 1993: I feel very well. Very centred. No regrets. Read "Out of the Shadows" by Patrick Carnes and made notes. Went out for fresh air and prayer. Sound of woman's voice locked into / triggered my addictive belief system. Had sex addict head on again, or belief system. Fear, sweat, pain, regret. Went out. Found it hard to interpret women's intentions / signals. Seems very confusing / complicated. Felt threatened by women. Were they out to get me? Do me some harm? Want to be with a woman but when they get near I

feel threatened and can not escape. This is before we even speak! Felt sick, panicky. They might come and get me. Fell “into the soup” a bit again, as in, “Decline and Fall”, by Waugh.

23rd May 1993: Struggled to study. Felt Shame of last night’s sexploits. Power of this addiction blew me away. Was rigorously honest and shared at SAA meeting tonight. Meditated for one hour. Shared much. Breakthrough! Relief. I have a false / dysfunctional / damaged belief system around certain problematic issues for me – alcohol, drugs, gambling, which I have changed via practicing 12 steps and abstinence based fellowships. Not that popular in UK as we think NHS will mother us. I digress. Tonight I had insightful breakthrough – I have dysfunctional / damaged belief system around sex due to being victim of sexual abuse from 10. I “act on” my belief system. It is not real. My beliefs are unreal. I need to root out all these false beliefs around women, sex, sexuality and my self. I can now see it for what it is. What do I do with this information?
[there are no entries for dates that are missing, I appear not to have made any diary entries on those days]

24TH September 1993: Sadness has come upon my soul Boundless blue, dense, heavy, blue smog of my heart. Have I now to don detectives hat and deduce from this blue funk what causes this melancholia, and thus fashion an easy remedy? ‘Tis fate struck me a cruel blow, perhaps, I should accept it. Would I were a prince. A fair fight I’d put up then. Wohin ist Gott?

28th Sept 1993: Get organised. Psyche o.k.

27th December 1993: Darkness. Depression. Felt I was possessed by a seven headed serpent daemon last night. 3 weeks now. I felt I was disintegrating. Pain. Longing for death. Self-destructive urges. Agitation. Dislike of my self. Spent Christmas trying to think up alternatives to suicide other than homicide. Must go to therapy, might help? “where are the leaves?, must be dead/ No more weeping.”. difficulty forming and maintaining relationships with women. Unresolved anger. Self-harming impulses. Food problematic.

18th March 1994: Woke dazed and shaky, spent morning trying to balance the caffeine and nicotine levels coursing through my veins. Still felt sickly so had a shave, etc. and felt much better! Missed R's lecture who told me later the feeling was mutual, as no one else was asking taxing questions. Felt weak returning home and stopped for a rest half way. Puzzled 'till I realised it was 5 pm and I had hardly eaten all day. 4 weeks break ahead so need for self-discipline and routine of reading as last break was start of my last depression, which I do not want to repeat.

18th March 1994: About a week ago I came up with the "theory of perpetual choice" – arguing we deny our omnipresent choice by using a language which attributes excessive power to patterns of choice in our past, I used the examples of "Character Traits" and addiction as examples of this linguistic avoidance and objectification of responsibility – a false ideology of historical determinism. T pointed out this had been thought - Sartre and Existentialism. Neither of which I'd read then. I've read some since. Sartre used the same examples – traits and compulsion! Did I think up existentialism independently? Probably not – I've probably read stuff indirectly influenced by existentialism and come to the same conclusions.

My identity is an ongoing dialectical discourse between the views, beliefs and values that I presently identify with and all the 'other' conflicting values, beliefs and views I engage with. For example, my positivist and project orientated belief is heightened by my engagement with and rejection of decadence and hedonism.

How can I break my habits of perception?

I always have choice, within the cultural, political, economic restraints I am enmeshed in. Perceptual choice is heightened by the omnipresent immanence of the ascension and the fall, progress or regression, freedom or submission. (The progression of Time towards Death). My identity evolves through the selective retention of variables, First prescribed, then random, then possibly chosen, I choose to Choose my Culture, a fictive kin of Intellectuals, some dead already.

How many of us exercise the maximum degree of self-direction open to us? Passivity is the easier option. Latent Cultural forces lie dormant, internalised, within the self, such latent forces are awaken when I attempt to asset an authentic Self. Slay the beast!
Sartre says we are the choices we make towards the issue of "being".

19th March 1994: I am directionless. Writing anchors me to a text. I read for seven hours today and then roamed the streets in the rain.
"Addiction and urge are possibilities rooted in the throwness of Dasien"
(Heidegger, 'Being and Time')
"Throwness" – as on a potter's wheel. "Dasein" – H's ontology. "Being there" in the world; searching for a meaningful existence.
Spinning – the world on it's axis and it's orbit, and me on my potter's wheel. In my 'Dasein' I can feel the centrifugal force or pull of urge or addiction. It's always a possibility. I felt it tonight. How am I to interpret these urges, Heidegger? The 'ars interpretandi' depends on what texts I've read. Understanding is circular. Where is the centre? Where is my faith? (the anti-dote to urge?) Will I choose to assert an authentic self? Will I take existentialism seriously? I come out of depression and have no direction! To what shall I commit? If I do not commit, will I be committed? 'A' restored my faith on the telephone. Satellites of sensation orbit my being and I can always orbit them, If I can't find a more meaningful existence.
I have a habit of choosing to give 'urge' power over me. Can I choose not to do this? And thus assert my authentic self? Tomorrow I will try an experiment, I will choose to get up when the alarm goes and renounce the 'urge' to lie in all day, go jogging, and renounce caffeine and nicotine, despite my habit of yielding to my urge to ingest them.

20th March 1994: Got up at 6:00 a.m. Decided not to go jogging. Went back to bed and lay there for eight hours. Got up again and had a cup of tea and a cigarette.
That is typical of me. Living my life in hyperbole. I think of my goals as a house of cards, if I don't get one they all fall down. I wish to pursue goals but not use

them as a means of self oppression. Hyperbole is dust. I will accept partial success in future. I would like to be an “intellectual”, a worker in the sea of ideas. Can I be more than a filter? These continental philosophers sound ok at first, but deep down their is clearly better philosophy hidden within Irish drinking songs. The reason is that when the Irish were preserving scholarly pursuits as valuable and putting gaps inbetween Roman word to improve things Satre and Heidigger’s forefathers were expending all their energies running about in the dark ages trying to catch a wild boar to ‘bring home the bacon’ so to speak. If an Irish drinking song had a bar fight with some continental philosophy it would always win, but it would be a brave philosophy lecturer that would risk such a point – Joyce could see that – “Lots of fun at Finegan’s Wake” and all that: as in, “Tim Finegan lived in walken street, a gentleman Irish mighty odd, he’d a beautiful brogue so rich and sweet, and to rise in the world he carried a hod. But you see he’d a kind of tippling way, with a love for the liquor Tim was born, to help him at his work each day, a drop of the ‘crater’ every morn, wasn’t it the truth I told you? – lots of fun at Finnegan’s wake, he fell from the ladder and cracked his scull, so they took him home his corpse to wake, they wrapped him up in a nice clean sheet, with a bottle of whisky at his feet and a gallon of porter at his head, pipe tobacco and whiskey punch, Tim my love – why did you die?, afits broke out and a bottle o whisky broke over Tim, up he rose and looked around – “thundering Jaysus, did you think I was dead?” – There you have it, the labour to rise in the world, the fall and the resurrection all hidden in a drinking song.

I was stuck in a coffee house earlier when youths fought in the doorway. The blood looked so surreal. Pride kills. A and R are going away so I need to develop some new friendships – outside of the fellowship.

21st March 1994: No cigarettes today. We are confronted with the reality of choice.

I am lost. A satellite without a body to orbit. What is the promised land? The new Jurusalem? What? What? My subjectivity spins from one orbit to another.

22nd March 1994: I awake and immediately ascribe ‘meaning’ to my day. My first dilemma as always, to get up or not to get up? That is the question. I fish

around my psyche for some philosophy to cobble together to get me downstairs, breakfast eaten, washed and dressed.

"The weight of this sad time I must obey, speak what we feel, not what we ought to say."

Went to King Lear. Will's right, justice is a fiction. A fiction we try to make fact. But there's nothing natural about it. I was distracted by a young couple copulating two rows down. ; a 'pleasant youth' seemed to mock mine, and I thought of hanging myself or stabbing myself from 'shame'.

I am unaware of how ashamed I am, of myself. We only notice the moods that pass, if it were icy winter all year we'd not note it. For years I've not stepped outside of shame to note it. From the age of 11 I felt ashamed of every sexual encounter I had. I felt such guilt I wanted to be physically ill. And such fear of discovery I wanted to die. Over seven years sex and death fused into one for me. The "beast with two backs" is death to me. It's five years since I had sex with a woman and I wanted to die then. It was her who'd filled my head with all her talk of sex and slipped her hands down my pyjamas when I was 11 and she was 16 only to scratch and dig her nails into my groin to give her some kind of thrill and me a scrambled brain, which I've still got twelve years later. It was not 'pleasant'. 'Pleasant' I am not familiar with. I wish my past were gone. I feel ill. I'd rather be dead and I feel ashamed of that as well! I'd like 'pleasant' instead of 'not-suffering'.

I went for a walk to get some peace of mind and was attacked by an Alsatian 10 yards down the way! It ran off when I kicked it, but I'm shaking like a leaf. I don't want "sex". I had "sex" for seven years and it drove me mad. I could have sex for £20 down some dark allay off Lumb Lane. Dogs want and have sex. No. What I want is to go to bed with someone who does not hate me, who did not bite and scratch me and tell me I'm going to Hell. (Animals do not do this to each other!). I would like to have some affection. Is that asking too much? I have not experienced "affection" and it is probably "pleasant".

23rd March 1994: I have just read yesterday's entry. I can't recognise myself. Did I write that 24 hours ago? I feel great now. I went to King Lear with T and had a very pleasant evening. I must read "Dr. Jeckle and Mr. Hyde". Was that me yesterday? I read Lear today. Edmund's speech about the 'globes' and

Astrology is existentialist. Power shifts between generations. The break with 'tradition'. "Beware language" is what it says to me. How far do our eyes pierce?

Such a bout of self-pity I had last night. It seems there is an 'identity' I can shift, subjectively into. Objectively nothing alters but subjectively I take on the persona of a tragic figure. A paradigm shift. I feel confident now and at peace.

24th March 1994:Being = Choice. Confronted by choice I try to avoid it. Referring to my ' past' is an attempt to deny my future potential. Addiction is the extreme form of referring to the past. 'Being' asks 'what shall I do now?', perpetually. The inauthentic 'being' self references to its past – that already achieved or experienced, and so "safe", accessible, ready at hand, convenient, familiar, and chooses not to move on to new potentialities but to REPEAT something and so live in-authentically.

Repetition is always a possibility of 'being' – a denial of the self. It is always the easier option. I must renounce the familiar if I am to become authentic.

I need a guiding principle? – God's will?

Which means:

1. prayer and meditation to know God's will and for power to practice it.
2. Moral inventory to separate divine from non-godly aspects of being
3. Confession and atonement
4. Renunciation of ungodly, inauthentic being.
5. Theological existentialism. Full potential = to realise the God within.

24th March 1994: Talked with A last night about philosophy, economics, theology and my bouts of self pity. Engaging and fruitful as always. Stayed the night but could not sleep with so much caffeine and nicotine coursing through my veins, so I read Sartre's "Existentialism and Humanism". I like much of this philosophy and intend to apply it to my life, although I tend more towards theological existentialism. Read Ezra Pound, then went to Lear for third time this week. For me its about the power one generation should have over the next, and the tragedy that can come from abandoning tradition for selfish reasons. Its also about the danger of language – that can deceive, and when actions do not mach words.

"...the yoke / Of the old ways of men I have cast aside" (Ezra Pound)

I ‘project’ myself into my future by the choices I make, and thus resolve the issue of being. I need to choose to commit to my projects, and by my actions realise them or die trying. Dreams are dust. I “value” a “way of being” by choosing and acting on it, as an example to others. I choose what texts to read and how to interpret them. What counsel to seek and what to ignore. I choose how to act and what goals to pursue. I cannot rely on what others may do, as they do as they please, thus Sartre talked of despair, a bleak realism.

“And the days are not full enough
And the nights are not full enough
And life slips by like a field mouse...
...not shaking the grass” (Ezra Pound)

I am crushed, I am 23, I suffer. A weight. I want to kill my self. Will I be the same when I am 43?

25th March 1994: I need to equate the choices I now make about what activities with what I will become. I need to bring to bear the weight of my future upon my present. My actions are not only an example to others, but in valuing that behaviour I am an example to my self.

My being has many possibilities. I must choose today what I am - And everyday.

What is called “addiction” is a possibility of being. It is an unwillingness to feel anxiety. An always referring back to some repeatable sensation, always unsatisfying, one chooses to repeat into a vertigo of endless repetition. Trapped into a circle without a future. Going nowhere. An unwillingness to feel anxious.

I am wondering whether to spend the summer reading or would that be obsessive? Should I prostitute myself to some capitalist in a so called “job”? – that is much more ‘acceptable’ than trying to educate oneself. I’ll see how the next three months go.

28th March 1994: 6:00 a.m. Woke and escaped into daydreams for eight hours. Shopped. Read for 2 hours. Ate. Escaped into television, hypnotized by images for 6 hours. Then started smoking again. What a day. Passivity. A ‘non’-day.

Q: Why? A: It was the **easiest** path.
What was that passivity about? A backlash to my existentialism? Whenever I form a plan an 'anti-plan' also always forms, and the 'anti-plan' has more power than the plan! Lack of power over my self appears to be my problem. I am a land full of battles but the bits I loosely group together and call my self (the bits in the battles I identify with) are always loosing the daily battles I have with the other bits that land on my island and leave, regroup, attack, taunt, leave, revisit, I am a small part of me holding out in the fog of war, why am I always losing the battle for control over my self? Other people appear in total control of themselves, no signs of a battle raging within them?.

26th March 1994: The text of my life, my creed, that which I believe in, which gives meaning to my life, is dissolving, deconstructing. The sentences and words separate and I can see nothing holding them together. Nothing behind. Nihilism. I don't see a good reason to believe in anything. Maybe this is a stage I need to go through? Life seems absurd. I am committed to nothing. I am on the outskirts again. Not depressed. Wohin ist Gott? The texts of my life are slipping away. I am dissolving into meaninglessness. I must choose some meaningful view.

27th march 1994: Nature is an eye-sore. Felt good today. Read for six hours. Haven't smoked for two days now. Just a matter of exercising choice. Heidegger says in inauthentic being and addiction we are always already alongside our being, i.e. trapped in circle without a future. Always referring back to our past.

29th March 1994: Went to psycho-therapy as usual. I talked of being fed up with being non-committal about my world views. I hop from one philosophy to another and am lost in a sea of relativity. I think it is time to commit to one way of looking at the world. I am acquainted with a few: communism, fascism, anarcho-capitalism, Welfare Capitalism, a smattering of world religions, but the one I most admire is Christ's message in the Gospels. By 'commit' I don't mean blind dogma, like the evangelicals appear to mean, but free, critical choice.
Here is my interpretation of St. John's interpretation of Christ's message:

In the beginning was the Word, and the Word was with God, and the Word was God. My body is Christ's sanctuary, look after it. Be born again. Remember John the Baptist's humility, Do God's Will (LOVE) and don't sin, and you will walk fearlessly in the truth. Spiritual thirst is quenched forever by the word of Christ. Spiritual hunger is satisfied by doing god's Will (labour for LOVE) not one's own will. If you really want to be healed "get up" and sin no more. Let Christ live in you by acting on his message, Judge according to rightness (depth) not appearance (surface), Validity is knowing where you are coming from and where you are going. To sin is to choose slavery, sin is slavery. Let him who has not sinned cast the first stone. The truth shall set you free, act not as you were conditioned by men, but as God wills, Live life to the full in Christ, choose to lay down your life and then take it up again in God's name, remember Christ quoted "you are gods" (10:34) In this life you will have trouble, also Christ 'wept', was 'distressed' and had 'a troubled soul'. Christ washed his disciples feet, Christ gave his disciples the power to forgive sins, You are a branch of god, bear fruit, and be pruned by the word of God to bear more fruit.

30th March 1994: My interpretation of Mathew's interpretation of God's will: Judas sold Christ for the price of a slave, and Christ suffered death on a cross and rose again to life, the inner (depth) life matters not the (surface) appearance, Love God and love others as you love your self, Forgive each other, Better to be drowned with a mill-stone around your neck that interfere with children, become childlike, take up your cross, The gates of the underworld symbolise its power to keep captives, Peter sank as he doubted, The kingdom of heaven is a treasure hidden in a field, Banished daemons may return, JTB preached repentance and forgiveness of sins, Jesus was tempted in the desert for 40 days and did not yield, Love your enemies. The thought of sin needs to be dealt with as well as abstaining from sin. The eyes are the window of the soul, be reconciled, go by the hard road and the narrow gate, I cannot be the slave of two masters, choose God or Mammon. Happy are the poor in spirit, those who grieve, the persecuted.

31st March 1994: My interpretation of the translation of Mark's interpretation of Jesus' interpretation of God's will: Forgive others so God may forgive your

failings. Physical separated from the spiritual in terms of healing, divides man's way of thinking from God's way of thinking, Renounce your life, take up your cross, and live a new life. Some possessions can only be driven out by prayer, put your self last, a-hierarchical, Let the Holy Spirit speak through you.
And Luke: Your faith can save you. Detach from your past life, take up your cross and follow Christ, Property ownership secures nothing, give up your possessions to the poor, why not judge for your self what is right? Tragedies happen to anyone, it rains on the good and the bad, Some people mature later with a bit of love and support, try your best. Of 10 lepers, one thanked God.

April 1st 1994: Went to Bach's 'B' minor mass. R was singing in it. Very good only Bach's not my kind of thing, Too repetitive and safe, represents traditional theology apparently. Had very good talk with A. Helped to ground me again. I spend so much time reading I can lose touch. Anyway, I think liberation theology is the way forward for me.

April 2nd 1994: I have such hunger I fear it. I fear I will devour myself trying to satisfy it. What do I 'hanker after'?, what do I wish to entomb in my stomach, or mind or soul? I know not what I crave. I long for something. Something within cries out, but is it satiable?, "Satisfaction" refers to the atonement or reparation (repair) of an injury or wrong. Repayment of a debt. Is that why I always hanker after something more, trying to satisfy my unhealed wounds? Pouring repetitive acts into bottomless wounds. Or is it a desire for wholeness? To be 'at-one' with God, often mis-read as concupiscence.
What will satisfy my soul? What foolishness will I engage in trying? Why does nothing satisfy? I hunger on. I am too foolish and blind to let God's Grace in.

7th April 1994: What am I doing with my Life? Woke up this morning to a phone call from R, whom I have not heard from in six months asking If I would start a sexaholics anonymous meeting in Bradford. Why hadn't he come when R and I had started the meeting which folded? "Denial" he said. I shared with him where I was at, but am not willing to commit to that meeting a second time. I wished him well, but for me it is just a symptom of the underlying structural problems of the self. An ill constructed damaged self like mine is always prone

to structural implosions and tectonic shifts, reformations, etc. The solution eludes me, obviously not accessible via intellectual effort or I'd have got their by now. Must be another way into the mountain, but what? What chant will turn my base metal into gold?

After Narcotics Anonymous walked C back to her house, no sign of the lads who had been harassing them for being white / gay / women or what ever? Another situation where I need to tread carefully. (over what I say and why and how) care and tact. With C I brought up the subject of how certain situations can be dramatized into high theatre, and those playing the role can be caught up in the (adrenaline) action which always refers to itself, and the increasingly tense imaginings as to what the next scene will bring. They need to walk away from it. A offered them a room. If a conflict becomes your raison d'être then its resolution is a threat of death. I did not say that, as I thought I might be assuming too much or sympathising too little, but I think it is true.

Why am I so self-centred? *What is my raison d'être? What theatre am I engaged in that I am unwilling to walk away from???*

8th April 1994: Nice Meal with A, J,J and A at Jumbo in Leeds. Felt fed up walking home. Fed up with how I've been. Too much talk, theory and not enough practice. What I do seems like so much theatre. Identity Crisis after Identity Crisis. Re-running the "I can't cope" and "I want to die" scenes over and over again. I just need to grow up and walk away from all that. Just do what I need to do and stop talking about it. I'm like an alchemist searching for the philosopher's stone that will turn my base metal into gold. I need to stop studying the maps and start digging. Stop talking and start living. I am fed up with my self and all my talk.

10th April 1994: My central problem over the last three and a half years has been the "prodigal son" syndrome. I believe my first experience of this was when I joined Alcoholics Anonymous at 19 years old after five years of decline and fall through heavy drinking. The change was dramatic; I struggled with a major problem, and with help, renounced my past life and celebrated the prodigal son's return at weekly meetings. But then what? Getting on with life with its routine problems and gradual progress and set backs of concrete

everyday reality and being basically o.k. seemed too 'ordinary' by comparison. I yearned to re-enact the drama of the grand struggle and survival. So from time to time I manufactured my own crises. Not consciously, but habitually. My anxieties about my future, my identity crises, my suicidal depressions, my feelings of possession, not attending lectures, delaying reading and writing my essays until the eleventh hour, dragging up my sexual abuse (which needed to come out anyway), joining Sex Addicts Anonymous in Manchester for a while, all of these may be my re-enacting the prodigal son role. Rejecting my day to day reality of being o.k. and just getting better as a human being gradually now, growing impatient with this and hankering after some promised land, some spiritual perfection, and when that did not materialise regressing into some problem long enough to struggle out of it again with a sense of achievement. I need to stop doing this. Accept that basically I am o.k. and just do what needs to be done and grow up.

13th April 1994: I fear what I am becoming. Despite my desire to be alright. I dislike myself more. I seem to be getting worse. What am I doing? Waiting for Goddot?

14th April 1994: I think I am having a prolonged adolescence. My identity Crisis is normal. I am looking for some purpose, meaning and direction in my life. I am lonely. I would like a partner and some intimacy.

15th April 1994: I'm accepting I'm o.k. Getting on with Study. Feeling connected again. Giving up hyperbolic thinking. Also need to remember I can negotiate my boundaries at any point in time.

16th April 1994: I feel a new lease of life. Having walked away from hyperbole and accepted I'm o.k. I feel a creative life force rising up within, wanting to get out and express itself. God's Grace perhaps? Anyway its 1:30 a.m. and I'd rather get some sleep. This is the new "me" I've been praying for. "This week piping time of peace".

[No / or missing entries for next five months]

8th October 1994: I'm feeling much better. I'm confronted by choice. I am able to think. How hard do I want to work? I am no longer in the Gulag. Guard in ya treasure hunt - c, Sab a tour de force.

Appendix III

Clinical Notes for Ray Middleton Spanning seven years: (28th May 1993 to April 2000)

28 May 1993: Letter from psychiatrist (Dr. R) to G.P. re: Session held 14th May 1993:

Dear Dr K,

Thank you for asking me to see this interesting 22 year old man who told me about his alcohol dependence, drug abuse and even compulsive gambling in his early teens. He described all of this as self destructive behaviour and that even though he has conquered all of these he still has the same feelings. He tries to deal with them and usually can come through the bad patches but he is having a particularly prolonged one at the moment. He has suicidal thoughts and sees himself as being shot, dying or crashing his car. He has noted decreased motivation, feeling a bit depressed and feeling emotional pain from the past.

He said he was sexually, physically and emotionally abused by a woman when he was 11 and for a prolonged period over the following seven years. He now has angry feelings towards many women he meets in different situations. This has never been revealed to his parents or anyone else. He said emotional pain has always been there but he has been lifted out of it by drugs and alcohol but never on a permanent basis. He no longer wants to avoid this – he wants to go through this and "come out the other end and enjoy life".

Personal History

He was born in Leeds and has always lived in Yorkshire except when he hitch hiked around Canada in his late teens. He is currently living at his parents address as he has glandular fever and has returned from University. He thought his childhood was ok but has recently reassessed this and decided he was bored at Junior school even though he was seen as a bright child. He always felt an outsider, an observer and cold. He remembers at the age of about 6 cutting his hand with a razor blade he had stolen, in order to get in from the cold at playtime – he said that he could have asked to go in but he did not – instead he displayed this bizarre behaviour and unfortunately "it did

not work". He went to the Senior School where he seemed to be popular but he even questioned this as a meaningful interpretation. He obtained 'A' levels and a place at University but decided instead to go abroad. He returned and got several jobs and then another place at Newcastle University to do Business Studies. Three weeks into that he left because he was spending several hundred pounds on alcohol. He has had no relationships with women since the abuse stopped when he was about 19. His friends are mostly those he met through alcoholics and narcotics anonymous.

Family History

His parents are in their mid forties. He has two younger brothers and a younger sister still living at home.

Social circumstances

He used to live in a house with some friends but moved back home when he was poorly. He is about to purchase his own house. He neither drinks, smokes, nor takes illegal drugs. He said that being in a pub is not an issue any more.

Present Mental State

Mr Middleton was a casually dressed man and looked his age. He sat sideways for most of the interview although he did look directly at me as well as looking at the floor and into the distance. He did not seem to be intimidated by me or hostile to me although he described how he can feel very aggressive to any women who is the right age (between 17 and 24) who goes past him in any situation. He was clearly thinking and able to give very thoughtful answers to most questions. He was not anxious or agitated and though he said he thought he was depressed at times, objectively his mood was euthymic and there were times when he could smile appropriately. However, he described not having much enjoyment in life and at times feeling weighed down and under tremendous emotional stress.

It seems that he has felt alienated, isolated and distant from other people from a very early age. It also seems that he never been completely satisfied with his life and his part in it and it may be that his addictive behaviour gave him "temporary elevations out of that" but unfortunately they never lasted. Also again his hitch hiking around Canada was something he did again to run away but "I was always there at the end of it".

He described his childhood abuse in that the sexual pleasure would lift him out of his emotional pain, but the pain would flood back once the sexual acts were over. He said this would go on for several weeks, then she would reject him or he would explain how it was hurting him and she would give him a break for a few weeks and then it would start again and he described this pattern of enticement and then rejection which must have occurred 70 or 80 times over the seven years. He now feels pain, hurt, guilt, anger and fear.

He has no abnormal beliefs or experiences but he does get very intense inner distressing feelings which he describes as torment. He has on two previous occasions, aged 15 and 18 taken overdoses.

It seemed from his descriptions that he understood quite well the reasons why he was feeling the way he was but seemed eager to understand more and particularly to look at his childhood, his feelings and his relationships and how they developed from being small.

IMPRESSION

I do not think that Mr. Middleton has a mental illness. His description suggests that he has also felt alienated and has not felt as though he fully fitted in in terms of the people around him, both family and friends. He is questioning his early life and what he got out of it. He would like to feel differently about that. This is all complicated by the abuse which started when he was 11 and it was possible in this setting that the other addictive and compulsive behaviours occurred. He still has very painful memories and emotions as a result. He would like to work towards a better acceptance of this and would also like to think that one day he could have a normal and balanced relationship with a woman.

SUGGESTIONS FOR FURTHER MANAGEMENT

I suggested two options – one being contact with the therapist who works with male victims of abuse; the other being a referral to the psychotherapy department. He chose the second option and I will therefore send a copy of this letter with a covering letter to my colleagues there who I hope will see him with a view to further work. I have not arranged to see him again.

Yours sincerely,

Dr. R.

1994 to 1995 I attended weekly psychotherapy: Currently no notes sent from psychotherapy department, despite my request under the data protection act.

[age: 24]

04/01/1996: Clinical notes from inpatient psychiatric hospital admission:

Urgent referral from BRI (A&E) to whom he was referred by GP, Presenting Complaint: Overdose.

On 03/01/1995 took 8 tablets of seroxat + 10 pints. On 04/01/1995 took half bottle Kaline and Morphine, 10 pint of alcohol, melted boot polish strained through filter paper and cough mixture. Has Good insight. Previous diagnosis of Bipolar Disorder MDP.

Reasons: 1) "sort of suicide attempt only hoping to make it look like an accident because I felt guilty about committing suicide due to the affect it has on it has on other people", "I don't know why?".

2) "I have this idea – I have self destructive feelings – to harm myself"

3) "I was thinking too much – this leads to my psychological problems. I was trying to perform a chemical lobotomy so I wouldn't think as much and I would be happier. Although I seem to float in and out of partial insight.

....Also at Christmas took overdose of ecstasy and amphetamines. Has alcohol problem since age 13. Age 19 admitted to Alcohol Rehab Centre. Four and a half years sober after this. Drinking now for one year in very destructive manner. Had planned to go to rehab again....

Previous Psychiatric History: Bipolar Affective Disorder Diagnosed in august 1995 by G.P. Commenced on Lithium by GP after consulted psychiatrist.

Prior to this seen by a Psychiatrist 2 years ago at Uni – Thought he had Personality Disorder. Suggested Psychotherapy. Going for 2 years. Thought he was getting worse. Stopped three months ago. Raymond feels he get depressed every 6 months when he would visit G.P. Feel he had BP [borderline personality + Depression] since age of 10 when he was being sexually abused by older female. Parents did not know. Under lot of stress then. Bitten by her. Cut wrist aged 15. Occasionally self harm, e.g. hit fingers with hammer when feeling self destructive.

"I recreate dangerous situations to harm me, but if it does not happen, I harm myself." – "It's like I want to be punished."

Drug history – Seroxat 20 mg OD – initially June 1994 – takes intermittently. Stopped Lithium due to side effects (Aug – Oct 1995). Also takes illicit drugs – MDMA (ecstasy) and amphetamines. Smokes 20 cigs a day, Alcohol – 10 pints of larger a day. Can go without for a few days.

"I don't get angry, Aviod situations, Rationalise it."

Aged 20 he told parents about sexual abuse. Gets on well with family. Has resentments.

Pre-morbid Personality: Cleaver, precocious. "Bored to death" at school age 6-7. Difficulty communicating – did not know how to play games such as football but excellent at other areas e.g. in religion class – gave synopsis of Darwin's theory of evolution age 7. Age 7 cut hand with razor blade in playground because he wanted to go inside as playground was cold... "I resent being clever."

Personal history: Age 5 -11 – "Terribly boring" Age 11-18 "ok" (had separate worlds e.g. school was one, home was another) Age 18 went to Canada hitch-hiking, alone, for one year, until no money. Worked as labourer on Channel Tunnel. Then Newcastle University – Politics. Stayed three weeks – "Breakdown" – Alcohol related, hence Alcohol rehab aged 19. Next 2 years worked as drugs councillor. Then assistant chef. Then made chess sets. Voluntary and paid work for Oxfam. Bookseller in a Gallery. Then Degree in Sociology and Social Psychology – Graduated with First Class Honours. Then Financing his PhD on Addiction by teaching part time at University. Finished 10 weeks teaching seminars and planning to do Chapter two of PhD.

Relationships: One week relationship with female 4 months ago. "she wasn't violent or anything, no danger there" - looking for association of danger with relationship.

Mental State: Well dressed.

Mood – "Subjectively – "Bit detached and harbouring self destructive thoughts" Objectively: Low, smiles, laughs, suicidal intent present. "thoughts of being tied up by ropes, jumping out widow or from train."

Thoughts – "for long time had usual thoughts of suicide, e.g. being shot, hanging myself. Often just didn't take notice of them, they were just there."

"Sometimes I feel I am possessed by an evil creature inside me. Struggle going on drawing on religious symbolism. Arch angel is struggling inside me with a

demonic being." He is grimacing and curling his body up knowing this is going on inside him. Has partial insight. Occurs 4 to 6 months out of 12.
August 95 - Believed he was Karl Marx, Fredrick Niche, and 'the new Jerusalem' when manic etc. and paranoia that he was about to be arrested and images of hell behind him (6 months ago) as hell falls away at his feet. (monthly) - "Two police officers coming to my door to arrest me" (pseudo-hallucinations).

Feels entrapped to do things by external forces but manages to prevent himself from doing these things. E.g. violence towards women or stabbing someone – this led to a psychiatric interview at Bradford Uni by female psychiatrist [1993]. Never acted on violent thoughts – Never hit anyone - either male or female.
Perceptions – Visual hallucinations – seeing himself falling out of a window whilst tied to a chair screaming – this is now, whilst in this room having this interview.
Insight: present.
Impression: Psychotic Depression + Alcohol Dependence
Plan: Admit + Urine drug screen + Symptomatic relief for tonight.
05/01/1996: Contacted Psychotherapy department – has been client of psychotherapist since 1994 – Stopped attending Autumn 1995.
Referred to psychiatrist R in 1993 – No mental illness present at that time. Thought sexual abuse had led to drinking problem. August 1994 seen by psychiatrist Dr W – "Depressive illness due to sexual abuse" – referred to and commenced psychotherapy. August 1995 – Diagnosed Bipolar Affective Disorder. In manic phase. G.P. prescribed haloperidol then lithium – she discussed case with a psychiatrist. Old notes from '93 obtained. Chasing other leads.

Interviewed Raymond 05/01/1996: Feeling persecuted by something / vague / 'a force' – "I think it is my abuser, also it is more general" – "No one in particular at moment" Increased anxiety – 'wound up' "feeling like someone might approach me and harm me." (no change from being in hospital from being out of hospital)

Feel it is unfair. Get resentful that I feel persecuted because I haven't harmed someone. I was harmed. Things are the wrong way round. Where my abuser seems happy and well adjusted. Don't know this really – haven't seen her for 5 years.

Hence. If I tracked down my abuser and killed her it would be a cathartic experience, old testament – 'eye for an eye', If I shot her then that would relieve me of my suffering. Then I would suffer – I'm quite a moral person really.

I feel like I've been thru a lot of emotional pain since I was 10 – Actually my symptoms didn't start till I was about 12. The point I was getting to – I probably feel guilty about not shooting my abuser so I condemn myself to this suffering.

Main problems today: 1) Anxiety 2) Feeling persecuted 3) Guilt

Contacted psycho-therapist – story confirmed.

Plan: haloperidol 10 mg tds, lofepramine 2 nocte *Observations*: To stay on ward.

08/01/96: Interview: Feeling more relaxed in hospital environment. Had bad reaction (ESPE) to Haloperidol after 3 doses of 10 mg. Needed P.O. then intra-muscular Procycladine. Now refusing further neuroleptic. Mood: Calmer Thoughts: "Lack of Trust between myself and myself" – "I do not Trust myself to do inappropriate behaviour" Insight: Present.

Plan: Continue.

10/01/1996: Last well in July, probably manic – wrote a chapter of his PhD, working 12 hours a day – Bipolar problem. Seroxat led to high mood, then depressed episode again. Probably a three monthly cycle. This summer being "up" was problematic for first time. Believed he was Karl Marx. Mood at present: anxious and somewhat depressed. "persecuted and tortured" – especially at night. No suicidal plans. Misinterprets illusions at night. Drink and Drugs – admits he's used them.

15/01/96: "Been alright" except sat night, felt persecuted. People coming to get me. Strong sense of guilt. Self destructive feelings then. Feels fine today. No suicidal feelings. No psychotic phenomenon.

Plan: Continue.

17/01/96: Alcoholic binge yesterday whilst on leave. Regrets this now. Review meds. Plan for weekend leave to parents. Hopefully discharge week after next.

Mood: Bit low after alcoholic binge. Happy with Chlorpromazine / lofepramine. No persecutory ideas / no suicidal ideation.

19/01/1996: Asked to see. Increase in persecutory ideas. Believes he is being persecuted by a sadistic woman, possibly his abuser, possibly from another planet via telepathy. However Raymond has partial insight and can see these feelings "may be symptom of some sort of mental health problem".

Plan: Add 25 mg of PRN Chlorpromazine.

22/01/1996: Feeling unwell. Persecutory thoughts. "Heterosexual thoughts predispose me to feeling down" Conspiracy to get me. Had panic attack. Don't want to eat or see other people. Chlorpromazine helps. Sleep worse.

Plan: Increase Chlorpromazine.

24/01/1996: Observed to have visual hallucinations today. Aggressive towards inanimate objects yesterday – punched a punch bag. It helped. Increase Clorpromazine to 300 mg + PRN

24/01/1996: Very tense. "Feel I'm being tortured" Instigators? – Imagined. Mood fluctuates. Feels grip on reality varies. Doubts at time he is on Ward three. Felt ideas of self harm this a.m. "as a way to get out". No more alcohol. Not to leave ward unescorted.

29/01/96: Well. Wanting overnight leave. To discuss with Consultant. No psychotic features, no persecutory ideas, no suicidal ideation. Discharge soon. [was then discharged]

23/02/1996:

ADS Acute Day Hospital assessment:

What are your main problems?: Homicidal and suicidal thoughts (involuntary) + feelings of persecution.

How is this affecting you?: I get fed up and depressed. Think about suicide.

How did it begin? I was sexually abused by an older woman for a number of years from the age of ten. That's what seems to have caused my present difficulties.

What do you do now that helps? Go to sleep for an hour.

Have you had similar problems, how did you handle it? Yes, for past 10 – 12 years. Used to drink alcoholically as a coping mechanism.

Do you have any health problems? I worry about having a heart attack – although this is unlikely as I am only 25 years old.

What medication do you take? Lophepramine, procycladine, chlorpromazine.

How do you usually cope with problems in general? As best I can. I ignore them until the last minute.

At present, how do you see your future? Unavoidable.

Patient's presenting problems:

Raymond complained of various problems including feelings of guilt from being abused as a child, alcohol abuse, suicidal ideas, paranoid thoughts, stress from being unable to switch off from his PhD work – we talked about other community resources which might be more appropriate. ***Brief history*** – has drank excessively since age of 13, feelings of persecution and sees "visions" – unsure if hallucinations or just vivid imagination. Has various emotional problems. A doctor once told him he was "manic depressive". Shows a lot of insight into his problems. Lives alone. Has supportive parents.

28/02/1996: Inpatient Hospital Progress Notes:

Mental state: Feels guilty and restless when sees heterosexual couples. Angry, agitated, mood lowered, depressed.

Goal: To enable Raymond to come to terms with his depression and to work through it.

Intervention: Key worker to form therapeutic relationship with Ray, give medication and monitor effects, allow Raymond to ventilate thoughts and feelings, Advise stay on ward for first 48 hours, 10 minute checks to maintain safety.

29/02/1996: ADS Acute Day Hospital Progress Notes

Raymond was admitted to ward 3 yesterday. He was extremely distressed and presented himself to the police. Ward staff felt it was too early for me to see him.

29/02/1996: Ward (Hospital) Clinical Progress Notes

Is a little embarrassed that he has had to come back into hospital and feels a bit of a failure. Nursed 10 minute checks.

01/03/1996: Maintained 10 minute checks. Has not slept throughout the night. Complained of images of people every time he closed his eyes. PRN procycladine given.

01/03/1996: Observed to be very agitated at 7 pm, pacing about, with bloodshot eyes. I spoke with Raymond who said that he is feeling very tense and "angry and resentful". Raymond questioned whether he would ever get better. He said he would sit outside to attempt to calm down. After half an hour he was still agitated so duty doctor contacted, PRN 50 mg chlorpromazine prescribed following examination.

07/03/1996: **ADS Acute Day Hospital Progress Notes** We agreed to a programme of pottery initially + he will talk to me if he is not coping.

08/03/1996: Attended pottery executing excellent work. Mood and interaction appropriate.

13/03/1996: Ward clinical notes: Ray discharged today. Ray to carry on as normal as an outpatient.

[age:25]

1st April 1996:

Dear Dr S [GP]

I reviewed Mr middleton on 22 March 1996 following his recent discharge from [the psychiatric hospital].

On the whole he has been coping relatively well although he continues to complain bitterly akithisia and I have therefore added procyclidine 5 mg. He is still attending ADS [Day hospital] with benefit and I will see him in one months time.

Yours sincerely,

Dr. J

Consultant Psychiatrist

18th April 1996: Dicharge summary from psychiatric hospital:

Date of admission: 28/02/1996

Date of Discharge: 13/03/1996

Circumstances on admission: Raymond telephoned the ward and stated that he was feeling depressed and having suicidal thoughts. He had been

having suicidal thoughts for 5 days, they were very intense and he wanted to throw himself in front of a bus or take tablets. He also felt like killing somebody.

Personal History: Well documented in previous correspondence.

Mental State examination: Was casually dressed, not very well kempt man. Bit anxious and agitated, good eye contact, good rapport, speech clear and coherent and occasionally stressful but very cooperative. His mood was low and flat, thoughts preoccupied with suicide and to harm someone. Feelings of guilt and restlessness to see heterosexuals. His concentration and orientation normal, he was anhedonic and had no hallucinations, no delusions. Poor appetite and disturbed sleep. Suspicious of being followed and trapped. He had suicidal ideation but no active plan.

Physical examination: His physical examination was unremarkable. His serum bioprofile, Thyroid function and full blood count all fall within normal limits.

Follow up and treatment on the ward: During his stay on the ward...his appetite increased and he could sleep well. His disturbed thoughts of suicide and agitation disappeared. He started settling, he could communicate well and started asking for discharge. Before discharge he was sent on trial leave. He had a good leave and had a tendency to remain isolated. There was no suicidal ideation and he was discharged on 13th March 1996.

On discharge he was prescribed lofepramine 210 mg at night, chlorpromazine 200 mg tds, procyclidene 5 mg tds.

Yours sincerely,

Dr. B

SHO to [Consultant Psychiatrist]

16/05/1996: Day hospital clinical notes:

Main stress area: Problems due to abuse. He has used avoidance techniques previously but is trying to deal with these issues more positively. This causes a lot of anxiety which leads to negative thoughts of harming himself which he feels he has no control over.

Lifestyle patterns: Abused alcohol since 13. Avoided looking at personal issues. He uses his studies (PhD) as a means of escape from his own thoughts

but this causes problems as he puts a lot of pressure on himself and expectations.

What can they do to help themselves? Raymond has a lot of insight into his problems. He has started realising his negative thoughts only last a short time and is using diversion coping strategies. He acknowledges that he spends too long studying on his PhD but finds it difficult to do activities for "fun". But is attending ADS [day hospital] regularly to develop these skills.

14th June 1996: Letter from consultant psychiatrist to GP:

Dear Dr S,

I reviewed Raymond, as previously discussed, on 13th June 1996.

He was adamant that he now felt considerably better and was merely going through a difficult phase when he saw you. He denied any psychotic symptoms and seemed relatively settled. I have explained to him that the situation does need monitoring and it is important that he does approach staff, for example when he attends ADS [day hospital]. For the time being I have not altered his dose of chlorpromazine. ADS have kindly agreed to review his programme and this may be a way of providing additional support.

I have provided him with some Uvistock Ultra-block cream as his photosensitivity (Chlorpromazine induced) was rather obvious today.

I will see him again in one months time.

Yours sincerely,

Dr J

Consultant psychiatrist

[age:26]

13 / 02 /1997: Referral to Social Services Day-care:

Diagnosis: Manic Depression.

Reasons for referral: Day-care would reduce isolation and boredom as he has nothing to keep him occupied during the day. It would create new interests and enable him to make new friends and reduce anxiety.

26 / 02 /1997: Student Social worker assessment

Social History: Although he enjoyed University and studying he feels that returning to this may be too stressful. He would eventually like to return to some form of employment, but not sure what.

He enjoys the theatre, opera, talking to people, handicrafts, etc. He used to enjoy reading, mainly for academia, but finds if he tries this it brings on anxiety which he relates to the stress of university life. Ray feels that to combat boredom he would like to make new friends, learn new skills, ie, painting, drawing, art.

Care Provided: Ray feels his family have coped and still cope very well with his problems, however they find it stressful when he is in hospital. He does not feel that they pressurise him, but occasionally through good intentions, i.e. by suggesting employment they cause him some stress. .

Summary of Needs: Ray needs day care. To relieve boredom, isolation, make new friends and find new interests. Ray would like to build up his self-confidence and decrease his isolation in a safe and supportive atmosphere, with an awareness of his difficulties forming relationships with women. In the future he feels he may like to undertake some voluntary work.

Psychiatric History and present condition: When unwell felt persecuted that everyone was after him, and depressed. Had two admissions to hospital after overdoses and suicidal ideas. Previous to this attending counselling at Relate and University of Bradford and Alcoholics Anonymous. Problems stemmed from sexual abuse by older woman. He feels very well at the moment with occasional bouts of anxiety which he feels when he is under stress.

Medication:

Chlorpromazine 200 mg

Procycladine 5 mg

Lofepramine 210 mg

Self medicates.

Personal Capacities: Can cope very well at home, cooking, cleaning. If anxious finds it hard to motivate himself. Ray's dress and appearance was smart and tidy.

Personality and relationships: Seems chatty, but states when anxious finds it difficult to form relationships. Spends most of time with family and has 1 or 2 close friends. Has some difficulty forming relationships with women due to the abuse.

Education and employment record: 1st class degree in sociology and social psychology and commenced PhD. (1995) but dropped out when he became unwell. Voluntary work at OXFAM which led to employment but gave it up when ill. Presently attending Cellar [mental health] project on Fridays for woodwork.

- *Student Social Worker*

9th January 1998: : Letter from psychiatrist to GP:

Dear Dr S,

I reviewed Mr Middleton on 30th Decemeber 1997 on behalf of Dr. J. Due to various appointments being cancelled he has not been reviewed for one year and in this time he informs me he has reduced the dose of chlorpromazine down to 100 mg.three times daily and has stopped the lofepramine. He did this about 6 months ago and feels quite well though still prone to violent thoughts or thoughts of self harm particularly when in stressful situations with strangers. However he has never been violent.

He has taken to smoking cannabis, roughly 2 mg a day last month and it seems in part this is recreational but also to deal with “moods” which he feels it helps. In terms of medication the only side effects he is sure of is weight gain although wonders if apathy may also be induced by chlorpromazine. I advised that both are possible although the latter may also be induced by cannabis use.

He has agreed to continue with his current medication. I have advised him to try reducing the cannabis use and if this does not cause a worsening of his mental state it may be possible to consider reducing the chlorpromazine further when I review him in 3 months time.

Your sincerely Dr H, consultant psychiatrist

[age:27]

3rd March 1998: Clinical progress notes:

Suffering from depression for years. Reports has not painted for 2 -3 days (usually enjoys this). Last night he was thinking about killing himself (hanging or jumping from a bridge). No current plans as he thinks committing suicide is morally wrong.

13th March 1998: Letter from psychiatrist to GP:

Dear Dr S,

I reviewed Mr Middleton on 10th March. He remains somewhat low in mood with marked obsession thoughts about violence and self destruction. He finds these obtrusive, recurrent and tries to resist them. He has no plans to harm himself deliberately and can distract himself when he has the suicidal ideas. His mood is rather low he feels flat and tired. His concentration is poor and he has some sleep disturbance. I discussed the relative merits of changing Raymond from Lofepramine to Cloripramine which may well be more useful for obsessional type thoughts.

His medication at present is therefore Chlorpromazine, 200 mg three times a day,

Procycladine 5 mg and Clomipramine 150 mg prn nocte.

He has an appointment to be reviewed in 2 weeks time.

Yours sincerely

Dr W

Registrar to [Consultant psychiatrist]

31st March 1998: Letter from psychiatrist to GP:

Dear Dr S,

I reviewed Mr Middleton on 26th March.

He was much less paranoid and irritable and he no longer had as many intrusive and obsessional thoughts of harm to others. Advised to start reducing chlorpromazine down from 200 mg tds and 200 mg nocte to 100 mg bd and 200 mg nocte.

I will review him in 2 to 3 weeks but in the meantime Mr Middleton will try to make contact with [the day centre] in order to establish some daytime activities for himself.

Yours sincerely

Dr W

Registrar to [Consultant psychiatrist]

8th April 1998: Clinical Notes:

Admitted today informally. He is 27 yo. Received care and treatment here 2 years ago and also outpatient treatment for various “psychiatric” problems, i.e. depression, suicidal ideation, self harm, temptations to harm others, all these feelings date back to when he was 10 years old. He is unemployed and single. Also, had history of drug and alcohol abuse and received supportive input from AA. On admission very tense and agitated, expressed feelings of controlled anger and seeking reassurance for his present condition. This evening Raymond was saying he felt the need to harm someone. Given one to one conversation and reassurance and settled. Appears to have settled well onto the ward.

9th April 1998: Clinical Notes:

Ray spent the morning socialising with other patients. Approached staff and described intense thoughts, which he has been suffering from for many years. He describes suicidal ideation and plans to hang himself. He stated he also had thoughts to harm others, to stab someone. He claims that he would never act upon them. He states that because of the intense nature of his cognitions he becomes depressed due to the constant battle he has with himself to control them. He states that if he could rid himself of the compulsions he would not feel depressed. Offered appropriate support and reassurance which appeared to alleviate some of his anxiety.

9th April 1998: Clinical Notes:

Spent the morning socialising with other patients. No observed signs of depression. Pleasant and settled in mood. Socialising well with both staff and patients. No concerns expressed.

15th April 1998: Risk Assessment:

Total risk of suicide: 5 out of 32

Total risk of violence: 1 out of 17

Total risk of neglect: 2 out of 16

Total risk of care in the community: 4 out of 11

20th May 1998: Letter from psychiatrist to GP:

Dear Dr S,

I reviewed Mr Middleton [in outpatients] on 19th May 1998 following discharge from hospital. I saw him with his mother with whom he is temporarily staying.

He continues to have violent thoughts and according to his mother he had been "high" the first week after discharge from hospital but since then the ideas of harming other has returned. They both saw this very much in terms of mental illness – his mother mentioned a previous diagnosis of Bi-polar disorder, but on reviewing his notes it would seem he has had disturbances with loss of self-confidence and obsessive thoughts from a very early age and it is more likely to be personality problems. Frankly I am not sure he would fall into a diagnosis of bi-polar disorder and I did not contradict this opinion at the time.

He asked if his medication could be changed and I agreed to do this though advised this would be viewed as a symptomatic measure. I therefore substituted Thiorizadine 50 mg to 100 mg three times a day for Chlorpromazine.

Yours sincerely

Dr H (Consultant psychiatrist)

Psychiatric Hospital inpatient Discharge Summary, Dated 21st May 1998

Admission Date: 8th April 1998

Discharge Date: 20th April 1998

Diagnosis: *Obsessive Compulsive Disorder with secondary depression and anxiety, also Long-term Personality Disorder.*

Circumstances on Admission: Raymond was admitted to [the psychiatric hospital] complaining of decreased depressed mood and also increase of obsessive thoughts of harming other people which have become more intense and frequent in recent times. He has also had some ideas of self harm – wanting to shoot himself.

Past History: his has been well documented in previous correspondence. There is evidence suggestive of long term difficulties socialising and aggressive thoughts particularly towards women. He also has a past history of Alcohol Dependence Syndrome and drug misuse particularly in his teens. These problems may have been related to his recollections of being sexually abused by an older female.

Social Circumstances: He lives alone in his own house and is on income support.

Progress on the ward: On admission he was tense and agitated, expressing feelings of anger. He became more settled but it was not clear if it was related to a small increase in Clomipramine.

Review: He felt that his thoughts had become less severe and felt well enough for discharge though was still prone to violent thoughts and thoughts of self harm but he recognised that these thoughts were longstanding.

Discharge Medication:

Clomipramine 200 mg nocte.

Chlorpromazine 200 mg. tds.

Procycladine 5 mg. tds

Discharge Plan: He was discharged on minimal CPA with outpatient follow up. On 19th May he requested a replacement for Chlorpromazine to see if anything else would be more effective. He has been given Thioridazine in place of this.

He has now moved to stay with his mother, at least on a temporary basis.

Your sincerely,

Dr H

Consultant Psychiatrist

26th August 1998 (Letter dated) to GP from Locum Consultant Psychiatrist

Dear Dr S,

Clinic: 19th June 1998

Dr. H reported to you on 20th May. I noted the discharge summary of 21st May proposed a diagnostic formulation of "obsessive compulsive disorder secondary depression and anxiety..."

Clinical review: Raymond was most positive as he was feeling "a lot better...a lot more focussed." My objective impression was that he was certainly very well.

I note that he took his first class Social Psychology Degree at Bradford University in 1995. He is now planning to take up suitable part time work and engage in part time work at Bradford University as a Research Assistant – almost commendable.

Current Medication:

Clomipramine 150 mg at night (for 3 months) and he wants to come off this now

Thiorizadine 100 mg X 3 times

Procycladine 5 mg X 3 times

Overall Conclusions:

My overall conclusion is that Raymond is clearly very stable at the present time.

Further Management:

1. [outlined planned reduction in Clomipramine] The Thioridazine could be tackled at his next clinic session.
2. He was due to return to clinic in 4 months time.

With all good wishes,

Dr R,

Locum consultant Psychiatrist

*We apologise for the delay with this letter.

25th September 1998: Letter from psychiatrist to GP:

Dr Dr S,

Diagnosis: Recurent Depressive Disorder

Medication:

Clomipramine: 150 mg nocte

Thioridazine? Dose ? mg tds

Procycladine 5 mg tds

Clinical review:

I reviewed this man in out-patient clinic. Mr Middleton reports that he felt quite well at present, bright in his mood, sleeping and eating well with no violent thoughts. He hopes to return to work but I have pointed out that this can lead to stress and possible risk of relapse, but that on the whole it is a good idea. I understand that he had a recent admission this year with depression.

I spent some time discussing the roles of a mood stabilizer, as I understand the consultant who had assessed him in clinic had suggested the possibility of this. Although I can't find any evidence of him having any manic swings he certainly has had recurrent depressive episodes,, and LITHIUM has a role both in treatment of resistance to pressure and also in prophylaxis of depression.

However at this stage because he is feeling well I advised that this be kept in reserve should he relapse and it be considered then.

I have advised for him to continue on the current regime, but would advise that the THIORIDAZINE be reduced as he is on quite a high dose. There were no suicidal ideas today and I have arranged for him to be reviewed in 6 weeks time.

Your sincerely,

Dr. H

Consultant Psychiatrist

9th November 1998:

Assessment of Self Poisoning

Type: Overdose

Precipitants: Stress due to a few things such as financial and employment factors. Took overdose, then got in a Taxi to A&E at BRI.

Salient features: Previous overdoses, Has been to [psychiatric hospital] three times. Lives on own and tends to drink a lot.

Mental State examination: No psychotic features, low in mood but not suicidal.

Diagnosis: He thinks the overdose was an impulsive and stupid thing to do and does not think he will do it again. Ray said he would try to stop drinking.

Management plan: For discharge once medically fit.

3rd December 1998: Clinical notes:

Took 16 Thorizadine tablets. Had a bad day. Took pills and alcohol. Teetotal now. Quite well now. “Fine”. Will review end of Feb. – Consultant psychiatrist.

11th December 1998: Letter from psychiatrist to GP:

Dear Dr S,

I reviewed Mr Middleton somewhat earlier than planned after he took a small overdose of THIORIDAZINE tablets. I reviewed him on 3rd December at which time he was feeling much better and was euthymic.

He told me that the overdoses had been an impulsive act after he had been drinking heavily.

As he now seems back to his usual self I have not altered his medication and will see him again at the end of February.

Your sincerely,

Dr. J

Consultant Psychiatrist

17th December 1999: Clinical progress notes:

Presenting complaint: “Terrible feelings inside. I feel like I’m being tortured. Visual images of being tortured. I’m getting violent thoughts towards strangers.”

Involved with services since 1993. Various different diagnoses: “Persoanlity Disorder”, “Recurrent depression.” Psychotic depression.” Past history of sexual abuse by older female. Past history of alcohol and drug abuse. Lives in own home alone. On benefits. – Duty Doctor on Reception at psychiatric hospital.

24th December 1998: Clinical progress notes:

Is very depressed, suicidal, very low in low self-esteem. Admitted informally due to depression and suicidal thoughts. He is single and unemployed and received treatment and care on this ward about 6 months ago. Reiterated that he used to drink a lot (10 pints a night) but has not drank at all for over two

months. He has a past history of overdose, on admission although he was very depressed and anxious there was no feeling of suicidal ideation due to being on the ward. Soon settled on the ward and pleasant in his approach.

Goal: To be free from depression, achieve moderate self esteem, to lead positive life free from suicidal ideation.

Psychiatric Hospital inpatient Discharge Summary, Dated 3rd February 1999

Date of admission: 24/12/1998

Date of discharge: 20/01/1999

Diagnosis: Recurrent Depressive Disorder

Presenting Complaint: He was feeling low. He had a feeling that he wanted to harm others.

History of Presenting Complaint: Over the last few weeks he has had violent thoughts about hitting others. For the last few months he has been doing voluntary work in a cafe but it has closed over Christmas and he has no work to do and his routine has been disrupted. There were thoughts of self-harm. Suicidal ideation was also present. His sleep and appetite were normal.

Past Psychiatric History: He has been known to psychiatric services for the past six years. He was last admitted to the psychiatric hospital on the 8th October 1998 and discharged on 20th October 1998. At that time his ***Diagnosis*** was: Obsessive Compulsive Disorder with depression and anxiety with long term personality disorder.

Mental state examination at time of admission:

Appearance and behaviour: He was normally dressed. Anxious. Good eye contact. Speech – pressure of speech. Mood: subjectively depressed, objectively low. Concentration poor. Thoughts – no thought disorder. Perception – no auditory or visual hallucinations. Delusions – No delusions. Insight present.

Progress on the ward:

In the beginning he was quite low in mood, and had feelings of agitation. No suicidal ideation. Within a few days he settled on the ward, he was pleasant and interacting with staff and other patients. Within a week he had improved

and settled in his mood. He keeps to himself and interacts moderately with others, but prefers it that way. He was reviewed on 4th January 1999, his depression had lifted, no suicidal ideation. He sleeps a lot with CHLORPROMAZINE. He complained that he visualised images that were "terrible". Images like having his foot amputated.

He is seeing a psychotherapist on a regular basis. An outpatient appointment with his consultant psychiatrist has been arranged for one weeks time. Psychiatric social worker will continue to see him at his home.

Yours sincerely,

Dr K

SHO to [consultant psychiatrist]

12th March 1999: Clinical notes:

Has made a number of changes in life (not least cutting his hair!) says he feels less fragmented and more whole. Still using prayer as main coping strategy when he gets the thoughts... – Clinical psychologist.

12th April 1999:

Letter from my Clinical Psychologist to my Consultant Psychiatrist:

Dear Dr J,

You referred Raymond to me in January 1999 following his admission to [the psychiatric hospital]. A psychological assessment was made to see whether a cogitative behavioural approach might be helpful in the management of Mr. Middleton's obsessive compulsive ruminations. I met with him... [five times between 11th January and 12th March 1999].

As already documented, Mr. Middleton reports having obsessive thoughts for the last 12 years. Mr. Middleton's own view linked these thoughts to an early history of sexual and emotional abuse by an older woman when he was aged 11. The abuse last seven years. Mr. Middleton had been referred to a psychotherapy assessment in June 1993 after his first contact with Bradford Mental Health Services, but I can find no record of the outcome of this referral. Mr Middleton's insight into links with ealy abuse and subsequent self destructive behaviour did not seem to provide a buffer against subsequent depressive episodes and admissions to [the psychiatric hospital]. Mr Middleton

knew at the rational level that he would not act on the thoughts, but the mere fact that he had these thoughts made him question his sanity, e.g. “what normal person goes around thinking these things?” Mr Middleton also questioned his self worth e.g. “I must be a bad person for having these thoughts”. When he performed useful or kind actions he found himself questioning them along the lines of “this is not the real me”. The real me, I have to cover up.” It seemed that the latter thoughts were linked to Mr Middleton’s religious background and current Christian beliefs about good and evil. For example, one of Mr Middleton’s coping methods was to pray and have others pray for him. Mr Middleton and I discussed how he could challenge thoughts of good and evil at the rational level and how this approach would not necessarily contradict his beliefs that a “purging” of these thoughts could really only be accomplished by prayer and God.

Over the course of four meetings we were able to look at situations where the obsessive ruminations were most likely to occur, e.g. on his way to Alcoholics Anonymous meetings where he was most likely to experience a sense of isolation and frustration at not being “normal” i.e. having to go to A.A. when other men his age were engaged in relationships and out enjoying themselves. It seemed that the added dimension of frustration and bitterness would lead to increased physiological arousal levels and hence a lowered ability to control these thoughts. Other situations which led to an increase in the thoughts were those where Mr Middleton felt unable to be assertive in as much as he associated and standing up for himself and being assertive with being unworthy and bad. This was particularly apparent in his voluntary work where he felt he had to give a total commitment at some cost to himself and his own personal and social spheres. The situational evaluation and restructuring enabled Mr Middleton to cut down on his considerable commitment to the voluntary project and he began to engage in other and more varied pleasurable activities.

The above gains were small. It was apparent over the weeks of our meetings that Mr Middleton felt himself to be much improved in terms of the lifting of his depression noted by you at time of discharge on 20th January 1999. He told me he was much less plagued by the ruminations. He was finding considerable support from his church colleagues and told me he felt as if he had been

healed. Mr Middleton told me that he was able to rebuke any violent thoughts (which he saw as originating with the devil) by Christian thoughts. I found these coping techniques entirely in keeping with Mr Middleton's Christian beliefs, and while my own preference would have been for Mr Middleton to tolerate the thoughts as his own and challenge them on that level, I conceded that Mr Middleton's own methods were proving more than effective at the present time. Mr Middleton and I agreed that he would monitor his progress over the forthcoming months and that he could contact me again should he wish to do so. Mr Middleton remains in contact with [his psychiatric social worker] and finds these meetings helpful. I have closed the case at present.

Your Sincerly

Clinical Psycholgist

c.c. G.P., Psychiatric Social Worker

11th May 1999: Letter from my psychiatrist to my G.P.:

Dear Dr S,

I reviewed Raymond at Eccleshill Resourse Centre on 4th May. He remains euthymic and stable but complained of photosensitivity on Chlorpromazine and I have therefore reduced the dose to 50 m.g. at night. He remains on his usual Paroxetine i.e. 50 mg daily, and will be seen again in 3 months,

Your sincerely,

Dr. J.

Consultant Psychiatrist

12th August 1999: letter to GP from consultant psychiatrist

Dear Dr S,

I reviewed Mr Middleton on 5th August. He remains extremely well and has now stopped CHLORPROMAZINE. He continues on PAROXATINE, 50 mg daily.

I have discharged him back to your care.

Your sincerely,

Dr J

17th December 1999: Letter from psychiatrist to GP

Dear Dr S,

Raymond was reviewed on 16th December. [He had been to Paris] and found the experience quite unsettling. His mood has been troubled by a number of very distressing thoughts and images. For example, he told me that he felt that his mind was in the middle of a hurricane, and that he also had distressing visual images of him being tortured. . Associated with this was an overwhelming sense of fear and depression. He also told me that he had the experience of sentence “they are after you” addressing him, which he found very disturbing. This was not a hallucination.

Raymond was able to talk with a considerable amount of self awareness and understanding of his experiences and asked if it were possible for his medication to be reviewed. We spent some time discussing this and agreed [plan to stop chlorpromazine and start olanzapine, 5 mg].

Best Wishes,

Dr. T

21st December 1999: Letter from psychiatrist to GP

Dear Dr. S,

I reviewed this young gentleman in my capacity as duty doctor on 17th December and again on 20th December. He presented to me with a deterioration in his mood and in particular violent thoughts towards strangers, the feeling that he might drink alcohol and take an overdose, and unbearable feeling of inner tension. As you may know Raymond has quite a long history of involvement with psychiatric services and looking at the old notes this did seem typical of the kind of disturbances he experiences when his mood deteriorates. He put this deterioration down to a trip to Paris he had been on a few days before which had unsettled him. I was reassured to hear that he was battling with these ideas and had no intent as such to kill or harm himself. I think he came wanting support to help tied him over a rather difficult patch. He assured me that he had good support from his friends in the church and also from his parents and I got the impression that he would seek help if things got very bad.

I found him to be a pleasant man with good rapport, not agitated but with a worried troubled appearance. His speech was coherent and relevant but

somewhat monotonous in tome. I found his mood to be rather un-reactive and moderately lowered. His thoughts were as described above and while he was not suicidal as such he was quiet about what he might do if things got worse. He was not experiencing hallucinations as such, but certainly was experiencing words appearing in his mind suggesting that he might kill himself. Raymond and I agreed it was a good idea to change over to olanzapine but not at a time of turmoil. I therefore suggested that he went back to Chlorpromazine and increased the dose.

I advised him to seek help via the duty doctor at [the psychiatric hospital] to request involvement from the Home Treatment team.

Your sincerely,

Dr C SHO to [consultant Psychiatrist]

29th December 1999: Clinical progress notes

Has thoughts to "Destroy" himself but no plans and does not appear suicidal.

30th December 1999: Raymond phoned, explained he was feeling great, had stayed with a friend from church, had been discussing things with vicar, had good night's sleep, not wanting visit.

31st December 1999: Visited this pm, He seems to be doing well, though problems sleeping and he said he took six tablets instead of three. CPN visiting with me explained this would not help and would be better to try different ways to relax when going to bed. Raymond took this on board and said he would try.

11th January 2000: Letter from Home Based Treatment psychiatrist to my G.P.:

Dear Dr. S,

Re: Home Based Treatment service delivered from 29/12/1999 to 06/01/2000.

Diagnosis: Crisis admission F43

Medication: I cannot see that this is recorded in his notes but I am led to believe from his keyworker that this remains unchanged and is supplied by his general practitioner.

History of presenting complaint: Sadly I have not met Mr. Middleton myself as I have been away on leave for the entirety of his admission to the Home Treatment. His notes report that his main symptoms include feeling low in mood, having self destructive thoughts and the idea that he was being

poisoned. He appears to rapidly improve when given the opportunity to talk through these thoughts and ideas.

He will be followed up as an outpatient.

Your sincerely,

Dr. K

21st January 2000:

Dear Dr S,

Ray was reviewed on 20 January 2000. He had a brief spell on Home Treatment shortly after Christmas because he was saying he could no longer cope with the distress. I am not sure whether my attempts to change his medication from chlorpromazine to olanzapine contributed to this but he went back onto the Chlorpromazine after a couple of days because things were getting out of control.

Today he told me he was feeling a little better, but was still finding it difficult to keep in control of his feelings. He told me that his mood was up and down a great deal, and he went on to describe what he called “depression” in which he had a feeling of heaviness in his head, a feeling of hopelessness and that the future was bleak, on the other hand he described what he called a feeling of “destiny” when he had an increased self-confidence, felt that things would turn out well, and that he would also write a novel that would win the booker prize. On occasion when he has felt this way he has spent without regard to his budget, for example buying an art book for £30 when he had only £30 to last him for food for the week. He raised the question spontaneously with me whether he had a mood disorder, and also asked me whether I thought a mood stabilizing agent might help?.

I told him that I have an open mind about this, but before I would consider making any further changes to his medication it would be helpful if he could keep a diary of his mood on a daily basis, and I am also planning to get hold of his old notes to have a closer look through them to see what has happened in the past. I am seeing him again in four weeks to review progress.

Best wishes,

Dr T

Consultant psychiatrist

27th January 2000: Assessment / Ward Observations / Progress Notes

Referred by GP, Feeling low since last week, drinking heavily, 2 bottles of wine per day. This afternoon drank 2 bottles then cut wrists with knife. The cuts are superficial – not deep. Enjoys painting. Well known to psychiatric services. 6 previous admissions. Casually dressed, but well kempt, smelling of alcohol, smoky. No auditory or visual hallucinations. History of deliberate self harm.
Plan: spoke to CPN: He will assess tomorrow, tonight – go stay at his mothers, stop alcohol, refer to HBT.

30th January 2000: Assessment / Ward Observations / Progress Notes

No [thought disorder] but describes fleeting illusions whilst in bed of someone chopping his foot off. Informally admitted to ward. Currently complaining of lowered mood, anxiety and thoughts of taking an overdose, has made superficial scratches to his arms. Abused by older woman aged 10 – 18? Several previous admissions to [psychiatric hospital] following overdoses and also experienced alcohol related problems but states he has not drunk for 3 days and receives support from A.A. Recently been drinking 3 to 4 bottles of wine a day - but had been abstinent for a year prior to this. Smokes 20 cigarettes a day. No illegal drugs for one year, used to abuse amphetamines and cannabis. Drank heavily 14 to 19 then rehab. Off alcohol 19 – 24. On/off anti-depressants. Psychotherapy for 2 years. On/off alcohol last few years. Seven psychiatric hospital admissions in last four years. Says his occasional "lapses" with alcohol helps with symptoms for 1 hour but then feels worse. Shadowy figures hover over his bed at night "torturing" him, feels pain over entire body. Thought of killing his abuser last year, but realised he was not well and just went home. Thoughts come into his mind "Destroy yourself Raymond" Not his – thought insertion? No thought broadcasting. Thought of taking overdoses to escape the pain he feels – not to kill himself. Feels badly served by system "because I don't believe in hurting anyone else and I cooperate and I can give a good account of myself so people think I can cope but my coping mechanisms are not working." Cognition insight – excellent. Chronic problems related to mood and perceptual disturbances, urges to self harm. Lives alone in flat, isolates himself, unemployed, angry about abuse, has supportive family. Identified need to structure life. Increase in distress and planning to take tablets

(OD) to escape this distress. Tension, anger, pressure in head, anxiety ++, sweating, shaking, perceptual disturbances, sleep poor – awake till 4-5 a.m. trying to distract self by reading but not working. Self harm – superficial scratches at 1 am last night.

31st January 2000: Urine drug sample taken and placed in fridge.

1st February 2000: Raymond has spent the morning in social areas laughing and friendly with fellow clients. Appropriate in mood and behaviour.

3rd February 2000: Raymond stated he was feeling immense anger, which he felt was due to past abuse history. Raymond stated he sometimes finds it difficult to cope with feelings of anger and in the past has turned these feelings inward in the form of self destruction, e.g. drug and alcohol misuse. Discussed using relaxation techniques which Raymond agreed to implement and participate in relaxation groups on the ward and discussed Raymond attending self-help group for people who had been abused. Raymond stated he felt more calm at termination of interview.

18th Feb 2000:

Dear Dr. S,

Just a quick note to let you know Raymond was recently an inpatient with us in Lynfield Mount Hospital. He came to see me [in outpatients clinic] on 18th February 2000. He is doing well but continues to have episodes of low mood. In spite of this he is quite optimistic about the future and present. He is currently seeking employment and staying at home with his family. He is sleeping well and his appetite is normal. He has no suicidal ideation or intent. While he was an inpatient with us we discussed his medication and we agreed that we would work towards a period without any psychotropic drugs. [plan of medication reduction outlined]. I have arranged to see him again in four weeks,

Your sincerely,

Dr. P

Psychiatric Social Worker's "Closing Summary", dated 21/09/1999:

Raymond seen on 12th July 1999 – appeared to be very well. Due to be seen in clinic early August.

Seen by Dr. J on 12th August 1999 – discharged back to G.P.

[G.P.] had seen Raymond on 9th September 1999 when he had reported an episode of persecutory ideation. Also hostile feelings towards the person who abused him as a child have re-emerged – he had thoughts of trying to kill her and had taken the train to where she lives. These thoughts had quickly subsided and have not re-appeared.

He has not actually planned how he would kill her but had considered what prison sentence he might receive for the crime.

He had stopped his chlorpromazine and was restarted on this by his G.P.

I rang Raymond on receipt of this letter [letter from G.P.to psychiatrist – copy not received by me] as it was not possible for me to see him immediately in clinic.

Raymond told me that he was not feeling better and was due to be seen in clinic next week. Arranged to visit 21st September 1999.

21st September 1999 – visited – Raymond appeared to be well and settled. Attributes recent episode to combination of stress – he had been looking for agency work and reducing his chlorpromazine.

He is due to see his G.P. this week and his psychiatrist next week.

I do not plan to see him again unless requested to do so by [his psychiatrist.]

- ***Psychiatric Social worker***

Psychiatric Social Worker's note, dated 23/12/1999:

- Raymond Contacted the Home Based Treatment Team on 17th Dec 1999
- He had seen Dr. T [psychiatrist] the previous day and felt his coping mechanisms were "slipping away"
- Hearing a voice telling him to "kill yourself Raymond". Also experiencing violent thoughts – towards strangers.
- T. Arranged for Raymond to be assessed by Dr. C at [the psychiatric Hospital]
- The outcome of that assessment was that Home Based Treatment were to be involved and he was to be started on Olanzapine,
- He will require a new keyworker, ideally a CPN, initially to monitor compliance with medication. This case to be reallocated with City Mental Health Team [CMHT]
- ***Psychiatric Social worker***

3rd April 2000: Letter from Consultant Psychiatrist to G.P.

Dear Dr. S.,

I saw Raymond on 21st March 2000. He remains quite well. ...We had a long discussion about future plans and Raymond asked to be discharged from psychiatric services. I agreed to this...However we have agreed that he would get back in touch if his mental health deteriorates. Thus I have discharged him from our care today. As noted above he is not on any prescribed medication from us.

With best wishes,

Dr. B (Consultant Psychiatrist)

Appendix IV: Ethics Checklist

UNIVERSITY OF BRADFORD
MAKING KNOWLEDGE WORK

APPLICANT'S ETHICS CHECKLIST

This checklist is designed to help you to decide whether or not ethics approval is required and, if required, to decide on the appropriate ethics review procedure -
please read guidance on page 5 before you complete the form

Who should use the checklist?
A checklist should be completed for all empirical research projects involving people, by the Principal Investigator [PI] or the Principal Supervisor [PS] in the case of a supervised student research project.

Guidance on the 2 different ethics review procedures that together make up the University's Ethics Review System (i.e. 'University' and 'NHS') is available on the University Ethics website

If the project involves human tissue/biological fluids you should contact the University human tissue bank for advice in the first instance. Contact Ethical Tissue on 01274 235897 or visit www.ethicaltissue.org

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Project Title:.....

Name of Principal Investigator / Principal Supervisor:

Contact Details – email address .....

Department/School .....

Name of Student (if applicable):.....

Contact Details – email address .....

Summary of Project (max 150 words):

Q1	**Is the proposed project an <u>empirical research</u> project involving people?** • will the project include primary data collection from human subjects, their data or their tissue? • Will it constitute an 'investigation undertaken in order to gain knowledge and understanding'? (this includes work of educational value designed to improve understanding of the research process) A more detailed definition of Research, Audit and Service Evaluation is available on the <u>University Ethics website.</u> If you answer 'Yes' to Q1 ethical approval may be required, move to Q2. If you answer 'No' to Q1 then a research ethics review is <u>not</u> required. **Note:** there may be occasions where a project is not defined as research but still raises ethical issues – please submit for review in these cases.	**YES/NO**
Q2	**Will the research project involve the <u>NHS</u>?** See guidelines on the <u>University Ethics website</u> If you answer 'No' to Q2 move on to Q3 If you answer 'Yes' to Q2 ethical approval will be required by NHS Research Ethics Committee (REC) Contact Ethical Tissue on 01274 235897 or visit <u>www.ethicaltissue.org</u>	**YES/NO**
Q3	**Will the research project involve any of the following in the UK:** ▪ Testing a medicinal product ▪ Investigating a medical device ▪ Taking samples of human biological material (e.g. blood, tissue) ▪ Prisoners or others in custodial care (e.g. young offenders) as participants ▪ Adults with mental incapacity as participants ▪ Other vulnerable groups (e.g. vulnerable children) as participants If you answer 'Yes' to Q3 ethical approval will *<u>usually</u>* be required by <u>Ethical Tissue</u> or NHS Research Ethics Committee (REC) or where the project includes participants which need approval under the Mental Capacity Act approval will be required by the Social Care REC. See information specific to research in Social Care on the <u>University Ethics website</u> If you answer 'No' to Q3 move on to Q4	**YES/NO**

Q4	**Will the research project involve human participants and/or human data (*but not accessed through the NHS*)?** If you answer 'Yes' to Q4 University ethical approval is required unless data/participation is uncontentious (see guidance overleaf) If you answer 'No' to Q4 move on to Q5 Please give brief explanation below of type of data/participation in cases which you consider to be uncontentious (see guidance on page 5):	**YES/NO**
Q5	**Will the research project involve human tissue (but not requiring NHS approval – see Q3)?** If you answer 'Yes' to Q5 University ethical approval is required If you require advice on human biological material please contact Human Tissue Act (HTA) Designated Individual: Professor Diana Anderson on ext 3569 or email: d.anderson1@bradford.ac.uk) Contact Ethical Tissue on 01274 235897 or visit www.ethicaltissue.org If you answered 'Yes' to Q5, is the human material over 100 years old and archaeological? If 'YES' please refer to the Biological Anthropology Research Centre (BARC) guidelines at http://www.barc.brad.ac.uk/BARC_human_remains_policy.pdf	**YES/NO**
If you answer 'No' to Q5 and have answered 'No' to Q2, Q3 and Q4 ethical approval is not required.		

PLEASE COMPLETE and SIGN *ONE* of the boxes below:

1. I have discussed this project with my student and confirm that there are **no ethical issues** requiring further consideration.
(Any subsequent changes to the nature of the project will require a review of the ethical considerations)

Name (Principal Investigator/Principal Supervisor):
Signature: **Date:**

Name (Student):
Signature: **Date:**

I confirm that there are **ethical issues** requiring further consideration and will refer the proposal either to Ethical Tissue or fill in and submit a full ethics application to be considered by the appropriate Research Ethics Panel..
Name (Principal Investigator/Principal Supervisor):
Signature: **Date:**

Checked by Chair of Research Ethics Panel

Annex 1

Ethical Scrutiny by a University Research Ethics Panel is not required if:

- **The project is NOT a research project.**

- **The research project will only involve unlinked or aggregated human data which was collected and which was, at the time, subject to relevant research ethics panel approval.** However, where this is the case the researcher should at least confirm this in an email to the Research Support Unit's Ethics Administrator so that the Ethics Administrator has a record and can inform the Chair of the appropriate Research Ethics Panel that the researcher plans to go ahead without ethics approval. The email should confirm that the research project does not require ethics approval because it only involves unlinked or aggregated data, which when originally obtained from people was obtained in accordance with the protocol as approved at the time by an appropriate research ethics panel. The email should also briefly explain how the researcher now plans to use the unlinked or aggregated data.

- **The research is Public Domain Data:**
  The Economic and Social Research Council's (ESRC) Research Ethics Framework states that ethics approval may not be required for data sets that exist in the public domain (e.g. datasets that are available from the Office for National Statistics or from the ESRC's Data Archive) so long as the appropriate permissions from individuals have already been obtained (i.e. informed consent) and where it is not possible to identify the individuals from the information provided. It must be remembered that public domain data is still covered by the laws of copyright.

- **The research involves Simple Uncontentious Questionnaires:**
  If a research project's only involvement with human subjects is a simple brief questionnaire with uncontroversial content it may not require ethical approval. It is the Principal Investigator or Principal Supervisor's responsibility to decide whether a project comes under this category and must indicate this on the form and attach the document for information.

Guidance on supervisor and principal investigator sign off of uncontentious research

Audit and service evaluation are usually uncontentious, and guidance on how to differentiate between research, audit and service evaluation is given at: University Ethics website.

Even where a project is clearly research, as a supervisor or principal investigator, you can sign off simple, ethically uncontentious projects as not needing further ethical scrutiny. To do this, you should consider the level of risk to participants and researchers, the level of effort required by participants, the level of intrusion into participants' lives and the level of sensitivity of both the general subject matter and the information requested of participants. Basically, the lower these levels, the more likely the research is to be uncontentious and the more confident you should feel about signing off.

The following examples may help.

These studies can almost always be signed off by the supervisor or principal investigator:

- Brief questionnaires asking opinions about matters which are clearly not sensitive (attitudes to a product, beliefs about the usefulness of a course).
- Brief interviews about such topic.
- Observational studies about everyday behaviour in public places which involve no risk to subjects or the researcher.

But the following studies almost always need further scrutiny by a University Ethics Panel:

- Long questionnaires (these require considerable potential inconvenience to subjects).
- Long interviews
- Any questionnaires which ask subjects about intimate behaviours or issue likely to cause distress or would in other ways normally be regarded as contentious or sensitive (e.g. illegal activities, attitudes to abortion, capital punishment, immigration, euthanasia).
- Any interviews which examine these matters.
- Observational studies which involve intimate behaviours, behaviours which are not normally public or which might normally be considered contentious or sensitive (Activities of ethics committees, appointment committees, etc; professional consultations).

Naturally, this list is for illustration only, and should not be considered in any way exhaustive, permissive or prescriptive. For example, there are many categories of research not mentioned here which would definitely require ethics approval (e.g. treatment research). Rather the list demonstrates the issue of proportionality. Thus, even though the method may be the same for activities requiring and not requiring further scrutiny, the *content* in some way distinguishes between the two categories.

At the same time, there is obviously some middle ground. Are ethics committees not public? Is what is discussed so sensitive that the proposal needs further scrutiny? What about asking people about their views on the actions of senior members of staff in their organisation? Probably, it is in these middle ground areas that further advice should be sought from a Panel Chair about whether the project can be signed off by the supervisor or principal investigator alone. Given that, in so doing, the supervisor or PI is attesting to the ethical probity of the study, it is usually best to err on the side of caution where there is uncertainty. Panel chairs are very happy to advise.

(**Dr Martin Brinkworth**, Chair, Biomedical, Natural and Physical Sciences Research Ethics Panel, m.h.brinkworth@bradford.ac.uk, ext. 3584

Andy Scally, Chair, Humanities, Social and Health Sciences Research Ethics Panel, a.j.scally@bradford.ac.uk, ext. 6431)