MADHOUSE AND THE WHOLE THING THERE: AUTHENTICITY, AUTOETHNOGRAPHY AND PSYCHIATRY

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ABSTRACT

This thesis has been concerned with the question of authenticity in relation to autoethnographic mad narratives. Emerging from the ‘narrative crisis’ in the social sciences, autoethnography is a methodology that utilises personal experience (‘auto’) in the observation and analysis of social phenomenon (‘ethnography’). Along with other forms of first-person accounts of madness, autoethnography can arguably provide useful insights into the subjective experience of going mad and using mental health services, whilst also providing critiques of biomedical psychiatry.

However, many of these accounts are predicated on an argument from authenticity, even when using theoretical frameworks that repudiate any notion of a true self. In this thesis, I thus analysed the concept of authenticity in relation to mad narratives, arguing for a redeployment of the concept using De Certeau’s (1984) distinction between ‘strategy’ and ‘tactics’. In doing so, I argued that a ‘tactically authentic’ autoethnography would be a narrative that incorporated multiple perspectives, be ambitious in its textual representation, be systematic in in its analysis of the data, and relate the narrative to social theory. Following mental health and survivor research, I also argued that a tactically authentic account of madness would also incorporate critiques and analysis of the psychiatric system.

Therefore, in responding to these critiques of autoethnography, and to address the main thesis questions, an innovative autoethnographic methodology was developed, called a ‘quadrilogue’. This method incorporated four perspectives in recounting my psychotic breakdown and

psychiatric hospitalisation that occurred in the early 1990s. The four perspectives were: mine; my mother's, represented by her diary that she kept at the time; the clinical team, as represented in my NHS clinical notes; and the reflexive perspective from the researcher, compiled from my own and others' reflections on the data.

Analysis of the data generated three main themes. The first of these, double binds, using Bateson's (1972) Double Bind theory to show the transcontexual ways in which the psychiatric system inflicted double binds on me, my family and staff. The second theme, mis/recognition, argued that the discourse of psychiatry itself was constituted in a 'differend' (Lyotard, 1983) that prevented me, and to a lesser extent my mother, from adequately framing our complaints. The third, despair, argued that despair is unrepresented in the psychiatric research literature, despite being present in first-person accounts, and was a key aspect of my experience in the narrative. However, this 'despair' was marginalised by the psychiatric system in the narrative, and lacks an adequate conceptual framing in the literature based on service user and survivor experiences.

There were at least two key contributions to the literature. The first was that in developing the quadrilogue, I had constructed a methodology that addressed issues in the literature and could be used to inform future autoethnographic research. The second was in the generation of new theories, as well as the adaptations of existing theory, grounded in the experiences of those who have use, or have used, mental health services.

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PROLOGUE

It is this deep blankness is the real thing strange.
The more things happen to you the more you can't
Tell or remember even what they were.

The contradictions cover such a range.
The talk would talk and go so far aslant.
You don't want madhouse and the whole thing there.

William Empson, 'Let it Go'

'The past is never dead. It isn't even past.'

William Faulkner, 'Requiem for a Nun'

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It’s the usual routine in my job as a clinical psychologist in the UK National Health Service (NHS), first thing in the morning: drop my bag and coat on the desk; exchange pleasantries with the few team members in this early (“another day, another dollar” intones the nursing assistant); turn on the computer; go to the kitchen to make a coffee; check emails (not so bad, but it is still 8am); open the patient data system; swipe my card in the card reader; pick up the to-do list.

First action: respond to the care co-coordinator’s query from yesterday evening (“Simon, could you maybe see this really nice guy for therapy? I think he could really do with a chat”). I search for the client on the system. It barely even registers that the client has a vaguely similar name to mine.

Until, emblazoned on the screen, somewhere near the bottom of the returned searches: my name, address and date of birth.

I stare at the screen for a few seconds in wry disbelief. I have been taken back for a moment.

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I suddenly snap out of the spell, look around quickly to see if anyone’s near me. The coast is clear. I return to the screen. I feel anxious. What else do they have on me? I am so tempted to open the record, but I know I can’t do that – this ‘patient’ is under a different directorate. Even though these are my notes, I will lose my job if I open a record of a patient not ‘belonging’ to me.

***

An idea occurs to me. What’s on the other system? Old, paper clinical notes are archived on a separate system and my contact with the mental health service ended long before this system went online. I open the programme. Different password (of course) and I can’t remember this one, so I need to reset. Quickly now, other team members are beginning to file in slowly. Yes, that’s it, I’m in. I type Clarke, Simon. Several records, but sure enough, I am there. 404 pages of me. Fuck.

***

In the car, in the car park, outside the clinic. Privacy needed. I am on my mobile phone to the Data Protection Manager of the mental health service. Yes, that’s right I say. No, I didn’t open the record on the online system. Yes, I know I could lose my job if I did that. I wave nervously as a colleague walks past into the clinic with a client in tow. Yes, I say back to the Data Protection Manager, I was a patient in the 1990s and I now work here for the same mental health service. Yes, I recovered. You haven’t come across this kind of a case before? A pause. OK. Well…how can I get hold of my notes then? I don’t know what’s on the system and I’m concerned that my colleagues could access them. A Subject Access Request? Yes, I would. Very much. Thanks.

***

The large package, a full ream worth of paper, sits with me on the passenger seat all the way home, as if it were a person. When I get home, my wife is waiting for me. I carry the large package to my chest like a baby. It’s here I tell her, dropping the fat package on the table. We unwrap it together. The A4 cardboard box that was inside the package sits on the table.

Are you going to open it then? She asks.

I’m not sure, I say. I then open the lid and start rifling through the first few pages.

God, there’s so much of it, she says. Her fingers pull out one sheet from the pile – PATIENT PROPERTY LIST. Tears well up in her eyes. It’s like you were going into prison. You were just a kid. A kid scared out your mind.

I’m not ready to read it, I say. I don’t think I can handle it. It was such a shit time. Could you put it back in the box? Maybe I’ll look at it later.

***

I’m still not sure what I want to do, I tell my PhD supervisor. I think I know what I want my PhD to be about, but I am not sure how to do it. I want to look at psychosis and the experiences of using mental health services, but I don’t think I want to use a conventional psychological approach.

What’s wrong with a conventional psychology approach? He smiles wryly. He is, after all, a ‘conventional’ psychologist.

I don’t know, I reply, conscious that I might be overstepping a boundary. It’s just…I pause and take a breath. Psychology deals with what it calls empirical ‘data’. Either quantitative or qualitative – it doesn’t matter, the process is the same. There is something that you ‘find’ that is ‘real’ which is more ‘real’ than what you as a ‘subject’ might ‘experience’.

But the more you abstract from the experience, the less real it becomes. Psychology has many layers of this abstraction from the subject of experience – to responses from a questionnaire, to data in a data set, to results from a statistical inquiry. Or themes from an interview – also taken from experience, by a researcher, with their preconceptions and bias, filtered, extrapolated and ultimately fitted into a format consumable for an institutional process, that is often a million miles away from the original experience. Frank (2005) mentions this when he talks about the dangers of chopping up stories into data.

He smiles, and then laughs. So it’s a question of authenticity then?

I guess so.

Why not do an autoethnography then? He says.

I'm not sure what that is, I reply.

It's a research method. You use your own experience as data.

***

What's wrong? Asks my wife, her furrowed brow blue in the reflected glare of her laptop screen over which she peers at me.

Nothing, I say. She throws me a look over the brim of her computer.

I sigh. I've finished writing out my experiences and memories as bullet points. I now need to write them up as an autoethnography, as a narrative.

So what's the problem?

It's just…the one perspective seems to rule. I write my experiences down, but what does it matter? It's what I experienced and how I made it. So what? Who really gives a shit?

She shrugs. So look at other perspectives then. What about your notes? They might be really useful to look at, now you're writing your own experiences down. That's another perspective. How would that feel?

It's an interesting idea, I think.

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You’re doing a PhD? My mother asks. But don’t you already have one?

I have a Doctorate in Clinical Psychology, I say. A DClinPsy. It’s a professional doctorate. This is different. It’s research.

OK, she replies. I don’t think she quite gets it, but I can see she’s intrigued. Why are you doing it?

I dunno, I say (I do really). I guess I’m just interested in things. There are some questions I need to answer. Also the training. Having a PhD will also be good for my career, as well. I end somewhat lamely.

What’s it about? She asks.

I take a deep breath inside – I’m not sure how she will feel about this. It’s about madness, I say. And authenticity. It's about that time when I was in hospital as a teenager. I’m doing something called autoethnography. It’s where you use your own experience. A bit like autobiography, but more focussed.

She is silent for a good few seconds. Her expression is inscrutable.

Did you know I kept a diary of that time? She says. Another pause. Do you want it for your research?

I can’t believe she’s just offered me this. I wasn’t expecting this. Of course I want it, but it also feels like quite a responsibility to her. That would be amazing, I say. Are you sure?

Yes, if you think it will help. I haven’t read it since I wrote it, to be honest. I don’t really want to read it.

I don’t really expect her to give me the diary, but on our way out several hours later, she disappears off to the basement suddenly. When she returns, she hands me a blue A4 lined textbook. Here you go, she says. You really think it will help?

I’m sure it will, I say, awed. Thank you.

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But it’s more than that, I tell my PhD supervisor. Narrative research reconstructs experience to fit a neat trajectory. All of the messiness is ironed out, all of the uncertainty, and confusion, and pain. The story is presented in a nice, neat linear way: beginning, middle, end. But’s it’s not like that. Not when you go crazy. Maybe not even when you’re sane.

That’s fair enough, he says. This is one of our first supervision sessions since I changed supervisors. He is a mental health nurse by background and not a psychologist. He likes creative approaches to these issues.

But how do I get this across? I press. How do I communicate that going mad is often not some extension of normal human processes, like some argue, but is a radical movement into a different way of being, like some suggest?

My supervisor shrugs. Try experimenting he says. See where things go. Put different voices to the voices. Use different tenses. Sometimes that changes things.

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I sit at the same table as I sat three years' ago when I first collected my notes. My clinical notes are on the left, my hand-written recollections of the same events on the right.

And that, I think, is the crux of the matter. Much narrative research in mental health is based on the first-person perspective only, which can, if unchecked, lead down the same back-alley of mainstream psychology in its stubborn refusal to jettison the atomised, individualised self.

The failure of such a self is its inability to acknowledge that we are inescapably and unutterably social, to our very core. Our experience is not our own. For good or for ill, we are what we are to the people who live with us, and who we love, and sometimes who we hate. We are the product of what other people make us to be, and what we make of them.

It's like Patty Lather (2009) argues, "authenticity is much more complicated than singular, transparent, static identity categories assumed to give the writer a particular view" (p. 20).

I think about the people involved in my story: the clinicians who detained me, with all of the best intentions I suspect, but which left me broken and traumatised for many years afterwards; my family, who suffered with me, helpless, but who also contributed, unconsciously and unknowingly, to my distress; my wife, who worked with me to get these experiences down on paper; the therapeutic community, who helped me get my life back; and, finally, my PhD supervisors who guided me and helped me to recognise and give voice to the different people and perspectives around me. My subjectivity is shared amongst them.

And yet… it is a wry irony, and a deep paradox, that, ultimately, the 'buck stops here': one person with a pen and a pad, trying to make sense of all of this complexity.

But I don't think about these complexities too much, just yet. I put pen to pad. I begin to write.

CHAPTER 1. INTRODUCTION: MADHOUSE AND THE WHOLE THING THERE.

As the prologue indicated, this PhD project is concerned with the subjective experience of madness, most principally, how it is experienced and represented, and what the representations tell us about the social context in which madness occurs. Historically, mainstream psychiatry and clinical psychology has approached severe mental illness from epistemological frameworks that have either dismissed the subject of experience entirely by reducing the subject of madness to a collection of individual biological or psychological mechanisms (Rose, 1999) or depicted the experience from the (non-mad) perspective of the professional clinician or researcher (Beresford, 2007). Additionally, first-person narrative accounts of madness, usually written by survivors, are sometimes presented in forms that are coherent, linear and cohesive (Stone, 2004) but which arguably fail to capture the actual nature of the experience itself in terms of its dissonance or its non-linearity (Baldwin, 2005). Finally, the desire to avoid over salacious representations, sometimes called ‘patient porn’ (Costa et al., 2012), or the drive towards seeking overly positive, recovery’ accounts (Woods, Hart and Spandler, 2019), mean that the more negative representations of the experience are avoided altogether.

Thus, there may remain misunderstanding and obfuscation concerning unusual experiences such as psychosis (Stone, 2004) or a tendency to avoid very difficult, but no less true, aspects of the experience. Even more so perhaps, some of these misunderstandings arguably underlie research strategies, policy developments and treatment approaches that may be unhelpful or even destructive for those suffering with severe mental health difficulties (Wallcraft, 2013). There appears to be a vital need therefore for research to address some of these shortcomings in order to further the continuing development of authentic service user accounts of distress (Beresford, 2007). An attempt to address some of these issues form the basis of the thesis.

1.1 Personal Background

These issues are familiar to me from my own personal experience. I am a survivor of madness and using mental health services. As a teenager in the early 1990s, I was hospitalised and sectioned under the 1983 Mental Health Act after experiencing a psychotic episode, where, amongst other things, I received forced medication and Electro-Convulsive Therapy (ECT) as part of my ‘treatment’. I was diagnosed with paranoid schizophrenia and then spent the best part of my late teens and early twenties suffering a series of breakdowns, intermittently in and out of using mental health services. At this point in my life, the effects of these experiences had been fairly brutal: I had very little vocational experience, my educational attainments limited, and most of my friends were drug users.

Although I was diagnosed with bipolar mood disorder in the late 1990s and advised to take mood stabilisers, anti-psychotics and anti-depressants concurrently, conversion to Christianity afforded a brief respite, and then even some hope. I came off medication entirely, discharged myself from psychiatric community care and moved to London to begin a primary school teacher training degree. However, two years into my degree, in 2000, I had another psychotic breakdown. My religious façade crumbled and the fragile sense of hope that I had built over the past few years was effectively destroyed. Through a close friend, I made contact with a rather unique therapeutic faith community in Deal, on the south Kent coast. In what was a fairly radical decision, one which I have never regretted, I moved down to Deal to join the community full-time, whilst also switching from teaching to psychology.

By the time I had left the community ten years later, my life was very different to when I had arrived. I was now married and working as a clinical psychologist in the NHS after gaining a professional doctorate. However, I struggled in my new role. It seemed to me that the relentless drive towards standardisation and measurement was matched only by an associated unwillingness to ask fundamental questions about the metaphysical or socio-political context in which these knowledge frameworks were embedded. A simplistic narrative was adopted around such concepts as ‘wellbeing’ and ‘recovery’, with many service users often expected to make the best of very limited resources. The cognitive behaviour therapy I was encouraged to use (based on National Institute of Clinical Excellence guidelines) reduced the complexities of madness and recovery to atomistic machine language. There was a huge emphasis on medication and diagnosis, even within the early intervention service, and the interventions that really did seem to matter to clients (the day centres and community activities) were being closed or scaled back.

None of these approaches really captured my experience of either madness or ‘recovery’. At the same time, I struggled with the tension between my new identity as a mental health professional and my experiences of being a service user. It seemed to me that the times when I was most successful at my job was when I had been able to build a good relationship with my clients. This was also my experience from being in a therapeutic community. However, even though these insights were given some credence in the mental health system, there was still very little that was being done to apply these insights.

By the early 2010s, my wife and I had moved up to Nottingham and I had changed roles in my professional work. I became involved with the Institute of Mental Health at the University of Nottingham, and found an academic community where I could discuss these questions that had plagued me over the past few years. Questions such as, for example, what was madness, and how do people experience it differently? Why do we treat madness in the way that we do? How do people recover? Why do some people get better and others struggle?

Starting a PhD offered me the chance to explore these questions in a disciplined, systematic way. It also allowed me the opportunity to develop my research skills through an extended period of research training. Finally, doing a PhD would allow me to extend my knowledge of madness and qualitative research, which seemed to me crucial for research and mental health services.

1.2 Finding the Thesis

The thesis was thus borne out of these conflicts as a way of trying to find an intellectual answer to some of these concerns. My initial plan was to look at change in a therapeutic community compared to standard psychiatric care, using a longitudinal design across a number of indices that employed both quantitative and qualitative methods. However, my supervisor at the time encouraged me to first write an autoethnography of my experiences as a way of focussing the research question. I think his anticipation was that I would do this as a prelude to the ‘real’ study.

However, doing this preliminary exercise resulted in three things: it exposed me to poststructuralist and postmodern theory, particularly the works of Foucault, Derrida and Lacan and their critiques of humanism and ‘authenticity’; it foregrounded the importance of subjectivity against positivist methodologies; and it encouraged me to value my personal experience as a tool to begin interrogating the questions I had been asking. At the same time, I began re-connecting with service user and survivor narratives, particularly in their critique of mental health services and psychiatric orthodoxy. At the end of the process of writing the autoethnography, I realised that this was what I wanted the focus of my thesis to be on: what is an authentic representation of the experience of madness, and what does this experience tells us about the social context in which it presents?

Another reason for pursing this area for thesis was the availability of certain data sources. I already had a number of personal diary notes from the time period in question. However, and as the prologue illustrated, I had acquired my NHS clinical notes whilst working as a clinical psychologist in the same Trust where I had once been a service user 15 years earlier. When I began planning the autoethnography, I realised these documents could provide a useful and interesting source for the thesis, especially when used alongside my own diaries. When my mother offered me her diary for use in the thesis, I realised that these three sources could be used together in an interesting way, that could advance our understanding of mental health and make a novel contribution to knowledge.

The PhD thus shifted towards a deeper exploration of my personal experience of madness, alongside a theoretical critique of mainstream psychology and psychiatry. My combined perspectives as a psychiatric survivor, professional psychologist and researcher seemed to present a highly unique vantage point from which to explore madness that was not necessarily well represented in the research literature. Pursuing a PhD thesis in this area therefore presented me with an opportunity to mine my own experiences in detail in order to develop research questions that reflected my interest and concern in the understanding of madness and its treatment. Doing a PhD would also allow me to build a research methodology that could begin to address these questions in a thorough and systematic way. Additionally, it would contribute to the critique of mainstream psychiatry and clinical psychology that eliminate the subject of experience from their epistemological frameworks.

Having identified the focus of the PhD, I originally intended to depict three separate breakdowns in three different time periods (1994/5, 1996 and

2000), as a way of analysing differences across the social context. This would have allowed to look at the process of breakdown, but also breakthrough and recovery, especially my time in the therapeutic community. Indeed, I thought that focussing on both the breakdown and the recovery might also provide some useful points of comparison, in terms of how different environments experience madness.

I eventually decided to focus the thesis on just the first breakdown, which took placed between 1st September 1994 and 16th January 1995. The decision to focus the time period on the pathway into admission was based upon two main reasons. The first was in terms of the principal research question: the period of the first admission provided the opportunity for a more detailed analysis of the psychiatric system, particularly inpatient services. This level of detail would not have been possible if I also focussed on the recovery aspects. The second reason was in terms of data saturation: the clinical notes started in 1994 and ended in 1998, my mother's diary started in 1994 and ended in 2000, whilst my diaries and personal records also began in 1994 and extended to 2004. This was too much data for one thesis; in order to manage this volume of data it was necessary to impose a limit to the time period from which data was used. As the bulk of my clinical records and my mother's diary are in the period of the first admission, and in order to tell the most informative story possible, it was necessary to limit the focus of the thesis to the period of the first admission in late 1994 and early 1995. In doing this, it meant not using the material from the other time points.

The decision to focus the thesis on just this one time was a very difficult decision to make because it necessitated a cutting away of an important area of my experience, namely the experience of recovery. It was almost like I had to edit my life, sacrificing part of my history in the retelling. It also meant the thesis was consigned to focus on the very dark depths of experience, where there was little hope or light. However, I believe this was the best decision, even if done with a very heavy heart, because it allowed for a more focussed analysis, particularly of the psychiatric system and its problems. I do not think I could have done justice to either aspects of my experience within the limits of a PhD thesis, so the decision to focus on the first breakdown was a necessary evil. It also represented a commitment to tell a story as honestly as possible, a story that was ‘excessive and leaky but based in lack and ruin rather than plenitude’ (Lather, 2009, p. 22). Ultimately, there are some things that can never be recovered, and these things deserve to be heard.

Having established the time period and data sources in which the thesis was to take place, I was then able to focus the thesis around core questions and concerns. The following sections provide an outline of the research questions the thesis is intending to address and a structure of the thesis.

1.3 Aims and Objectives

There are two main objectives for the research thesis. The first is to build a novel research methodology from both the social sciences and the humanities that is more able to convey the subjective experience of madness, including the unusual experiences associated with severe mental health difficulties, as a form of ‘insider research’ (Wilkinson and Kitzinger, 2007). As I will discuss in the next chapter, this issue can be illustrated in reference to the concept of ‘authenticity’. The second aim is to contribute to the critique of the epistemological frameworks used by mainstream psychiatry and clinical psychology that marginalise or eliminate the subject of experience. Alongside these aims, an overarching purpose of the doctorate is to explore how the subjectivity of madness is constructed according to different perspectives and discourses.

The following research questions will therefore be addressed:

1. What is an authentic representation of madness?
2. What methodology can be developed on the basis of the concept of authenticity?
3. What can this representation say about the social context in which madness occurs?
4. What are the implications of this representation for future research, theory and practice in madness?

The nature of the thesis is interdisciplinary, with themes across the disciplines of critical mental health, critical theory, sociology of health and illness and health humanities. It has therefore been necessary to take a broad approach to a review of the relevant literature, with topics ranging from knowledge claims in the social sciences, critical approaches to psychiatry and clinical psychology and the nature of authenticity in mental health contexts.

There have also been a number of research outputs that have been produced from the thesis, including peer reviewed journal articles, book chapters and conference presentations. These have been outlined in Appendix 1.

1.4 Structure of the Thesis

This thesis is organised according to 9 chapters as follows:

Chapter 2, Theoretical Literature Review, critically assesses the status of first-person narrative accounts of madness, in particular autoethnography. I argue that what I call autoethnographic mad narratives are often predicated upon an implicit ‘argument from authenticity’. I then offer an alternative conceptualisation of authenticity, ‘tactical authenticity’, based on De Certeau’s (1984) distinction between ‘strategy’ and ‘tactics’.

Chapter 3, Methodology: The Quadrilogue, examines different methodological issues in relation to autoethnography, in particular the distinction between ‘realist’ and ‘evocative’ autoethnographies, whether autoethnography is experimentally ambitious or textually conservative and the status of mental health survivor narrative as empowerment or exploitative. I then present my solution to some of these issues, the ‘quadrilogue’, whilst also discussing ethical issues.

Chapter 4, The Narrative, presents the main data in the form of a 9-part, four-perspective narrative, from pre-admission to discharge. Between each part are original documents from the clinical notes.

Chapter 5, Analysis Method, which outlines the process of coding and analysing the data using of critical Thematic Analysis. The three main themes from the data are identified: double binds, mis/recognition and despair.

Chapter 6, Double Binds, discusses Bateson’s (1972) double bind theory in relation to organisational research, identifying from the narrative examples of conflict between primary and secondary injunctions in the mental health service’s communication and practice.

Chapter 7, Mis/recognition, introduces Lyotard’s (1983) theories of the ‘differend’ in order to show how key areas of biomedical psychiatric practice prevented me and my mother from being able to frame our complaints through the operation of psychiatric language.

Chapter 8, Despair, discusses my main stated reason for seeking help, ‘despair’, and explores how my subjectivity mapped onto psychoanalytic and existential theory on psychosis.

Chapter 9, Conclusion and Implications, re-visits the main research questions and the themes emerging from the literature and theoretical review, summarises the main results, identifies implications for future research, and discusses the main limitations of the thesis.

1.5 A note on terminology

Before proceeding however, I would like to clarify my chosen terminology. I have deliberately opted to use the term ‘madness’. Although controversial, this term is preferable, in this context, to the narrow medical symptomology represented by other clinical definitions such as ‘mental illness’ or ‘psychiatric disorders’ (Baker, et al., 2010). ‘Madness’ encompasses the broader social, psychological and cultural dimensions which are often the ones that matter most to the subjects experiencing mental distress (Burstow, 2015). With the emergence of sub-disciplines such as ‘Mad Studies’ and political movements focussed on the emancipation of service-users from stultifying institutional discourses (Starkman, 2015), the choice of ‘madness’ already reflects the strategic approach to discourse I am arguing for.

I also recognise that various terms have been used to describe the recipients of mental health service treatment, including ‘patient’, ‘service-user’, ‘consumer’, ‘client’ and ‘survivor’ (Beresford, 2007). More recently, the ‘mad positive’ movement has appropriated the self-designated term of ‘mad person’. However, whilst I support some of the endeavours of the so-called ‘mad movement’, like many people who have used mental health services, I do not self-identify as a mad person. In recognition of an inclusive approach, I have therefore decided to use both ‘service user’ and ‘survivor’ interchangeably here to refer to people experiencing or who have experienced madness or distress within a mental health institutional context. I also recognise that the term ‘patient’ is considered pejorative by many in the service user movement; however, as this term was frequently used in the clinical notes, I have also opted to use the term when referring directly to these sources and in my accounts.

CHAPTER 2. ‘TACTICAL AUTHENTICITY’ AND MAD NARRATIVES

INTRODUCTION

R. D. Laing wrote in the preface to *The Divided Self* that he wanted to ‘make madness, and the process of going mad, comprehensible’ (Laing, 1960/1990, p. 9). The problem, Laing argued, was that the categories used by biological psychiatry often bear little relationship to the actual experience of patients. Thus, by presenting madness in purely reductionist biological language, our understanding of what it is like to go mad becomes entirely mystified.

Although Laing did not have direct experience of madness himself when he wrote *The Divided Self*, the purpose of making madness comprehensible to those without first-person experience has arguably been a key driver behind the growth in psychiatric ‘illness memoirs’, ‘autopathographies’ (Aronson, 2000) and ‘patient narratives’ (Woods, 2011) of psychiatric experiences. Such accounts provide an important source of knowledge about the experiences of madness from the ‘inside’ (Woods, 2012). There are several well-known narratives that have influenced the development of clinical theory and practice (Schreber, 1903; Greenberg, 1964; Barnes and Berke, 1990; Saks, 2007; Taylor, 2014), along with a plethora of lesser known works used in medical training programmes (see Hornstein, 2008). According to many, such accounts ‘have a vital role to play in our comprehending, mapping, and negotiating of madness’ (Baker et al., 2010, p. 2).

Alongside the potential of first-person accounts of madness to generate knowledge about the experience of ‘madness’, there is also an emancipatory potential, whereby mad narratives create ‘new ways of understanding mental distress and of working with people to identify new ways of living with or overcoming distress and providing services’ (Faulkner, 2017, p 509). This ‘experiential knowledge’, Faulkner (2017) argues, ‘has a significant contribution to make where some of the basic premises of professional knowledge are strongly contested’ (p. 509). In other words, narratives about madness can provide critiques of mainstream discourses about ‘mental health’ and perhaps even provide alternative conceptualisations of ‘madness’ to biomedical psychiatry. Conceptualised in this way, they can both be linked to the emerging field of Mad Studies and the more established areas of anti-psychiatry (Spandler and Poursanidou, 2019).

First-person accounts thus afford something important and unique that performs two distinct, but at times related, functions: to provide information and insight into an often ineffable and mysterious experience; and to challenge the paradigm of bio-medical psychiatry itself from the perspectives of those who use, or have used, services. More recently, the methodology of autoethnography has emerged that often blends these two aims together in mental health research (McWade, 2019). I would argue, and this chapter will try to show, that many of these attempts are often predicated on what I call an argument of *authenticity*.

Some established thinkers such as Charles Taylor (1991) have argued that the values of our era coalesce around ethical precepts based on a notion of authenticity. Yet authenticity, precisely as a term with extensive cultural capital, is hardly neutral or homogenous, relating as it does to a whole range of practices, values and concepts in public life (Vannini and Williams, 2009). It is also a term that is laden with considerable conceptual baggage linked with humanism and its notion of the 'essential' or 'true' self (Ferrara, 2009). For these reasons, some autoethnographers have dispensed with the concept of authenticity completely, whilst also trying to establish the value of first-person accounts on an entirely separate basis (e.g., Grant, Short and Turner, 2013). In my opinion, these latter attempts have not been very successful, as I will argue more fully in this chapter.

In what follows therefore, I will outline a theory of authenticity that I believe supports the valorisation of first-person accounts of knowledge in mental health autoethnographies without falling into several persistent traps. These 'traps' I will also identify in the course of this chapter. I make the following claims in support of my argument, namely:

1. Authenticity is a heterogeneous concept, but one which encompasses a series of values and practices that do cohere;
2. Homogenising the concept of authenticity, conversely, opens the door to methodological difficulties and dubious practices and affiliations;
3. Attempts to support first-person knowledge claims inevitably centre on some implicit variation of what I call 'the argument from authenticity', even when they explicitly deny it;

4. A modified concept of authenticity can be a viable basis to support first-person knowledge claims in a non-essentialist way – I call this approach 'tactical authenticity'.

I will begin this chapter by locating the concept of authenticity in terms of its linguistic, historical and conceptual background. To indicate some of the traps associated with it, I will then show how the recent positive psychology movement has re-appropriated the concept of authenticity in service of a neo-positivist and neo-liberal agenda. I will then explore how the poststructuralist critique of humanism has already complicated the idea of authenticity. In the final section, I will develop from these debates the notion of a tactical concept of authenticity which, I argue, may be politically useful in both asserting, and deploying in transformational ways, the value of autoethnographic accounts of madness.

2.1 Authenticity: Conceptual Background

Unsurprisingly, the origins of the word 'authenticity' are complex and diverse. It first appeared in English from the mid-14th Century onwards when it had the sense of 'authorised', 'authenticated' or 'recognised by legitimate authorities' (for example, the acceptance of new doctrine by the Church authorities). It was borrowed from the Old French word *autentique*, which had the related meaning of 'canonical', as in, entitled to be included in the cannon of sacred knowledge. The French *autentique* derived in turn from the Medieval Latin term *authenticus*, which itself was directly derived from the Greek term *authentikos*, meaning 'original, genuine, principal'. The root *of* *authentikos* is *authentes*, which combines *autos* (‘self’) and *hentes* (‘doer, being’) to mean - in contrast to its later relation to external authorities such as the church - ‘acting *on one’s own* authority’. This Greek word, *hentes*, comes in turn from the Proto-Indo-European word *sene*, meaning to ‘accomplish’ or ‘achieve’, implying an action that produces recognition. Indeed, some interpreters also cite the Greek word *authenteo* which means to have ‘full power over’ to the extent of ‘usurping another’ or even ‘committing a murder’ (Trilling, 1972).

Therefore, there is a tension at the heart of our conception of authenticity: between authenticity defined as ‘accurate representation of a reality’ and authenticity defined as ‘recognition or authority’. Arguably, our own era privileges the former definition; for example, the Oxford English Dictionary currently defines authenticity as being “in accordance with fact, as being true in substance”. Given these diverse etymological roots, it is no surprise that modern usage beyond the dictionary definition is equally diverse. ‘Authentic’ can mean ‘real’ in the sense of not a copy (e.g., an ‘authentic’ or verified Van Gogh painting, with a corresponding market value); or it can denote the subjective fidelity of an artistic representation (e.g., Wilfred Owen’s poetry presents ‘authentic’ depictions of the experiences of war); or it can be used to describe the integrity of a person or behaviour (e.g., Donald Trump is an ‘authentic politician’ in that he ‘tells it like it is’ etc.). In terms of personality descriptors, we generally describe someone as authentic in terms of their genuineness, forthrightness, honesty and congruence.

One could still understand authenticity through the ancient Greek rhetorical theory of *ethos*: it is what gives truth-value to someone's speech or discourse because of the integrity and relevant experience of the speaker. It is not just that the content of the speech is factually true, but that the one who speaks is especially - perhaps even uniquely - entitled to speak on this topic by dint of their personal experience. It is this latter meaning of the term 'authenticity' which is often used to establish arguments and approaches from the basis of 'lived experience' (Voronka, 2016).

2.1.1 Authenticity and existentialism

Before considering the concept of authenticity's importance in relation to narrative research, it is necessary to look at how it has been established as a concept in academic discourse. Whilst the term and the meanings it conveys have undeniable social currency, authenticity is more than just a cultural value or useful social heuristic: it has also enjoyed status as a recurring concept in philosophical discourse. As a fully formulated intellectual understanding of the world, modern academic concepts of authenticity derived largely from the work of continental philosophy in the 1930s through to the 1950s, particularly Martin Heidegger and Jean Paul Sartre (Kaufmann, 1975). Both explicitly used the term 'authenticity' in their work and were influenced by the works of Søren Kierkegaard and Friedrich Nietzsche, who also foregrounded issues of individual subjectivity and personal agency (Guignon, 2008). However, as I will show, some of the issues encountered in autoethnographic accounts of mental health are linked to how authenticity has been conceptualised in various academic discourses.

Early Heidegger (1998) formulated his version of authenticity, in the second section of Division Two of *Being and Time*, according to the neologism *eigentlichkeit*, which names the attitude in which one engages in projects *as one's own* (*eigen*). Heidegger was playing on the ordinary German term 'eigentlich', meaning 'truly', which has the root 'eigen' meaning 'own' or 'proper to'. Adding 'keit' to *eigentlich* turns it into a transitive project, an unfolding which also implies a process of 'owning' or 'propering'. Therefore, for Heidegger, authenticity involves taking ownership of one's unfolding life in terms of one's relation to a trans-individual Being. This would be in contrast to the majority of people who are content with a form of inauthentic 'thrownness' into the everydayness of 'the-they' which alienates them from Being (Guignon, 1984, 2008).

For Sartre (1948), relatedly, authenticity consists in avoiding the 'bad faith' that comes from denying the inescapable tensions between choice and circumstance. The authentic person here is the one who makes genuine existential choices but also takes responsibility for their consequences, despite the horror or disgust they may feel towards the ultimate meaninglessness of the universe (Kaufmann, 1975). Where Heidegger tends to think of authenticity as an alignment with Being such that the Cartesian cogito is left behind, Sartre's existentialist humanism grounds authenticity in a cogito that knows it is "condemned to be free": after the death of God, the only authentic position is to refuse to let oneself off the hook with merely inherited worldly moralities, and instead confront the ethical stakes in every one of our choices and actions. If Heidegger's authenticity implies a participation in the epochal Being of a world, Sartre's authenticity invokes an isolated individual defying worldly conventions - so much so that in his *Being and Nothingness* the prisoner is presented as a paragon of authentic freedom (Guignon, 2008).

Although both Heidegger and Sartre's work were highly influential in developing values and practices based on the foundation of individual subjectivity (Guignon, 1984), both thinker's notion of authenticity have been subjected to sustained criticism on both ethical and philosophical grounds. Adorno (2003), in particular, developed a Marxist critique that characterised Heidegger's 'jargon of authenticity' as an ahistorical form of obscurantism that promises the 'unconcealment of Being' but in fact 'gives itself over either to the market, to balderdash, or the prevailing vulgarity' (2003, pg. xix). In other words, Heidegger's notion of authenticity served ideological purposes, obscuring real historical contradictions associated with power and exploitation.

According to Adorno then, the jargon of authenticity could ultimately be used to legitimise both the bureaucratic tyranny of Nazism and the exploitative language of advertising in late Capitalism. If Adorno (1973) has a contrasting notion of 'authenticity', it is a negative authenticity that confronts the non-identity at work in identity. Regarding Sartre, Jacques Derrida (1972) pointed out that he never quite dispensed with the notion of a Cartesian self that makes choices, and analyses those choices, somehow outside of the constraints of societal context or language. For Derrida, Sartre's project of an existential humanism for the era following the death of God was thus ‘nothing other than the metaphysical unity of man and God, the relation of man to God, the project of becoming God as the project of constituting human-reality’, so much so that ‘Atheism changes nothing in this fundamental structure’ (Derrida, 1972, p. 116). Sartrean existentialist authenticity for Derrida would smack of onto-theology and metaphysics.

As these philosophical debates illustrate, the tensions within the concept of authenticity, between the representation of an essential reality on the one hand and questions of authority and ownership on the other, are played out in relation to fundamental philosophical questions such as the very nature of thought. They also show how the notion of authenticity is tied up with concepts of individual subjectivity and (non)identity. As I have already argued, the importance and value of individual subjectivity is crucial to establishing first-person accounts of madness, particularly through methodologies such as autoethnography (McWade, 2019). There are therefore resonances between these conceptual debates and the main questions of the thesis.

However, these conceptual debates are not limited to past debates between rival existentialist, Marxist and post-modernist philosophical schools of thought. More recently, humanist and positive psychologists have taken on a version of authenticity which has important ramifications for narrative research in madness. In the next section, I explore this version of authenticity and some of its main problems in order to show the problems with a version of authenticity that this thesis is explicitly rejecting.

2.1.2 Authenticity and positive psychology

Although existentialism was beginning to decline in influence in Europe around the 1960s, several of its main theoretical tenets were to be revived, albeit in a culturally idiosyncratic way, in American humanist psychology. Carl Roger’s articulation of the ‘actualising principle’ at the centre of human striving owed much to Kierkegaard, whilst Abraham Maslow’s famous ‘hierarchy of needs’ and ‘peak experiences’ similarly borrowed from Nietzsche (Medlock, 2012). Of course, the profoundly disturbing, even deconstructive, nature of Kierkegaard and Nietzsche’s thought is noticeably absent from Rogers and Maslow; there, the individual is conceived of in terms of ‘positive striving’ and the drive to ‘congruence’ rather than in terms of their relation to sin (Kierkegaard) or power (Nietzsche).

If American humanism seemed to borrow from an existentialist language shorn of its more pessimistic and challenging elements, then this probably represented something of the culture of both the United States and the growing discipline of psychology (Parker, 2015). However, the spectre of the essentialist Cartesian self, indirectly present in Sartre’s thought, is very much in the foreground in empirical psychology (Parker, 2007). It is little surprise then that the concept of authenticity would experience something of a revival through a marriage between American humanism and empirical psychology in the new sub-discipline of positive psychology.

According to its proponents, positive psychology is ‘the scientific and applied approach to uncovering people’s strengths and promoting their positive functioning' (Snyder and Lopez, 2006, p. 3). Distancing themselves from what they perceived to be mainstream psychology's preoccupation with the 'negative' aspects of human pathology, positive psychology instead focusses upon the 'positive' aspects of human nature, conceived by Seligman and Csikszentmihalyi (2000) as positive subjective experiences, positive individual traits, and civic virtues. These 'civic virtues' are tied to Classical character traits such as wisdom, courage, humanity, justice, temperance and transcendence, all formulated according to the basic assumptions of positive psychology: that there is a human 'nature'; that action proceeds from character; and that character comes in two forms, both equally fundamental - bad character and good virtuous character (Seligman, 2002a, p. 125). Seligman (2002b) summarises the positive psychology perspective on human functioning thus: 'When well-being comes from engaging our strengths and virtues, our lives are imbued with authenticity' (p. 14).

If the assumptions underlying positive psychology seem somewhat simplistic, this is probably due in part to a tendency in psychology to formulate concepts that can be easily subjected to quantitative evaluation (Parker, 2007). A more recent trend in the growing conceptual amalgamation between humanist and positive psychology is the rise of empirical measurement of key humanist concepts (Joseph, 2015). On this basis, the concept of authenticity has been developed from Rogers' (1961) notion of congruence and investigated as an 'individual difference variable' leading to formulations of the 'authentic personality' (Wood et al., 2008). In this 'new' approach to authenticity, authentic living can be understood as 'being true to oneself in most situations and living in accordance with one's values and beliefs' (Wood et al., 2008, p. 386), with psychopathology becoming the degree to which ‘the person experiences self-alienation between conscious awareness and actual experience (the true self)’ (p. 386). Finally, ‘the extent to which one accepts the influence of other people’ along with ‘the belief that one has to conform to the expectations of others’ (p. 382) marks the degree to which one is able to ‘resist external authority’ – the third component in Wood et al.’s (2008) tripartite conception of authenticity. This ‘authentic personality’ has then been measured in a number of ways familiar to empirical psychology: questionnaires, laboratory experiments and mood reporting via digital technology (Lenton, Bruder et al., 2013; Lenton, Slabu et al., 2013; Davis et al., 2015).

Empirical psychology literature has tended to look at associations between authenticity and popular positive psychology concepts such as ‘wellness’, ‘flourishing’ or ‘flow’ and this probably reflects the tacit assumption that authenticity can be used as a benchmark for other positive psychology concepts such as ‘wellbeing’ and ‘self-actualisation’ (Joseph, 2015). This approach has some rather obvious limitations. It is entirely possible that white supremacists in the United States, for example, could experience ‘congruence’ between their actual experience of hating black people and their values of ethnic purity, whilst also resisting the external authority of Liberal political consensus through hate rallies and armed militias, but we have yet to come across a positive psychology study that has looked at authenticity and flourishing amongst the alt-right. This example may be extreme perhaps, but it does illustrate the tendency amongst some psychologists to assume their concepts are ‘objective’ and thus apolitical (Parker, 2007), whilst simultaneously employing standards of measurement and theoretical constructs that are tied very closely to political practices that are far from neutral or benign (e.g., Wright, 2013, 2014; Davies, 2016; Cederström and Spicer, 2009).

There are further theoretical and methodological shortcomings in authenticity research within the narrow disciplinary confines of psychology. For instance, people who are ‘inauthentic’ are, by definition, highly unlikely to be aware of their supposed inauthenticity and hence highly unlikely to reflect this quality in the type of measurements used by psychologists. The difficulty appears to reside in how the complexity of identity, and the varied manifestations of selfhood in everyday life, may alter considerably according to different contexts and the different roles people occupy in these contexts (Ferrara, 2009). This leads however to the paradox of an inauthentic study of authenticity, one which ultimately relies on a binary notion of self that is built upon a true/false dichotomy often taken for granted by authenticity researchers. Psychologists have reprised the essentialist nature and meaning of a ‘core self’ (Parker, 2007), but this is especially true of a core self that is tied to the much narrower idea of living according to a pre-set criterion of ‘strengths’ and ‘virtues’.

Thus, for these reasons, I am not employing the positive psychology and humanistic concept of authenticity in this thesis and, indeed, the version of authenticity that I recommend stands in opposition to humanistic and positivist accounts. In the next section, I will explore another ‘version’ of authenticity that is tied to very different principles and practices to positivist psychology but which still, nevertheless, retains many of the issues identified in the previous sections. This version could be perhaps be called the 'narrative' claim to authenticity.

2.1.3 Authenticity and narrative

The complexities of studying authenticity, outlined in the last section, have led some psychological authenticity researchers to conclude that the best way of studying authenticity may be across a whole lifespan using autobiographical life-story narratives (Harter, 2005). Here, at least some form of developmental continuity in behaviour can be established beyond the immediate context of the psychological survey or experiment. As Harter (2005) elaborates:

> [N]arrative construction is a continuous process as we not only craft but also revise the story of our lives, creating blueprints that facilitate architectural development of the self. In so doing, one's life story can also emerge as a true story (p. 391).

In other words, the complexity of narrative construction and reconstruction, along with its relationship with the ongoing process of revision, mean that the 'truth' of the story (i.e., its 'authenticity') can emerge in the process of telling. Indeed, this was one of the reasons why leading psychologists such as Jerome Bruner (1990) endorsed narrative representations of 'mind' over the reductionist cognitive and behavioural approaches of mainstream empirical psychology. Is the future for the study of authenticity therefore to be found in narrative approaches, and not in empirical psychology?

In many ways, the place at which Harter arrives above probably represents more continuity with the concept's phenomenological and existential origins - i.e., narrative as self-making or autopoiesis as opposed, ultimately, to market research methods – which is probably why much of the research from the humanist stable tends to be qualitative (Joseph, 2015). Yet, narrative research has its own narrative of authenticity concerning its legitimacy and this is particularly the case with narrative research that comes under the general heading of 'autoethnography'. It is to these approaches that I will turn to now.

2.2 The 'Narrative Turn' in the Social Sciences

The value of research participants' subjectivities as valid objects of study in social science research has a long history in qualitative inquiry. Sustained questioning of positivist assumptions of researcher neutrality, scientific objectivity and the possibility of value-free research led to the flourishing of research approaches emphasising the value of 'lived experience' (Voronka, 2016). Drawing upon diverse theoretical frameworks, a plethora of subjective methodologies employ novel and ground-breaking approaches (Denzin and Lincoln, 2000). Similarly, the research inspired by these approaches also shed light on areas of experience and social life previously marginalised by social scientists, such as crime and imprisonment, mental health, ethnicity, sexuality and power (Holman Jones, 2005).

The works that arise from these subjective methodologies mark what many have labelled a ‘golden age’ in social science research (Denzin and Lincoln, 2000). However, despite attempts to mark out new territory in the investigation of personal experience free from the ideological baggage of positivism, many of these approaches are underpinned by theoretical assumptions that results in qualitative research taking on established social science conventions consistent with positivist social science (Riessman, 1993). Some of the conventions include a clear linkage to theory and hypotheses, the predominant use of impersonal ‘academic’ third person voice and the employment of conventional writing structures (Ellis and Bochner, 2006). Even more problematically perhaps, the researcher is often entirely invisible from the research, even if their assumptions and prejudices are visible in the work in indirect ways (Holman Jones 2005).

Given this, the initial surge of interest in qualitative approaches and their associated critique of positivism led to a position where the form and content of how research was communicated did not change. In essence, many qualitative approaches failed to capture and communicate the experience of subjectivity in any particular depth (Grant, 2014), especially in terms of the experience of certain subgroups within mainstream society (Biddulph, 2010). Indeed, it was often researchers from these subgroups who found that their personal experiences of difference were either misrepresented, or marginalised entirely, by the white, male, middle-class, heterosexual and abled hierarchies of mainstream academia (Biddulph, 2008). Arguably, new approaches were needed that captured such experiences but could also challenge the ‘onto-epistemological’ assumptions underlying such practices (Speedy, 2013).

Criticisms of positivism were thus sustained and extended during a period in human inquiry termed the ‘narrative turn’ (Riessman, 1993), or the ‘triple crisis’ of representation, legitimation and praxis (Denzin and Lincoln, 2000). Informed by postmodern and poststructuralist critiques of humanism underlying much of the research in the social sciences (Grant 2014), narrative researchers aim to honour, as close as possible, the lived experience of participants in terms that participants themselves describe. In practice, this entailed research which was either generated by the participants themselves, or participants were recruited by academics as ‘co-producers’ of the research (Ethrington, 2004).

Perhaps the most startling innovation in narrative research is the re-appropriation of the experiences of the researcher and the subsequent weaving of these narratives back into the reporting of the research process. This form of ‘hyper-reflexivity’ (Speedy, 2013) became a defining feature of the emerging methodology of ‘autoethnography’. As autoethnography is the narrative method par excellence in its employment of the first-person perspective, and because the first-person perspective in madness is the key focus of this thesis, I will examine the theoretical tenets of autoethnography in more detail in the next section, particularly its relationship with ‘authenticity’.

2.2.1 Autoethnography and narrative

It is in this climate of critique of positivism that the methodology of autoethnography emerged in the social sciences. Frustrated by research that failed to recognise the invisible and unacknowledged, yet very real, presence of the researcher (Ellis and Bochner, 2000), alongside disillusionment with what was perceived to be the increasingly sequestered and elitist position of academic discourse (Holman Jones, 2005), autoethnography sought to recapture something of the vitality of ‘lived experience’ in the research enterprise, with the researcher’s own experience becoming the primary ‘data’ (Bochner, 2001). ‘I become a detached spectator’ write Ellis and Bochner (2006) about traditional methods, ‘I become only a head, cut off from my body and emotions. There’s no personal story to engage me’ (p. 481).

In contrast, autoethnography focussed on lived experienced which prioritised both the stories of the researcher and researched, but also the first-person perspective as an important way of writing academic research (Ellis, 2004). This move was predicated on what Grant et al. (2013) depicted as ‘a shift from a single, monolithic conception of what should constitute scholarly work in favour of a developing pluralism’ (p. 3). A key element in this pluralism was an explicit argument for the authenticity of first-person accounts. As Art Bochner (2001), a prominent autoethnographic researcher, argues, narratives ‘have a major role to play in the ill person’s quest for authenticity, a journey he or she may never reach but cannot resist.’ (p. 147).

Autoethnography thus combines personal narrative (‘auto’) writing (‘graphy’) to reflect on, analyze, and explore socio-cultural practices and institutions (‘ethno’). Within autobiography, the focus is often on ‘epiphanies’ – ‘remembered moments perceived to have significantly impacted the trajectory of a person's life’ (Ellis, Adams and Bochner, 2011). These recollected accounts are retold for dramatic or personal interest purposes (Biddulph, 2008), often utilizing literary tropes (e.g. first or third person accounts, dialogue, imagery etc.) to increase the interest of the story and maximise impact for the reader. Ethnography, on the other hand, is a form of research which purports to illustrate the cultural, relational and social practices of a given community or a sub-culture within a wider social group (Ellis, 2004) through the researcher’s practice of participant observation – becoming an active member of the social group under observation (Anderson, 2006). Autoethnography combines both the conventions of autobiography in the retelling of ‘epiphanies’ with the explicit ethnographic goal of investigating the social world (Ellis et al., 2011).

Autoethnography is thus both a process and a product of social research, utilizing personal experience as primary data in developing an understanding of social phenomena (Denshire, 2014). In other words, the researcher’s experience of belonging to particular groups in society is used as the basis for exploring wider social themes relating to difference and belonging (Anderson, 2016). It is this combination of personal experience as ‘data’, used as a tool to interrogate and examine social processes, that distinguish autoethnography from similar approaches in the social sciences and medical humanities, such as autobiography or self-case study methodology (Le Roux, 2017). However, autoethnography is a ‘slippery term’

(McWade, 2019); it is by no means a homogenous methodology with clear boundaries between other approaches and disciplines (Wall, 2008).

In these terms, and at first glance, narrative approaches such as autoethnography would seem to provide an ideal basis for an empirical study of human life and subjectivity, both in terms of developing knowledge but also in terms of an ethical imperative to honour the experience of those being researched. It thus appears to combine both of those elements, knowledge and politics, that I identified in the beginning of this chapter as being crucial to mad narratives. However, the argument deployed here against the perceived hegemony of academia and for the restoration of the first-person perspective, was one of *authenticity*.

However, such ‘arguments from authenticity’ are not without issues. Autoethnography retains a difficult relationship with this concept that is reflected in several different ways. In the next section, I will outline some of the conflicts and, I would argue, contradictions in the autoethnographic employment of the concept of authenticity.

2.2.2 Autoethnography and authenticity

Unfortunately, many autoethnographic approaches fall prey to a set of problems that also underlie the empirical positive psychology approaches – namely, the assumptions surrounding the self, particularly the true/false binary, or even the notion that there is such thing as a ‘true’ self to begin with, outside of the way in which the ‘self’ is performed in a particular social context. Indeed, a more pressing problem has been the way some narrative approaches such as autoethnography have settled for a form of narrative reductionism based on an idea of authenticity. For example, Atkinson (2009) argues that because ‘narratives are treated as proxies for the direct apprehension of subjective, personal experience’ (S1.3) they are considered by autoethnographers as ‘sources of authenticity, grounded in the biographical particularities of speaking subjects’ (2.11). This results in a notion of supposed narrative exemplarity leading to a reductionism, an ‘equation of the social with the personal’ (2.14), In such a schema, according to Atkinson (2009), personal expression, via the first-person perspective only, takes the place of systematic and rigorous social analysis. Elsewhere, Atkinson (2013) refers to these assumptions as forming a ‘sentimental realism’ whereby ‘the narrating speaker is celebrated as an atomised subject’ (2.14) with its emotional truth to convey. It thus replicates the atomised, individualised subject of empirical psychology, discussed above in the positive psychology section, albeit with a very different methodological approach. However, like positive psychology, it is founded on the basis of an appeal to authenticity. Thus, the concept of authenticity is thus somewhat problematic in autoethnographic research because it revives the problematic binaries of existentialism whilst also employing a notion of the self that is atomised and individualised in the same way as positivist, positive psychology.

Given these problems, it is no surprise that some autoethnographers dispense with the concept of authenticity entirely. For example, Grant et al. (2013) argue for a form of autoethnography that is established on a different basis to a concept of authenticity that assumes a stable, coherent, ‘true’ self in a way that many of their predecessors do (e.g. Bochner, 2001) with its appeal to associated values such as integrity and emotionalism. Thus, Grant et al. (2013) call for ‘the poststructural narrating voice of the emergent ‘I’’ over the ‘narrative voice of the predetermined I’ (p. 8). By showing a self that emerges from a state of flux rather than a ‘true’ self that needs to be discovered, Grant et al. (2013) want to ‘show how subjectivity is produced rather than to display a privileged and secure, transcendent narrative identity position’ (ibid p.8). In order to do this, they advocate a textual disruption of the singular voice, a privileging of the distinctive voice that is constructed through textual devices such the use of irony, humour, mockery and silence.

Grant et al. (2013) therefore argue that their proposed solution avoids an appeal to the fixed, essentialist categories that result in the problems identified by Atkinson (2009). However, at the same time as repudiating an appeal to authenticity based on humanism, Grant et al. (2013) still try to establish validity for narrative research against the criticisms of positivism by appealing to a form of authenticity. Thus, it appears to be something of a contradiction when Grant et al. (2013) repudiate the role of authenticity so fully in their chapter because of its humanist assumptions of presence, and then assert that:

> Arguably, academic-, discipline- and profession-based practice based on personal knowledge and experience is more credible, ethical, imbued with integrity, empathic and potentially effective. This marks the difference between implicational and

> propositional knowledge: between knowing, feeling, connecting and doing, from the heart, based on personal experience, rather than solely on the basis of rationally acquired information. (p. 11).

By appealing to such values as credibility, integrity, feeling, ethics and personal experience, Grant et al. (2013) have foregrounded the same qualities we usually ascribe to the concept of ‘authenticity’ and which grounds the self in the same transcendent and fixed identity categories they have previously rejected. Therefore, although Grant et al. (2013) have succinctly summarised why autoethnography is such an important methodology, theirs’ is still an ‘argument from authenticity’ that surreptitiously employs the same categories used by earlier, humanist researchers. Of course, it is also possible that Grant et al.’s (2013) arguments are based on an overly-simplistic reading of Derrida (1976), maintaining, as they do, some of the binaries of presence (e.g., feeling/intellect, implicational/propositional etc.) that Derrida was at pains to deconstruct in his work. Either way, their solution is problematic and arguably inconsistent.

There is thus some important dilemmas here that need to be resolved: how can narrative research more generally, and autoethnography in particular, be legitimised when the main argument for its validity has resided in an argument for authenticity; and, if we attempt to abandon notions of authenticity on the basis that they re-inscribe humanist notions of presence, on what basis can we still emphasise the *strategic* importance of autoethnography? These dilemmas, and their solution, have important ramifications for the development of first-person methods in mental health research, particularly when the subject is something highly contested like the experience of ‘madness’ (McWade, 2019). The next section will explore the implications of these questions for service user and survivor narratives in more detail.

2.3 Strategic Essentialism and Tactical Authenticity

The psychiatric survivor and mental health researcher who wants to employ autoethnographic methods when voicing their experience could well be caught in a peculiar double-bind. On the one hand, the values of such approaches may lie in challenging stigma whilst also providing the opportunity to educate professionals, lay people and students as to the actual conditions and experiences of people who use services (Rose, 2019). On the other hand, there is a risk of falling into unhelpful binary oppositions when invoking concepts such as ‘voice’ or ‘lived experience’ (Voronka, 2016) that risk creating a different set of problems. As Rose (2017) observed, there is a tension between valorising ‘lived experience’ at the same time as utilising epistemologies that call into question the validity of such concepts as ‘voice’ or ‘experience’.

This dilemma is also present in other fields such as postcolonial theory and where perhaps an alternative solution may be found. For example, the postcolonial theorist, Gayatri Spivak (1990), recognised a similar dilemma in the position she often found herself occupying as a ‘spokesperson’ for ‘subaltern’ Indian women in the United States. However, Spivak (1990) also attempted to turn this dilemma to her advantage:

> But it is not possible, within discourse, to escape essentializing somewhere. The moment of essentialism or essentialization is irreducible. In deconstructive critical practice, you have to be aware that you are going to essentialize anyway. So then strategically, you can look at essentialisms, not as descriptions of the way things are, but as something that one must adopt to produce a critique of anything. (p. 51)

In other words, the essentialist categories of ‘Indian’ and ‘woman’ may indeed be problematic, but they do provide the (‘Indian’, ‘woman’) speaker with a certain degree of legitimisation in the mainstream discourse, a place from which to speak and from which some form of resistance and challenge can be mobilised. As Spivak (1988) elaborates, ‘it is within the framework of a strategic interest in the self-alienating displacing move of and by a consciousness of collectivity, then, that self-determination and an unalienated self-consciousness can be broached’ (p. 14). Could the same approach work for autoethnographic mad narratives, that is, legitimisation of the survivor’s ‘voice’ based upon this ‘strategic’ version of authenticity?

Whilst this approach may be superficially attractive, there are at least three problems when applied to madness narratives. Firstly, madness is a ‘limit experience’ which, according to Foucault (2001), has the ‘function of wrenching the subject from itself, of seeing to it that the subject is no longer itself, or that it is brought to its annihilation or its dissolution' (p. 241). It is an inherently deconstructive experience; when speaking or writing about such experiences there can be 'a disjunction between the content to be narrated and the possibilities inhering in conventional narrative forms' (Stone, 2004, p. 18). Secondly, madness is not a homogenous experience; some experiences may be constructed differently in different contexts (e.g., religious voice hearers in church and voice-hearing psychiatric patients in hospital) and so-called 'mad identity' incorporates a vast range of conditions, experiences and treatments (Miller, 2017). It is thus difficult to essentialise an experience as heterogeneous as extreme psychological distress, when the conditions for some experiences (e.g., eating disorders) are bound to differ significantly from others (e.g., psychosis). As Miller (2017) observes, 'the experience of psychiatric oppression in its various forms is presumably an important commonality, but there seems no reason to presume any further unanimity' (p. 17).

Thirdly, and perhaps most importantly, it is questionable whether intervening through essentialising experiential or identity categories actually works. Sometimes, the place you are given to speak from is simultaneously a major constraint on what you can say, or be heard as saying (Voronka, 2016). Indeed, Spivak eventually rejected the concept of strategic essentialism herself precisely because 'my notion just simply became the union ticket for essentialism' (Danius, Jonsson and Spivak, 1993, p. 35). In other words, strategically essentialising experience led to the very essentialist tendencies she was seeking to avoid in the first place (Wright, 2002). This is particularly pertinent to the field of mental health, where differences between experiences are even less likely to be anchored to singular identity categories due to the heterogeneous nature of ‘distress’. As Voronka (2016) observed when discussing strategic essentialism in terms of service user research, ‘using experience and identity as a commodity to gain entry into systems of power’ is a double-edged sword which can result in ‘entrenching and naturalizing difference’ (p. 199). As has been observed in the growing field of Mad Studies, it is often difficult to establish the boundaries from which it is possible to speak meaningfully about ‘distress’ or ‘madness’ (Spandler and Poursanidou, 2019).

However, a possible way out of this dilemma may be found in terms of taking another look at the concept of ‘strategy’ itself, especially in relation to other theories. For example, when discussing her eventual rejection of the concept of strategic essentialism, Spivak added a further important qualifying observation: ‘As to what is meant by strategy, no one wondered about that’ (Danius et al., 1993, p. 35). This raises an important question regarding the limitations of ‘strategy’ itself that may provide a clue as to why her project was unsuccessful.

A possible solution to this dilemma may therefore be found in the work of Michel De Certeau and specifically in his distinction between ‘strategies’ and ‘tactics’. De Certeau (1984) calls ‘strategy’: ‘the calculation (or manipulation) of power relationships that becomes possible as soon as a subject with will and power (a business, an army, a city, a scientific institution) can be isolated’ (p. 35-6). Strategy is thus, essentially, a military term having to do with territories and the top-down imposition of forms of rationality and practice that exert an ongoing control over users. By contrast, De Certeau defines ‘tactics’ as ‘a calculated action determined by the absence of a proper locus’ (p. 37), that is, without a territory of its own, which also occurs in a different temporality, one that seizes the opportune moment (what the ancient Greeks called *Kairos*) that appears within the metronymic regularity of rationalised time (*Chronos*). If strategy is determined by those with power, tactics are the operations used by those with little power who nevertheless find ways to subvert and adapt strategies to suit their own ends.

Tactics are thus adaptations to environments or territories that are shaped by strategy but move in opposition to it, against its grain. For example, town planners might determine the streets of a city with expectations of how people will use them, but those who know the environment, the ‘users’, will spontaneously adapt the routes they take to suit their experience (e.g., taxi drivers using shortcuts, or so-called ‘desire lines’ that traverse planned pathways). In this way, ‘strategy is transformed into tactics’ (p. 37) within its very terrain. De Certeau’s work thus identifies, within institutionalised forms of power, an immanent possibility of subversion which is not reducible to the forms of representation through which such power works, and yet necessarily accompanies them.

One could also define the relationship between psychiatry and the service-user/survivor movement in a similar way: although psychiatry as a discipline maintains a presence through its strategies of place (hospitals and university faculties), observation (measurement technologies) and bodies of knowledge (classification systems), service-user movements have nevertheless been able to gain a foothold within these institutions and move, precisely, across them somewhat obliquely. An example of this tactical appropriation of strategy can be seen in neo-liberal policies of patient engagement, which do give patients an institutional space in which to speak, at least in the UK where service-user representation in the National Health Service has in fact become mandatory (Rose, 2015), and thus to speak ‘against the grain’. Illustrating this, Rose et al. (2003) have shown that when participants were interviewed about their experience of electroconvulsive therapy (ECT) by service-user researchers rather than by professional researchers or clinicians, ‘satisfaction’ turned out to be significantly lower than had been found previously, thereby challenging the asserted legitimacy of ECT (Rose, 2008). In this instance, the tactics based upon contextualised, experiential knowledge which were then employed using the *language* of strategy (i.e., ‘evidence-based practice’ and ultimately ‘customer feedback’), were able to subvert the knowledge claims of the dominant strategic form of power, resulting in concrete changes to policy in terms of how ECT was administered. As Rose (2008) later elaborated, ‘We intervene on the terrain drawn by psychiatry and try to re-shape its priorities in a user-focused direction’ (p. 642). This example shows that tactical interventions can occupy the same terrain as the strategies that make up these fields, but precisely by displacing the identity-categories that I believe are part of the problem.

Autoethnographic mad narratives may therefore offer a similar tactic in terms of intervening into the discourses of psychiatry via the discourse of authenticity. As Charles Taylor (1991) recognised, ‘the moral force of the ideal of authenticity' (p. 17) is still 'one of the constitutive ideals of modern culture' (p. 18). Similarly, the liberal representational stance of Western culture (i.e., 'I respect your experience and I'm listening to what you have to say about it') provides opportunities for autoethnographic mad narratives to occupy a space within psychiatric research and practice, but in order to tactically disrupt it, rather as occupations are an important tactic among activists. Such approaches might therefore lay claim (or, indeed, re-claim) the original meaning of the term 'authenticity' which emphasises the importance of gaining recognition, and establishing authority for one's experience, precisely there where the 'owness' of experience is put into radical question.

As opposed to its strategic counterpart, tactical authenticity, I would argue, makes it possible to give voice to the radical heterogeneity and singularity of the experience of madness. The next chapter provides a review of some examples from the literature of tactical authenticity in the production of mad narratives and introduces my own suggested solution, the 'quadrilogue'.

SUMMARY

This chapter explored the concept of authenticity related to mad narratives in the research method of autoethnography. Despite varied etymological and cultural roots, authenticity has been used to mean primarily 'real' as in 'not a copy' or, less commonly, to mean pertaining to 'authorship' or 'authority'. These tensions have been reflected in philosophical debates concerning identity and subjectivity and have found expression more problematically in recent empirical positive psychology research. Some researchers have attempted to reclaim the notion of authenticity, principally through the methodology of autoethnography, but these attempts often result in a deployment of the same categories (often surreptitiously) that affect positive psychology. Although these issues are confronted through Gayatri Spivak's notion of 'strategic essentialism', a possible solution was proposed in Michel De Certeau's distinction between 'strategies' and 'tactics'.

CHAPTER 3. METHODOLOGY: THE ‘QUADRILOGUE’

INTRODUCTION

The purpose of the thesis is to examine authentic representations of madness and what these representations tell us about the social context in which madness occurs. As the previous chapter discussed, problems in the use of the concept ‘authenticity’, particularly in first-person research in madness using methods such as autoethnography, led to my development of the concept of ‘tactical’ authenticity utilised from De Certeau’s (1984) distinction between ‘tactics’ and ‘strategy’. The implications of ‘tactical authenticity’ for narratives of mental health are that the procedures and style of the mainstream (their ‘strategies’) may be employed, but as a deliberate tactic to disrupt and to challenge those very same structures. In the sense of narratives and stories of mental health (or ‘mad narratives’), such narratives are welcomed by the liberal injunction to ‘tell one’s story’ and the focus on ‘lived experience’ and ‘public and patient involvement’. However, once acquiring space within this strategy, narrative approaches can then disrupt the dominance of strategy by raising awareness of issues that would otherwise not be considered. In some ways, I am doing the same thing in terms of tactical authenticity in terms of intervening in the strategic terrain of a PhD thesis.

Having discussed some of the issues with the concept of authenticity and the methodology of autoethnography, this chapter will discuss my methodology for the thesis, an adapted version of autoethnography based on ‘tactical authenticity’ which I call the ‘quadrilogue’. This section will explore some of the issues in using autoethnography, including whether to use a realist or evocative method, textual conservativism versus genuine experimentalism and the issues of representing mad narratives without falling into what has been called ‘disability tourism’ or ‘patient porn’ (Costa et al., 2012). Identifying the ways in which my methodology aims to overcome these difficulties, I will then present my method, including the data sources used and the style of presentation. Finally, I will discuss the ethical issues that arise from the methodology, primarily focussing on two areas of ethics pertinent to autoethnography: ethical issues arising from ‘relational ethics’ (the representation of others) and ‘risk to self’ (risk issues to the researcher).

3.1 Autoethnography

3.1.1 ‘Evocative’ or ‘realist’?

Unlike many traditional qualitative research methods, there is no set format for doing autoethnography (Denshire, 2014). Indeed, as Ellis and Bochner (2000) and others (e.g. Holman Jones, 2005; Grant et al., 2013) have argued, autoethnography is in a constant state of reinvention and re-creation. To some extent therefore, all autoethnographies remain experimental in nature and cross boundaries with other qualitative methodologies such as narrative enquiry, community psychology, performative ethnography, self-case history, biographical research and reflexive ethnography (Ellis et al., 2011). Indeed, as Ellis (2004) states, autoethnography even crosses many different boundaries between disciplines and styles and the autoethnographic researcher should be committed to developing their own idiosyncratic style.

Despite this, there has often been fierce debate within the autoethnographic community about the style and form that autoethnography ideally should take (Denshire, 2014). Although autoethnography is a notoriously difficult method to categorise, two main styles are typically referred to in the research literature: ‘analytic’ autoethnography and ‘evocative’ autoethnography (Tolich, 2010). The former style more closely resembles traditional social science methodology, indicated by its focus on data gathering via tried and tested methods (e.g. interviews, documents, focus groups etc.), data triangulation through multiple sources, a consideration of multiple perspectives, the use of the impersonal academic third-person pronoun, and other such devices (Anderson, 2006; Chang, 2008).

For these reasons, many argue that there is considerable overlap between analytic autoethnography and reflexive ethnography (Ellis and Bochner, 2006). In contrast, ‘evocative’ autoethnographies often eschew traditional research methods (Gannon, 2006). Data is drawn primarily from the researcher’s own experience and the exact source from which the representation is drawn may not always be entirely clear, or be gathered systematically (Holman Jones, 2005). In addition, the style of ‘evocative’ autoethnography can depart quite markedly from traditional social science methodologies with the styles being more experimental in nature (Ellis, 2004), utilising creative methodologies from the arts and humanities, including the use of dialogue, personal reflections, dreams, poetry and other forms (Ellis and Bochner, 2000). Finally, evocative autoethnographers prioritise the use of the first person pronoun in the use of research as a point of principle and an epistemological statement of intent (Ellis, 2004).

The two approaches to autoethnography also differ substantially in terms of their epistemological perspectives. Whilst evocative autoethnographers are usually tied more closely to narrative approaches and social constructionist paradigms, analytic approaches traditionally align themselves with more realist paradigms, albeit often critical realist (Anderson, 2006). In relation to theory, there are often marked differences between the two approaches. Whilst analytic autoethnographers still maintain a clear link between social science theory-derived data analysis and the informing of theory (Anderson, 2006), evocative autoethnographers tend to eschew such tight boundaries (Grant, 2014). In contrast, and as examples of the former style, Allen-Collinson (2011) employ an autoethnography derived from phenomenological theory (named ‘autophenomenology’), whilst other autoethnographers have used sociological theory such as Actor Network Theory and Grounded Theory (Anderson & Glass-Coffin, 2013).

In a 2006 special edition of the *Journal of Contemporary Autoethnography* representatives of the two approaches discussed the relative merits and drawbacks of their version of autoethnography. In terms of contrasting arguments, ‘realist’ researcher Anderson (2006) argued that there is little difference between ‘evocative’ or ‘emotional’ autoethnographies and approaches from the humanities. In contrast, the evocative autoethnographers argued that the analytic autoethnography advocated by researchers such as Anderson (2006) are virtually indistinguishable from traditional reflexive ethnography (Denzin, 2006; Ellis and Bochner, 2006). As Ellis and Bochner (2000) have pointed out, the form the autoethnography takes will often depend upon whether the researcher allies themselves primarily with the arts and humanities, or with the social sciences.

However, in practice there can be considerable overlap between the two approaches and attempts to rigidly categorise individual autoethnographies on such as basis proves very difficult (Anderson & Glass-Coffin, 2013). For example, Grant (2014) has placed themselves very firmly in the 'evocative' camp whilst retaining a strong link with theory, particularly poststructuralists theorists such as Derrida and Foucault. In contrast, other autoethnographies such as Short, Grant and Clarke (2006) have retained a largely evocative style but retaining analytic elements such as the link to social theory and a structured approach to representing data. As Le Roux (2016) has pointed out, it is often a challenge to categorise autoethnographies effectively due to the diverse and varied relationships to theory and methodology in individual accounts.

Such distinctions between 'analytic' and 'evocative' are thus somewhat arbitrary and reflect perhaps more an academic need to police disciplinary boundaries than a real division between approaches (Holman Jones, Adams and Ellis, 2013). Indeed, one of the authors labelled as 'realist' in the original special edition of the *Journal of Contemporary Autoethnography* has since acknowledged the risks of 'presenting an overly intellectualised and reified map of different social science traditions and their prescriptive assumptions for how to conduct "autoethnography" within different disciplinary paradigms' (Anderson and Glass-Coffin, 2013, p. 58). This recognition that boundaries between approaches are fluid and permeable rather than fixed and determinable has led to some suggesting a 'middle way' between producing emotionally-resonant data derived from personal experience, and the need for scholarly rigour (Stahlke Wall, 2016).

My particular approach to these issues has been guided by the 'tactically authentic' theoretical approach outlined in chapter 2. In other words, boundaries between different disciplines and approaches are not fixed or objective, but form part of a larger 'strategy' within academic discourse. In order to be able to intervene 'tactically' in the strategy of the academy, one must conform to certain requirements, including academic and scholarly rigour. However, having gained access into academic discourse on its own terms, one can then subvert the 'strategy' by introducing 'evocative' depictions of personal experience in a 'tactical' way that can generate conversations about topics that may otherwise be dismissed, ignored or judged not academically rigorous enough (Le Roux, 2016).

Therefore, my method of the 'quadrilogue' outlined in more detail below, includes both evocative depictions of personal experiences, alongside a rigorous and systematic approach to synthesising the research 'data'. Further, I eschew binaries between 'realist' and 'evocative', preferring to combine elements of both approaches in a similar vein to Stahlke Wall's (2016) 'middle way'. Such apparent binaries between different methods, present in the debate between 'realist' and 'evocative', are also present in debates around the style and presentation of autoethnography, which will be discussed below.

3.1.2 Experimentally ambitious or ‘textually conservative’?

Another issue in autoethnographic research is the style and format researchers should use in the presentation of results. From the outset, autoethnographic researchers have adopted writing forms that eschewed traditional academic social science and ethnographic presentational forms, utilising a variety of techniques such as dialogue, poetry and performance techniques (Ellis & Bochner, 2000). All of these formats have been noted for going beyond the standard introduction-method-results-discussion format of social science articles. This has led to criticisms from mainstream social scientists, such as a lack of validity, objectivity and parsimony (Tolich, 2010). Indeed, some researchers have questioned whether autoethnography should be considered research at all (Le Roux, 2016).

In many ways such an approach has been valorised by autoethnographic writers for its appeal to emotion over reason and, as I explored in the last chapter, has been established, problematically in my opinion, on the basis of an appeal to authenticity. However, Atkinson’s (2013) criticisms have taken a different angle. For Atkinson (2013), autoethnography is not ambitious enough: its experimentalism, rather than being innovative, is ‘textually conservative’ and first-person narratives are presented in fairly conventional ways whereby ‘nothing disrupts or reflects upon the text’s surface’ (p. 24). Further, Atkinson (2013) argues that many standard autoethnographic texts, whilst appearing to be experimental, demonstrate a ‘failure of nerve’ whereby a ‘preoccupation with a narrative of feeling’ (p. 24), which Atkinson (2009) calls ‘sentimental realism’, takes the place of genuine experimentalism. This conservative approach to textuality and a primacy given to emotions rather than analysis ‘often result in new forms of naturalism’ (p. 24). Atkinson (2013) elaborates his position further:

> the failure of nerve I allude to resides in the embrace of a restricted set of textual practices that are the reverse of modernist experimentation. They revert to conventionally realist or naturalistic writings, often based on personal experience and feelings that do little justice to the potential of truly experimental texts. Moreover, these contemporary textual types often appeal to an emotional response in the reader rather than inviting an intellectual, analytic engagement. (p. 27)

According to Atkinson (2013) therefore, autoethnography does not go far enough and falls into many of the traps which I discussed in chapter 2, most notably the adoption of realist narrative forms and an uncritical acceptance of apparently self-evident binaries such as thought/emotion and reason/experience. Such tendencies can be evidenced in contemporary mental health autoethnographies. For example, Grant, Leigh-Phippard and Short (2015), identifying with postmodern and poststructuralist social theory, present a narrative paper ‘in contrast to those conventional qualitative approaches emphasizing thematic content analysis as a procedural basis for the interpretation of lived experience' (p. 280). Instead, their 'process of analysis was assumed to be inscribed within the act of crafting repeated iterations of the stories in the context of the co-evolving paper as a whole' (p. 280). Despite these arguments, the paper then proceeds with three first person narratives that are presented one after the other in a fairly conservative format whereby there is no attempt to disrupt the surface of the text at all. The first-person perspectives, although discussed by each narrative, are presented as if the text itself provided an untroubled and clear window into the authors' experiences, despite the authors repudiating such assumptions.

The problem therefore is that autoethnographic research often assumes an untroubled relationship between experience and its inscription, replicating the humanist assumptions plaguing early qualitative research, even where such approaches have been rejected. This appears paradoxical, given that many narrative approaches borrow extensively from postmodern theorists such as Derrida and Cixous (Speedy 2013). There is thus an apparent contradiction between the use of terms such as 'lived experience' on the one hand, and the valorisation of poststructuralist theory on the other, which, to a lesser or greater extent, eschews the validity of those very same terms (Rose, 2017). In contrast, Atkinson (2013) argues that ethnography derived from modernist literary conventions provide a possible way forward that avoids the sentimental realism identified above. Atkinson (2013) elaborates:

> There is, of course, no single modernist genre. But it is worth pausing to remind ourselves what modernism gave us. Its distinctive literary, formal properties included disrupting taken-for-granted narrative formats; the fracturing of temporal and perspectival frames; multiple and/or ambiguous points of view within the text; a close attention to the detailed description of material circumstances; and multiple voices and idioms in the text (p. 23).

To what degree does Atkinson’s (2013) critique hold up against the autoethnography literature? Whilst Atkinson’s (2013) analysis of established autoethnographic texts may find them wanting, there are still examples from mental health autoethnographies that innovate along the lines he identifies. For example, Short et al. (2007) developed an autoethnography of one of the author’s breakdown (Grant) with the other authors presenting their experience of Grant (Short) and a reflective commentary on the other two authors’ experiences (Clarke). This is presented in a novel narrative format, with three columns representing each perspective presented alongside each other on the page. However, whilst innovating in terms of presentation, the paper still retains the singular voice of each author and, although the paper refers to events in the past, does not disrupt or explore the fracturing of temporal and perspectival frames.

The notion of ‘fracturing temporal and perspectival frames’ has been a key part of what has been referred to in the autoethnographic literature as ‘layered accounts’. For example, by juxtaposing fragmented personal accounts with theoretical analysis and reflections on method in a ‘layered account’ of psychological distress, without imposing the ‘panoptical’ view of any particular ‘voice’, Rambo (2013) represents the dissociation of trauma as it manifests in the context of the psychotherapy room, fracturing temporal and perspectival frames. However, Rambo’s (2013) approach still suffers from being told exclusively in the ‘I’ of the first-person perspective and, in this way, employs earlier tropes of the ‘argument from authenticity’ and does not quite escape the charge of ‘sentimental realism’.

The problem of the first-person perspective more generally, but particularly in mental health, in terms of representing the multiple identities of service users and mental health professionals, was confronted by von Peter and Schulz (2018) through their usage of the term ‘I-as-we’. One of the authors, a licensed psychiatrist who also had personal experience of severe psychological distress, recognised that in talking about their experiences, ‘I was not speaking about myself as a person (even though I was using the word ‘I’), but rather speaking in my role as a psychiatrist, embedded in and secured by a (particular) profession and school of thought’ (von Peter and Schulz, 2018, p. 1295). These socially embedded structures are ‘not a random product, but is the result of a continuous, often invisible category work’ (ibid, p. 1296-7) that employ ‘strategies of demarcation, purification, marginalization, hierarchization, dissociation, and homogenization’ (ibid, p. 1297). To dissolve these structures requires a process of coproduction based on an acceptance of ‘transdifference’, the use of ‘reflexivity’ and the cultivation of ‘reciprocity’ in both service users and professionals (von Peter and Schulz, 2018).

However, whilst the tactics described by von Peter and Schulz’s (2018) offer a challenge to established patterns of essentialising, it also arguably fails to take into account the wider discursive strategies of a dominant biomedical psychiatry (which the authors rarely acknowledge in their paper). Such structures may make it difficult for there to be the equanimity of perspective that von Peter and Schulz (2018) call for, especially when there are clear differentials in power between service users and psychiatrists (Russo, 2016a), undermining any attempts at broaching difference (Voronka, 2016). As Russo (2016b) has identified, emphasising the second person voice of ‘you’, rather than the more isolating ‘I’ and the potentially objectifying ‘we’, may be a more effective strategy in this regard.

That there are clear inequalities between different ‘voices’ in psychiatry offers the autoethnographer with some tactics to challenge such differences, whilst also introducing the multiple voices and idioms identified by Atkinson (2013) as textual innovation. One way in which mental health autoethnographers have achieved this is by the juxtaposition of the ‘official’ discourse of psychiatry (e.g. a service user’s clinical notes) presented alongside thick descriptions of the experiences of survivors and carers in order to show how the everyday experience of a psychiatric patient is transformed into a discourse that serves strategic power (e.g. O’Hagan, 1996). Building on the work of Biddulph (2006, 2008) and Foucault (2001), Fox (2010, 2014) developed a method called ‘auto-archaeology’, mixing official documents such as school reports and medical notes, alongside his personal account. Recognising both the ubiquitous nature of inter-institutional discourses with their strategy towards homogenisation and pathologisation, Fox (2014) showed how the ‘psychiatric industrial complex’ fixed his sexual and psychological identity through the processes of diagnostic labelling and pastoral ‘training’. However, whilst useful as a tactic to disrupt dominant institutional and discursive strategies, Fox’s (2014) account still retained a naturalistic format, presenting his account in a singular, first-person voice that was not integrated alongside the ‘official’ documents, detracting somewhat from the analysis.

Taken together, these works point the way forward to possibilities of employing personal experience in a tactical way whilst taking into account Spivak’s point, *a propos* of Derrida, that the metaphor of ‘voice’ itself carries the danger of essentialising ‘representationalism’ (Landry and Maclean, 1992) and Atkinson’s (2013) critique of textual conservatism. One strategy to create an authentic mad narrative is through the utilisation of different perspectives and texts in an unfolding dialectic or conversation. Frank (2005) proposes a dialogical approach to illness narratives informed by the work of Russian philosopher Mikhail Bakhtin, in which the multiple viewpoints of the ‘self’, situated in its social context, are explored concurrently. Frank (2005) thus formulates a socially-situated self that interacts with multiple actors in a matrix of socially-constituted discourse, and not the atomised social self of liberal humanist discourse.

The present research continues Frank's ideas by proposing a 'quadrilogue' as a form of an autoethnographical mad narrative. As I will discuss below, in my autoethnographic account this includes the disruption of taken-for-granted narrative formats through the use of multiple perspectives presented together a la Short et al. (2007); fracturing temporal and perspectival frames through the use of different voices and idioms, introducing the second-person 'you' for my perspective advocated by Russo (2016b); including multiple and ambiguous points of view through the use of different idioms including my mother's diary and my clinical notes; and a close attention to material circumstances through a detailed analysis of the different texts. Before I introduce my method however, one further issue particularly relevant to mental health autoethnographies is discussed below, that which Costa et al. (2016) and others (Rose, 2019) have called 'patient porn'.

3.1.3 'Patient porn' or survivor empowerment?

As I discussed in the previous section, issues of power cannot be avoided in service user or survivor autoethnographies that seek to explore the relationship between madness and its social context. One of the first examples of an autoethnographic exploration of these issues was Kathryn Church's (1995) *Forbidden Narratives*. This book, based on Church's PhD thesis on service user/survivor participation in Toronto, illustrates the process by which Church experienced a personal health crisis during the data collection, which resulted in profound difficulties, but which also changed the direction and focus of her PhD. In this method she christened ‘critical autobiography’, her personal experiences were woven into the analysis of her participants’ stories of mental health activism and resistance, with the aim of transforming the subjectivities of mental health workers and policy makers (Church, 1995). This allowed for an incisive critique of some of the shortcomings of ‘consumer engagement’ that were predicated on fixed binaries between consumer/professionals and ill/well that were, by implication, supporting biomedically-orientated perspectives on distress and illness.

Church’s (1995) initial research has been influential in the development of narrative approaches to researching service user and survivor experiences of the mental health system. However, one of the dangers of attempting to tell one’s story of mental health services is the possibility that first-person accounts slip into overly-gratuitous or over-aestheticized representations retaining the somewhat uncomfortable character of ‘patient porn’ or ‘disability tourism’ (Costa et al., 2012). In mental health in particular, certain discourses enjoy greater legitimacy, based upon established professionalised hierarchies, power relations and reified ideology (Parker, 2007). These claims of legitimacy do not always correspond to accurate and nuanced understanding of what it is like to be mad even though they dominate the mainstream of clinical practice (Wallcroft, 2013). When applied to ‘recovery’ narratives, this may result in the psychiatric survivor’s stories being co-opted to support dominant strategy. Costa et al. (2012) elaborate:

> …the resignification of language such as “resilience” and “recovery,” as told through client accounts, is a means by which mental health service systems have been able to absorb resistance accounts, sanitize them, and carry them forward in ways that are useful for them, without disrupting their dominant practices. It is precisely through this recalibration of norms that mental health systems are able to maintain their cultural and economic status which occurs partially through the incorporation of the patient story wherein this incorporation ruptures away from the history of psychiatric survivor storytelling to radicalize, towards one that uses stories to further solidify hegemonic accounts of mental illness. (p. 87)

One solution to the risks of ‘patient porn’ and the co-option of service user narratives may be found in terms of ‘tactical’ authenticity, discussed in the previous chapter. Commenting on her research, Church (1995) observed that, ‘The most critical task we face is to become connected with the sociality of our subjectivities, to the ways in which our subjective experiences are filled with and constitute the voices of the mental health system’ (p. 128). In other words, an important way of utilising a tactically authentic approach through representing subjectivities as a lens to view the ways the language and practice of the mental health system institutes itself into the service user’s ‘voice’. Indeed, this aim of ‘constituting the voices of the mental health system’ through my experience of inpatient treatment is one of the aims of this thesis, particularly in terms of offering critical perspectives on a primarily biomedical orientated psychiatric system.

In other words, stories can play a role in reclaiming marginalized identities by building solidary and inspiring activism (Costa et al., 2012), or else in establishing identity through a form of performativity, without slipping into the perversions of exhibitionism or voyeurism. A narrative account sensitive to these risks may provide a basis for assessing the knowledge claims of survivors outside of the ‘master’ discourses (Dickson and Holland 2017) of the academy or the psychiatric profession. Indeed, my methodology has been informed by such criticisms of autoethnography from both the perspectives of social research and issues specific to mental health survivor and service user research. Thus, the ‘quadrilogue’ was developed specifically to address these issues in both format and emphasis. In the next section, I will outline some of these criticisms of autoethnography and how my method of the ‘quadrilogue’ was developed to answer some of these critiques.

3.2 Research Design – the Quadrilogue

The quadrilogue is a novel autoethnographic method that I designed as part of the thesis and which re-presents different perspectives together to tell a multi-layered narrative of a particular event, or series of events. Some of these perspectives can be based on sources in the past, or reflections in the present, or some combination of both. In my thesis, I am using the quadrilogue to depict my experiences of a psychological breakdown and the subsequent pathway into admission to an inpatient psychiatric unit, which took place between 1st September 1994 and 16th January 1995.

The idea for a ‘quadrilogue’ originally evolved from the process of gathering data sources together and deciding how best to represent the data. It should be noted that the term ‘quadrilogue’ need not imply a direct dialogic engagement between some or all the sources used in research, but that the juxtaposition of different texts together effectively encourages them to 'speak to each other', or at least the reader to approach them that way. This echoes the idea of both contextually mediated documents and intertextuality in social research (Speedy, 2013). Such an approach recognizes not only the dialogical self of Frank’s (2005) research, but more so: a multifaceted self that is situated within a network of social and institutional relationships, and which also crosses time from past to contemporary perspectives. In this way, it addresses some of the critiques of autoethnography made by Atkinson (2013) and other discussed in the last section, as well as some of the pitfalls of ‘authenticity’ discussed in chapter 2. As a new autoethnographic methodology, the quadrilogue represents a novel contribution to the literature.

The four perspectives in the quadrilogue are mine (Simon), my mother, the clinical team and the researcher. All four perspectives are represented by a range of different sources. In the next section, I discuss the process of the development of the quadrilogue, including the data sources used and how they were combined together.

3.2.1 Stage 1 – Simon’s account

The process of recording my personal recollections of the events in the narrative was conducted from October 2013 to December 2014. As I discussed in Chapter 1, the autoethnography was originally started as an exercise to identify the core themes of the thesis and was written as a standard first-person narrative describing my thoughts and feelings related to a series of events between the years of 1994 and 2004. However, as I discussed in Chapter 1, the focus of the thesis shifted to the events of the inpatient admission, i.e. the dates of September 1994 to January 1995, as the autoethnography progressed.

My account was based on personal recollections, conversations with family members, diaries written just after discharge, poems and diary entries written during another breakdown a couple of years after the events recorded in the narrative. There were four diaries in total and these were A5 notebooks bound at the top and written in blue, green, black and red biro. They were mostly undated, so it was difficult to establish exactly when they were written. My recollection is that I started writing just after discharge (January 1994) and sporadically added to them over a period of 6 years until 2000. The diaries mostly capture feelings and impressions of the experience of admission, mixed with some very obscure phrases, quotes from well-known writers, images, drawings and poems.

There was a lot of information to synthesize. In order to identify the key memories or events, or what autoethnographers have referred to as the ‘epiphanies’ (Ellis et al., 2011) of the narrative, I began free-associating memories of this time. Any memories, recollections and impressions were recorded in a Microsoft Word file as they were recalled, usually in the form of brief sentences or bullet-points. I also read through my diaries to see if they prompted any further memories and, if so, they were also recorded. I talked with family members about their recollections of the period and recorded their response in the same file. I kept a diary on me at all times and if another memory came to mind, that was also recorded and then added to the Word database at a later time.

Once these memories had been collated together, I then began to identify those experiences which were the most important in terms of illustrating a facet of madness, or the relation of the person experiencing madness to the social world around them. Having identified around 20 discrete experiences or memories that appeared to be the most significant, I began the process of writing them up as short narrative excerpts. Thirty-five of these excerpts where eventually written and each excerpt was given a title that described the facet of patient experience described in the excerpt (e.g. ‘first assessment’, ‘admission’, ‘ward round’ etc.).

When writing these excerpts up, I initially began experimenting with using first and third person perspectives but neither of these two perspectives felt quite right. The second person perspective is often used by autoethnographers to facilitate engagement with the text (Pelias, 2000), so I started performing this second person perspective in conferences and presentations. I found that this perspective worked better and seemed to be well received by audiences. Following positive feedback from supervisors, colleagues and from a journal who accepted a submission using the second person, I decided to use this perspective exclusively for my account in the thesis.

However, the use of the second person perspective also had a theoretical aim. Whilst the first person ‘autoethnographic I’ is problematic because it falls into the trap of assuming an omniscient self that is capable of speaking on behalf of the narrator, the third person account is problematic for the opposite reason: i.e. it risks writing *about* the experience, from a distance, rather than *from* it, close up (Ellis et al., 2011). This is especially problematic comments in relation to the use of ‘lived experience’ in mental health research as Russo (2016b) comments, ‘Based on third-person knowledge - speaking about someone rather than speaking to and with them - these approaches, by definition, exclude dialogue’ (p. 240). For these reasons, it ‘is not suited to the complex task of addressing and responding to a person in crisis’ (ibid). Therefore, writing in the second-person for me is a deliberate example of ‘tactical authenticity’: it would enable the reader to be better immersed in the experiences of the patient and represents ’speaking to and with’ (Russo, 2016b) – an important method of ensuring the reader is able to engage with my subjectivity as a psychiatric subject.

3.2.2 Stage 2 – Clinical team account, ‘dialogue’

The perspective of the clinical team is represented by my National Health Service (NHS) clinical notes. The notes were acquired following a subject access request under the Data Protection Act 1998. Narrative accounts comparing service user experiences alongside professional perspectives as represented in medical notes has been used as an effective device to critique psychiatry (O'Hagan, 1996). Having gained access to my medical notes from the period when I experienced several breakdowns and extended mental health service user (1994-1996), I decided to use my medical notes alongside my own accounts for two main reasons: to create a dialogue between my account and the medical team; and to be able to better critique psychiatric practice by a direct comparing and contrasting of my representation with the representations from the psychiatric team.

There is a range of documents in my clinical file. These include: letters, medical reports, test results (e.g. blood tests, x-rays, urine samples), record forms (e.g. ECT, seclusion), legal documentation (e.g. Mental Health Act papers), social care documents (e.g. benefit application forms) and hand-written medical process notes. There are over 400 pages of the case in total, written by a range of different medical and mental health professionals including nurses, psychiatrists, GPs, social workers, occupational health and care assistants. The first document was a GP referral letter dated 1.9.1994 and the last document was an invitation to participate in a research study dated 16.9.99. The documents were initially unsorted, and the first task was ordering the file into a chronological order and creating an archive inventory of each document created. There were two main classes of document: the letters, reports and test results; and hand-written process notes. These were collated separately and ordered into sections according to phase of care (9 sections in total).

Once the notes had been collated and read through, I then had the task of identifying relevant sections of the document to use. Relevant individual clinical worker process notes were selected on the basis that they described the same events depicted by my account. These were copied directly into the narrative alongside my representations, as two separate columns on the page, in order to facilitate a ‘dialogue’ between the two accounts.

3.2.3 Stage 3 – Mother’s account, ‘trialogue’

The original intention of the thesis was to use my account and the clinical team’s account together, as a form of ‘dialogical’ (Frank, 2005) research. However, when discussing the progress of the thesis with my mother in 2014, she told me she had kept a diary of the periods between 1994-2000 when I was under the mental health service. Unsolicited, my mother offered to give me the diary for my research. This added a third perspective to the narrative, my mother’s, through the use of her diary. The ‘dialogue’ had thus become a ‘trialogue’ (Amering, Mikus and Steffen, 2012).

The diary was handwritten in a blue A4 lined exercise book in red, black, green and blue biro. The first entry was on 1 September 1994 and the last entry was recorded on 29th August 2000. There were three main blocks of entries, each recording a different episode of my mental health difficulties: the first recorded entries from 1 September 1999 to 12th July 1995; 1st July 1996 to 13th April 1997; and 30th May 2000 to 29th August 2000.

Once I had made the decision to focus the thesis on the period of the first breakdown and psychiatric detention, September 1994 to January 1995, I only used entries from my mother's diary for this period of time. All of the material from this period was used in the narrative, and the relevant sections were represented in the narrative alongside the events described by the other two accounts. As there were gaps in my mother's dairy at times of a few days or even a week, the gaps in the narrative were represented by blank space in the narrative. There were thus now three columns on the page, each column representing one perspective in the 'trialogue'.

3.2.4 Stage 4 – Researcher account, 'quadrilogue'

Having developed a trialogue with mine (Simon), my mother's and the clinical team's accounts, all which described the same or similar events from the same time period, I began to realise that there was another perspective in the data that was not yet represented in the narrative, but one which had a crucial say in the form in which the narrative would eventually take. This was my perspective as a researcher in the present making decisions about which material to include in the narrative and beginning the process of trying to make sense of the data. Indeed, my perspective was also informed by other people's response to the data, such as delegates at conferences, my supervisors, colleagues, and friends and family who I discussed the data with.

The boundaries between researcher and research subject are inevitably blurred in autoethnography (Ellis et al., 2011). This necessitates the use of a form of ‘hyper-reflexivity’ (Campbell, 2016) whereby the researcher engages on active reflection of their role in the research process. This type of reflexivity occupies a liminal space between reflection on the data and formal analysis using theory (Speedy, 2013). In my thesis, the processes of hyper-reflexivity were aided in a number of ways, including: by keeping an active research diary; having a notebook on me at all times and recording impressions and observations as they occurred; discussions with supervisors and colleagues; reflection and feedback from conference and seminar presentations; and through reading other autoethnographies and reading theory. Through doing this, I generated a research diary of over 54,000 words. The diary recorded my key responses to the data, including thoughts, impressions, emotions and reflections and decision-making in the process of putting the narrative together.

However, the question remained of how to represent this process in the research. Reflexivity is a crucial component of qualitative research (Riessman, 1993), yet the actual process of using reflexivity in the research is not always represented explicitly and transparently (Mazzei and Jackson, 2009). As Lather (2009) has pointed out, the issue is that the researcher ‘voice’ becomes airbrushed out in the presentation of a final, polished research product. This criticism has also been made of autoethnography (Tolich, 2010).

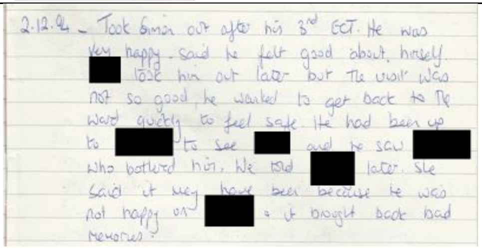
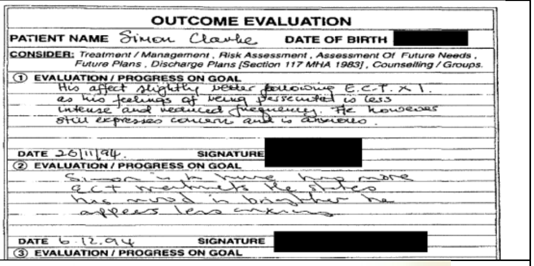
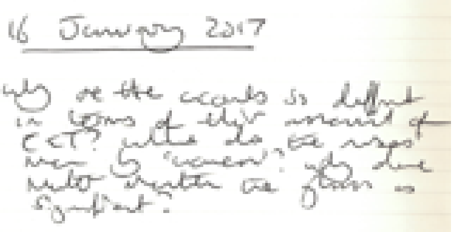
In their study on women living with HIV, Lather and Smithies (1997) developed a novel response to these issues: by recording their interviews with women in its entirety, along with their researcher comments on the data underneath the interview text. Around this time, I also read Bennington's (1993) biography of Jacques Derrida, in which Derrida's commentary on the biographical material written by Bennington is represented at the bottom of the page, whilst alongside reading Short et al.'s (2007) autoethnography, in which one of the authors (Clarke) provides a commentary to the 'data' at a column at the far end of the page.

These works provided me with the idea of integrating my 'researcher' perspective into the narrative as a fourth perspective. The main purpose of this fourth perspective was to contextualise the data for the reader by providing a commentary on the significant events recorded in the narrative. Important themes were also identified and discussed, including important discrepancies and divergences between the three accounts. It was also there to ask questions about the other three perspectives and to provide a bridge between the narrative itself and the analysis of the data. Hence, a 'quadrilogue' of perspectives on one extended episode that allows for some 'dialogue' between the different perspectives

When the three perspectives of the patient, carer and clinical team had been rendered in the narrative, I read through the narrative again in entirety, recording my responses to the data and then comparing these responses to my previous diary entries. I then started writing this fourth perspective alongside the other three perspectives in the narrative. When this fourth perspective had been completed, it formed a fourth voice in the narrative.

The data sources corresponding to all four perspectives is represented in Table 1, below.

Table 1 Data sources used in the quadrilogue

Perspective	**Data sources**	**Example**
Patient	Recollections from personal experiences, poems and diary entries.	 We are almost ready. I shan't leave my body. You lose your mind.
Carer	Diary entries from my mother from the periods 1994-2000.	 2.12.94 – Took Simon out after his 3rd ECT. He was very happy. said he felt good about himself. [redacted] took him out later but the visit was not so good, he wanted to get back to the ward quickly to feel safe. He had been up to [redacted] to see [redacted] and he saw [redacted] who bothered him. We told [redacted] later. She said it may have been because he was not happy on [redacted] & it brought back bad memories.
Team	My NHS patient file 1994-1997, including staff clinical notes, letters from psychiatrists and reports.	 **OUTCOME EVALUATION** PATIENT NAME Simon Clarke DATE OF BIRTH [redacted] CONSIDER: *Treatment / Management , Risk Assessment , Assessment Of Future Needs , Future Plans , Discharge Plans [Section 117 MHA 1983] , Counselling / Groups.* ① EVALUATION / PROGRESS ON GOAL His affect slightly better following E.C.T. x 1. as his feelings of being persecuted is less intense and reduced frequency. He however still expresses concern and is anxious. DATE 26/11/94. SIGNATURE [redacted] ② EVALUATION / PROGRESS ON GOAL Simon is to have two more ECT treatments. He states his mood is brighter. He appears less anxious DATE 6.12.94 SIGNATURE [redacted] ③ EVALUATION / PROGRESS ON GOAL
Researcher	My ongoing reflexive research diary (2009-present), supervision notes.	 16 January 2017 Why are the accounts so different in terms of their amount of ECT? [illegible] the ways [illegible] by 'women'? Why have [illegible] [illegible] are [illegible] as significant?

The final excerpts were selected in the process of constructing the quadrilogue in tandem with going through the other data sources. Excerpts were eventually selected on the basis that they 'talked' with the other sources, in terms of depicting the same situation as another source, or a process of care that was recorded in another source (e.g. ECT, seclusion etc.). Once the sources had been compiled in the quadrilogue, minor aspects of expression or wording were amended.

In the final version of the quadrilogue, I was influenced by Goffman's (1959) essay, The Moral Career of the Mental Patient, in which the journey of the psychiatric patient is traced through the various phases of hospitalisation. Goffman (1959) labelled these phases pre-patient, inpatient and ex-patient (although the essay only focused on the former two phases). I therefore divided the quadrilogue into various 'parts', each of which corresponded to a phase in my journey from before I made contact with the psychiatric team, through hospitalisation, to when I was discharged.

As a final construction, relevant documents from my clinical notes that related to the process were inserted between each of the relevant parts. This was for the purpose of allowing the reader to engage with the narrative, especially where there are letters whereby the sources can be presented 'in their own words', as well as containing interesting information about the process. The forms and proformas are also historically relevant artefacts of paperwork used in psychiatry at the time and so added another layer of contextualisation. This intervention was inspired, in part, by Fox's (2010, 2014) use of archive material as an 'auto-archaeology' based upon Foucault's (1961, 1977) analysis of psychiatric and disciplinary power.

3.3 Ethics

In conducting this research study I adhered to all ethical guidelines as outlined by the University of Nottingham and informed by ethical procedures pertaining to research into mental health such as the Declaration of Helsinki. Copies of the Participant Information Sheet, Research Probes and Consent Form are available in the Appendices. Ethical permission was obtained from the School of Education at the University of Nottingham. As autoethnography involves writing about the author's own experience, ethical issues can be complex (Denshire, 2014; Ellis and Bochner, 2000; Turner, 2013). There are several ethical issues that need to be considered and they can be divided into two main areas: the ethical issues of representing other people in the research, often referred to as 'relational ethics' (Ellis et al., 2014) and the ethical risks relating to the self-disclosure of personal experience in research, what could be referred to as 'risks to self' (Tolich, 2010). The following section will discuss in more detail how these risk areas relate to the thesis.

3.3.1 Relational ethics

The first of these ethical issues, that of 'relational ethics', is very frequently highlighted in autoethnographic research (Turner, 2013). One of the inherent difficulties in autoethnographic writing is how to represent other people in the research aside from the author, especially family members, friends, colleagues and past acquaintances (Wall, 2008). Most autoethnographers should acknowledge that their writing involves a commitment to 'relational ethics' (e.g. Ellis, 2007) and some argue that relational ethics provides a more rigorous requirement for ethical behaviour than other standards (Ellis et al., 2014). This term recognises that the autobiographical and 'personal experience as data' elements of autoethnography often mean that other people are represented in the research in ways they would not be if they were research participants in a more conventional Social Science methodology (Stahlke Wall, 2016). Relational ethics thus acknowledges that the research does not take place in a vacuum and they have a responsibility for how other people are represented (Turner, 2013). As Wall (2008) summarises:

> There is a need to be concerned about the ethics of representing those who are unable to represent themselves in writing or to offer meaningful consent to their representation by someone else, especially someone with whom they are involved in a trust-based relationship (p. 49).

However, this issue is much more complex than it first appears, particularly in terms of how the principle of relational ethics has been applied in individual research projects. Tolich (2010), in particular, has been very critical of what he perceives to be notable lapses between the theory and practice of relational ethics in autoethnographic research, where the usual standards for ethical behaviour in the Social Sciences such as the International Congresses of Qualitative Inquiry's 'Position Statement on Qualitative Research and IRBs (Congress of Qualitative Inquiry, 2007) have not been adhered to. Some of the examples Tolich (2010) cites include: not seeking ethical approval from IRBs (Rambo, 2007); providing no evidence of gaining consent from participants who are mentioned in the research (Jago, 2002); ignoring obvious power imbalances between the researcher and the represented, such as academics representing students in their autoethnography (Jago, 2002); providing information about colleagues and students that provide easily identifiable information (Jago, 2002); not considering the role of coercion that might apply when seeking consent from friends or family (Ellis, 1996).

One of the key points that Tolich (2010) makes is that the examples cited above clearly fell short of the ‘relational ethics’ standards set by Ellis (2007) and others. In response to this, Tolich (2010) advocates a set of 10 standards for the autoethnographic researcher (p.1607-8):

1. Respect participants’ autonomy and the voluntary nature of participation, and document the informed consent processes that are foundational to qualitative inquiry;
2. Practice “process consent,” checking at each stage to make sure participants still want to be part of the project;
3. Recognize the conflict of interest or coercive influence when seeking informed consent after writing the manuscript;
4. Consult with others, such as an Ethics Committee;
5. Autoethnographers should not publish anything they would not show the persons mentioned in the text;
6. Beware of internal confidentiality: the relationship at risk is not with the researcher exposing confidences to outsiders, but

confidences exposed among the participants or family members themselves;

7. Treat any autoethnography as an ‘inked tattoo’, i.e. something that cannot be easily erased, by anticipating the author’s future vulnerability.
8. Photovoice anticipatory ethics claims that no photo is worth harming others. In a similar way, no story should harm others, and if harm is unavoidable, take steps to minimize harm.
9. Those unable to minimize risk to self or others should use a nom de plume as the default.
10. Assume all people mentioned in the text will read it one day.

On a superficial reading at least, Tolich’s (2010) critique of autoethnographic practice and his subsequent recommendations appear to make sense. I would also argue that Tolich’s (2010) observation that ‘The word auto is a misnomer. The self might be the focus of research, but the self is porous, leaking to the other without due ethical consideration’ (p. 1608) resonates with the critique of ‘solipsism’ levelled at autoethnography (Atkinson, 2009). It is also important to hold autoethnographer researchers to account, especially where due consideration of the other in research has been neglected and as outlined in many of Tolich’s (2010) examples. Tolich’s (2010) point that all autoethnographic researchers should seek Ethics Committee approval or consultation before proceeding represents good research practice and, in most cases of PhD research conducting at Universities in the UK, is a statutory requirement for all research, including postgraduate. For these reasons, I sought ethical approval from the School of

Education at the University of Nottingham, where the research was taking place, before compiling the sources together.

However, I also take issue with Tolich's (2010) guidelines when they appear to treat autoethnography as if it were the equivalent of other research methodologies in the Social Sciences. The use of personal experience as data, especially as much of such experience is retrospective, complicates straightforward application of Tolich's (2010) principles. For example, in my thesis there are two principle 'others' in the research: my mother, as represented in her diary; and the clinical staff, as represented in the notes. How should I treat issues such as consent and coercion as raised by Tolich (2010)? In terms of consent, the clinical notes contain over 400 pages of notes, a wide variety of sources and literally dozens of authors. Would it be feasible to contact every single clinician and ask their permission for use of their notes or reports? For example, the case notes are over 25 years' old; it would simply be impossible to track down every single author of every single note that was written, even if they could be identified (many of the notes are hand-written, unsigned, and often illegible).

Would it therefore be appropriate to only include clinical notes from those authors who could be found and thus give prior permission? But this raises other questions as to whether this would even be appropriate. The clinical notes are about me and about my care. Professional guidelines (General Medical Council, 2013) state clinical notes should be written with other people in mind, including patients. The PhD offers an important opportunity to analyse in more detail some important processes of care that speak to wider issues such as the nature of madness, how madness is represented in discourse and the relationship between the experience of madness and how it was treated in a particular time period. In terms of power dynamics, I did not have a voice at the time; the clinical notes were written about me, but I had no opportunity to have a say about them, or even read them.

The PhD therefore represents both the ideals of academic freedom and the personal empowerment of service users to review their care in the public forum of academic debate and discourse. Would it be right or appropriate for clinical staff to be able to have the final say on such matters, particularly if the findings produced conflict with their interpretation of events, or how their professional competence has been represented? Taking this example to its extreme, if a psychiatrist in the thesis did not like his or her representation, they could be provided with the power to silence the research. This is problematic if there were examples of bad clinical practice that would need to be exposed. It is again worth pointing out that all identifying information regarding location and staff identities has been removed, so it is unlikely they could be identified from the thesis.

In the case of my mother, the ethical issues are still more complex. It is my mother’s diary, and it is her words and experience represented in its pages. However, her words and experience in this instance relate specifically to me. So, in practice, who does this data really belong to, me or my mother? The issue of ‘ownership’ in autoethnographic research can be difficult to assuage (Grant and Zeehan, 2014). It is also important to note that my mother gave me the diary willingly and in full knowledge of its purpose to support my PhD. She did so by expressing her conviction that the research was saying something important about the experience of madness and how such an experience impacts those around them. Despite this, I was still required by the Ethics Committee to treat my mother as a research participant and provide her with a Participant Information Sheet and Consent form (see Appendix 2). In discussion with my supervisors, we agreed that it was important to make sure that my mother (who is not an academic) was very clear how her diary would be used in the PhD and that her diary (or extracts from her diary) may be used for subsequent publications arising from the thesis. I therefore went through the somewhat surreal process of gaining my mother’s formal, signed consent for use of her diary, even though she was adamant that this was unnecessary, although she also acknowledged the bureaucratic necessity of gaining such permission and was happy to do so.

However, another issue arose in the ethics process that is peculiar to autoethnographic research, but which is not easily resolved by citing guidelines provided by Tolich (2010) and the Congress of Qualitative Inquiry (2007). For example, the Ethics Committee also stipulated that my mother should be invited to read a final draft of the thesis before publication, alongside any publications that arise from the research subsequently on completion of the thesis. As this was a requirement for ethical approval, I told my mother that she would be welcome to read the thesis prior to publication. Somewhat to my surprise, she told me that she did not want to read anything relating to her diary because she did not want to revisit that time in her life.

Indeed, she told me that she has not even read the diary since she wrote it (over 25 years ago) and was deeply ambivalent about its contents.

Her response represents an important issue about whether it is ethically appropriate to stipulate that all ‘participants’ (as the Ethics Committee identified my mother) should be offered the opportunity to read the research. In some cases, it could even be re-traumatising for participants. Whilst Tolich (2010) and others (Ellis, 2004) make an important point about ‘process consent’ (i.e. making sure that consent is revisited throughout the research process), especially when it comes to the point where such research is made public, it also highlights the need to recognise that everyone will have a different relationship to such research. Process consent thus needs to be sensitive and handled carefully, particularly in the case when the participant is family or friends. Blanket requirements in such complex cases, as advocated by Tolich (2010), may actually be more ethically problematic if wider contextual issues are not thoughtfully considered. The wider question of who the data belongs to in autoethnographic research, and this thesis in particular, is therefore a complex issue unlikely to be resolved, or perhaps even navigated effectively, with the somewhat formulaic and ‘tick box’ approach argued by Tolich (2010).

Indeed, I think that the checklist presented above actually does not go far enough in considering some of the complexities the autoethnographic researcher is faced with. It is worth noting here the emphasis Tolich (2010) places on the nature of risk in his examples and considering whether they are sometimes over-stated. For example, referring to my thesis again, what exactly are the risks to the other participants? In terms of the clinical staff, all staff and locations were given pseudonyms. However, according to Tolich (2010) this does not go far enough: it might still be possible to identify some staff members from the description in the data, or extrapolate from my biography where the events would have taken place. This possibility also relates to point 6 (‘internal confidentiality’) on Tolich’s (2010) guidelines and raises the issue that some people internal to the research (e.g. clinical staff) may be able to identify their colleagues from the research. Even considering this possibility, how likely would this be, given the time frames? Perhaps even more so, what exactly are the ‘risks’ they would face? If they are represented in ways that might not be too flattering, surely this is something that requires discussion rather than avoidance?

A final point on this issue therefore relates to the political nature of research and, in particular, mental health and narrative research. If, for example, there are examples of bad practice, or clinical staff not performing in ways congruent with their professional standards, surely the research has a duty to identify and discuss the reasons for why this might have happened. Narrative writing recognises the researching of personal experience is almost always a political issue (Holman Jones, 2005) and that autoethnographers will occupy the position of social critic, exposing inequalities or hypocrisy (Grant et al., 2013) particularly when it involves abuses of power (Sparkes, 2007). Thus, consideration of others needs to be balanced against the importance of the social message and the explicit purpose of the research (Ellis & Bochner, 2000). This is especially the case for research involving experiences of power imbalances. In my thesis, this could relate to a number of issues such as, for example, being legally detained against your will in a psychiatric unit when your rights have been taken away (whether this was justified or not).

Going back to the purpose of the thesis, the main research questions are: what are authentic representations of madness?; and what do these representations tells us about the social context in which madness occurs? It is thus to discuss madness and its social context, more generally, not the behaviour of individual staff members. Some ethical guidelines appear to be geared towards protecting personal feelings or reputations but against developing systemic critiques (Dickson and Holland, 2017). The latter is my goal for thesis and not becoming a ‘whistleblower’ for negligent individuals. I therefore believe I am acting ethically by including information relating to staff, even without their consent, as it is very unlikely they could be identified and so the personal risks to them are relatively minor. With regards to my family, I have taken care to anonomise their details by using pseudonyms and consulted with them in the development of the research.

3.3.2 ‘Risks to Self’

The other ethical issue, that relates to ‘risks to self’, incorporates two main areas. The first of these elements is that the process of doing autoethnography can be a distressing one as it involves exploring aspects of past and current personal experiences (Ellis, 2000). This consideration is especially relevant to writing autobiographical writing about mental distress more generally (Grant et al., 2013) as a key purpose of the writing is to try and evoke the experience emotionally for the reader in order to help them become more immersed (Stone, 2004). However, this also comes with risks; as Grant and Zeeman (2012) have noted, autoethnography can come with a ‘health warning’ because touching these experiences can be painful and exposing. The researcher may therefore need to ensure that he or she has enough support in place to embark on such as project (Speedy, 2013).

I acknowledge that the research may touch upon painful or difficult personal issues for me. I have a support structure already in place and significant others have made themselves available to talk through any issues that may arise through the research. However, I also recognise that it is very difficult to anticipate what particular difficulties may arise. I am thus receiving personal therapy, whereby any issues provoked by the research can be discussed, explored and processed. Any adverse experiences will also be discussed in supervision if and when necessary in order to ensure I am making best use of the available support mechanisms.

The second element of ‘risks to self’ relates to the disclosure of personal information. As many researchers have observed (Tolich, 2010), a doctorate (including any subsequent publications that result from it) places the personal experience of the researcher in the public domain. It could thus be potentially exposing for them if, and when, deeply personal information is made available in this way. This issue is particularly relevant for my thesis, in which the material is particularly personal and distressing. However, I have also given this project, and the nature of such disclosures, careful consideration. Over the last few years I have been very open about my past experiences in both public and professional contexts. Prior to starting the PhD, I wrote publicly accessible online blogs and have spoken at conferences about my personal experience of mental health difficulties. This decision was made on a political basis, that the sharing of these experiences represented an important intervention in the field of mental health. I am thus fully aware of the ramifications of this project. To some extent therefore, this information is now already part of the public domain, since I made the decision to be more open about my experiences a few years ago. I thus believe I am conducting this research ethically, in line with university and research guidelines. However, I also believe I am conducting this thesis according to the often-demanding spirit of the ethics of autoethnography. Having discussed the ethical ramifications of the thesis, I will be presenting the quadrilogue in entirety in the following section.

SUMMARY

In this chapter, I have outlined my methodology, an adaptation of autoethnography I have called the ‘quadrilogue’. This method utilises multiple perspectives and voices to narrate the experience of going mad and being admitted to an inpatient unit. These perspectives are mine, my mother’s, the clinical team and reflective voice of the researcher. The quadrilogue was developed in response to both criticisms of autoethnography, most notably epistemological divisions and textual conservatism, and mental health narratives, most notability that of ‘disability tourism’. Finally, ethical issues derived from the project were discussed, specifically what has been called ‘relational ethics’ and ‘risks to self’. The quadrilogue represents a methodological innovation and thus represents a novel contribution to knowledge.

CHAPTER 4. RESULTS: THE QUADRILOGUE

INTRODUCTION

The last chapter outlined my methodology, an adaptation of autoethnography which I called ‘the quadrilogue’. The quadrilogue is a novel method through which multiple accounts of an event, or series of events, can be represented alongside each other for the purposes of comparison and discussion. In my thesis, the quadrilogue represents my account alongside my mother’s and the clinical team’s accounts, with the researcher’s account as the final column. The next section presents the quadrilogue in full.

1.1 Reading the Quadrilogue

The quadrilogue is divided into 9 parts representing chronologically the pathway into admission to the inpatient psychiatric unit, and out again via the discharge process. Each part is given a title that represents an important facet of the inpatient process. The nine parts of the quadrilogue are:

1. Prelude
2. Assessment
3. Ward round
4. Admission
5. Transfer
6. ICU
7. Leave
8. ECU

9. Discharge

As discussed in the last Chapter, in between each sections I have included scanned images of some of the actual documents from my medical notes. This for the purposes of providing an immersive experience and also for relaying information. A short paragraph summary of the relevant part precedes each part, so that the reader is able to follow the overall narrative from beginning to end, which may be difficult when reading the quadrilogue in full.

The intention of the quadrilogue is to present an immersive narrative. Other than a few pilot readings (e.g. friends, family, supervisors), it is still a relatively untested method. At first, this may appear overwhelming for the reader and they might find themselves with a number of choices: e.g. to read down or to read across, which account to start, where to read first. The reader may also find themselves back tracking across different sections to catch-up. I do not have a single recommendation for the reader about how to approach the quadrilogue. Rather, in the experimentalist spirit of the quadrilogue, I would suggest that the reader may their own way to engage with the narrative.

It needs to be highlighted that the quadrilogue presents a lot of information on the page and may offer a narrative thread that is unfamiliar and thus difficult to follow. Therefore, the reader may find it heavy-going at first. Some aspects of the narrative can also be profoundly upsetting to read, especially in sections where there is physical restraint and forced medication.

I would advise that the reader takes care of themselves when going through the narrative.

1.2 A Note on the Text

My mother’s diary and the clinical notes have been represented exactly as they were recorded. This includes the presence of spelling and grammatical errors, typographical idiosyncrasies, the use of short-hand notation, acronyms (often without explanation), medical terminology and technical/clinical language. Aside from my own, all names of family members, friends and clinical staff have been given pseudonyms. Locations, including the name of wards, have also been replaced with fictional pseudonyms.

Part 1. Prelude

I was suffering a severe psychotic breakdown, experiencing extreme feelings of alienation and despair. My family were worried about me and trying to engage with me, with little success. I had just been to see the GP, apparently at my mother's instigation, and the GP had made a referral to the psychiatrist. In this scene, I described my sense of isolation from my family, heightened interpretation of events, and an interaction with my mother, whilst all the time being distracted by voices. In her account, my mother described and summarised her perception of my current situation and the events leading up to my admission. She also speculated as to what might have caused my difficulties, reflecting on my development and interactions with other family members and with school. The clinical team account is represented by the GP's referral letter to the psychiatrist, where the GP mentioned my request to 'see a psycho-analyst', described my current symptoms, and offered some hypotheses with regards to diagnosis and treatment.

Part 1: Prelude

Simon

It is dark, and you stand on the patio at the back of the garden, slightly raised up from the house below.

You pace back and forth, smoking one cigarette after another, the mad roulette of voices rolling around your head like an aural carousel.

Meeting you at your parent's gate…

Because I do not hope…

The dogs are still playing in the yard…

Reflected from my golden eye…

Everyone is very kind to A…

Mother

In Summer 93 we became aware that he had been taking drugs. Pot and L.SD He'd told his brother that he thought he was going mad. He told us later that week. He went to the drug rehabilitation centre at Wodenborough and spoke to a counsellor there. He seemed to be able to reassure him. He also saw Dr Carmen who advised him to go to a centre in Swapanley. We don't know if he went, and we couldn't betray Dr Carmen and let him know we had been talking about him as he was very much his own person and could resent too much interference in his life. I remember he felt guilty about "wasting the counsellor's time" as he felt people were worse than him. He wanted to go to university, this had been quite important to him before he took drugs – so we had got him into Portown College to get the necessary qualifications.

Clinical Team

THE SURGERY
DAMSON HILL
ATTERCOTE
COUNTY POSTCODE

Town

(Area code) Number

1.9.94

Dr __________
Consultant Psychiatrist
Clinic Name
Clinic Address
Town, County, Postcode

Dear Dr ________,

Reflection

In choosing when to begin the narrative, it seemed fitting to start at the point at which the 'problem' becomes formally established by a medical professional. Indeed, the GP letter was the first main entry in the notes and it already frames the 'problem' in a particular way in relation to medical psychiatric categories and notions of 'typical' and 'atypical'. There is also a brief institutional cross-checking through information provided on schooling and work. It is interesting to note that it is these particular details which are highlighted as important to the GP, as opposed to other factors, such as relationships or hobbies, which suggest immediately that institutional cross-checking is important. I also noticed that my request to see a 'psycho-analyst' was referred to a psychiatrist and not a psychological professional,

Simon

We will tell you what to do…

More or less as one tries to guard an excellent billiard table…

What you have to do…

You observe your family talking through the kitchen window below; they move in and out of focus like fish in an aquarium.

They cast anxious glances up at you when they pass the window, and then circle for another round, deep in conversation with each other.

The voices inside continue:

Because I do not hope to turn…

Mother

He was taking maths GCE (which he hates) A level English & Sociology. He didn't enjoy it very much – he soon dropped ~~english~~ maths. He was difficult to get up in the mornings and soon lost his motivation. He got a job at the a hotel nearby a couple of evenings a week to give him pocket money. He went out with his friends once or twice a week. Mainly he spent most of his time in his room. He became fascinated by psychology & philosophy and that is mainly what he read. He was fascinated by Jim Morrison, Kafka, Jung Wittgensing. Recently he has been reading the bible and the Ko-ran. There was no competition between his brothers but I know he envied them, especially the ease with which my 18 yr old seemed to have all the attributes to be successful. They are both good looking my 18 yr old especially so, plenty of friends

Clinical Team

RE: CLARKE Simon D.o.b. 25.11.74 Tel _________

House, Road, Town, County,
Postcode

I would be grateful if you would send this young man an appointment to come and see you. He came to the Surgery this week saying that he felt he needed to see a Psycho-analysist.

Reflection

which either indicates the GP's lack of familiarity with 'talking cures', or else a reflection of the lack of prevalence of talking therapies more generally at the time this was written - the early 1990s. It is apparent to me now that the GP has offered a fairly detailed summary of my psychological state, suggesting that he had taken time with the assessment and with his thoughts about the assessment. As this was the family GP who had known me all my life, this is perhaps to be expected. My mother's account in this section is unique in relation to other entries in the diary in that they were 3 loose pages of A4 and were undated. This account ends with the admission to hospital, so I presume it was probably written shortly after then. It is a curious document in that it reads almost like a summary and meta-reflection of the

Simon

This dullard knows that he is mad…

Until the time when the great player comes…

What you have to do…

Who will carefully examine the table…

but the quarry will not escape them…

Will not put up with any damage done to it previously…

When you look long into the abyss…

Your mother throws a lingering glance up at you, opens the door and comes up to the patio.

Mother

popular – it is a ‘macho’ family of men. Although he never tried be like them. Although he went out he never dressed up to ‘get girls’. I remember him having a date once. I remember him joking once when the question of sex came up that ‘chance would be a fine thing’. My husband told me yesterday that when Simon was 3 yrs old his mother had said to him, that James & David will always manage and get by but Simon is different, he needs more looking after. I always felt he was a normal boy, sensitive, thoughtful, always talked a lot – had his own opinions, articulate. He had a good relationship with his father. With me it was more volatile as we both tend to flare up quickly, but he was affectionate and was able to express his feelings for us. He didn’t get both A levels just the English. Shortly the exams he started working full-time at The

Clinical Team

I asked him his problems and his main complaint is that he feels a lack of sensitivity and is emotionally flat. On questioning him more closely about these feelings, he says that he lacks any sense of creativity, he is not motivated, has no energy and no longer experiences pleasure or joy and admits to feeling depressed.

He sleeps badly and wakes in the early hours of the morning. Atypically he feels better when he gets up and feels worse as the day goes on.

Reflection

circumstances that have led to admission. In doing so, it also offers some post-hoc justifications about her and my dad’s parenting that, at times I think, suggest guilt, along with some re-framing of my development in terms of specific indications of problems, including a Grandparent’s comment concerning my apparent psychological fragility and need of care, and unfavourable comparisons with my brothers. This is one of the few entries that offers any form of speculation of this sort: most of the diary records events and frustrations, with few thoughts or reflections.

In my own account, I have presented a brief scene that has tried to capture something of the terror and desperation that I felt at the time. I cannot remember the GP visit the scene refers to.

Simon

She lights a cigarette, sucks and inhales a long drag, which is then expunged in one long exhale through fluted lips.

She asks you about your visit to the doctor.

You reply non-committedly.

There is a sudden rustle of branches and a dull ‘thunk!’ as an apple falls from the tree and rolls down the patio to your feet.

The voices continue:

To survive.

Tell me that I am not glad!

Because I do not hope.

Mother

Cricketers. It was long hours – 10am – 10pm / 11pm a break during the day, he usually stayed there. He didn’t seem to mind the job, it put no demands on him, it was casual and apart from always being late he went all the time. Shortly after the results of the exams he had a car accident in which he wrote it off. He had smashed into the walls. He had lost control when turning a corner and done a complete U turn. Richard had brought the car for him & James about 6 weeks previously. Simon used it the most as he needed it for work. We never expressed any anger over the car. We were just so glad he was alive. Perhaps that made him worse? Over those weeks he isolated himself more, then about 25th August he was obviously distressed One night I picked him up from work. He felt he was going to die that night – he didn’t

Clinical Team

He took ‘A’ levels at the local Technical College, getting a C grade in English and failing Social Studies.

Currently he is working as a kitchen porter but only sees this as a ‘filling in’ job.

Reflection

Indeed, this is not an exact depiction of an actual interaction, but a recreation of what would have been several interactions - around this time I spent most of the evenings pacing up and down the patio. The ‘aural carousal’ described here is an attempt to give an indication of my state of mind at the time, which had become dominated by a repetitive cycle of phrases and writings that I had read over the past two years. Now these phrases were operating almost autonomously according to very disturbing suggestions of some impending threat or punishment. I hope it conveys to the reader something of how cut-off from the world around me that I felt at the time and how little control I felt I had of my own mind, something of which is also indicated by my mother’s account.

Simon

When he himself begins to play…

never mind how fast it is running through the forest already.

but then, when he himself begins to play, lets himself go…

The abyss also looks into you.

Wildly, in the most inconsiderate manner.

Your mother finishes her cigarette and grinds the stub on the patio with her shoe. She grimaces a smile and goes back inside.

Another apple drops with a thud. You continue to smoke and pace, smoke and pace, smoke and pace, the words whorling and whorling and whorling around your head.

Mother

know how – he said "I have the whole of philosophy on my shoulders". He felt in a vacuum, no emotions. He'd mentioned a couple of times that he was worried he had schizophrenia. He told me he had suicidal thoughts. It was coming up to bank holiday weekend & I couldn't get him into the Dr's until the Tuesday so I arranged for him to talk to a counsellor to talk through his problems. He didn't find it very helpful. He saw Dr Carmen who sent him to the day centre at Wodenborough. He didn't find it very helpful and didn't really want to go back but I told him he must go through the motions of living, to plod on and we will come through this. He changed his hours of work to evenings and weekends. He gradually became more agitated & withdrawn. I don't think he slept much recently.

Clinical Team

I see him as a young man who probably has an underlying personality disorder but is definitely depressed. I have, therefore, prescribed him Prozac 20mg daily but feel he is in need of your further assessment and advice regarding management.

Thank you for seeing him and for your help.

Your sincerely,

<u>Dr Carmen</u>

General Practitioner

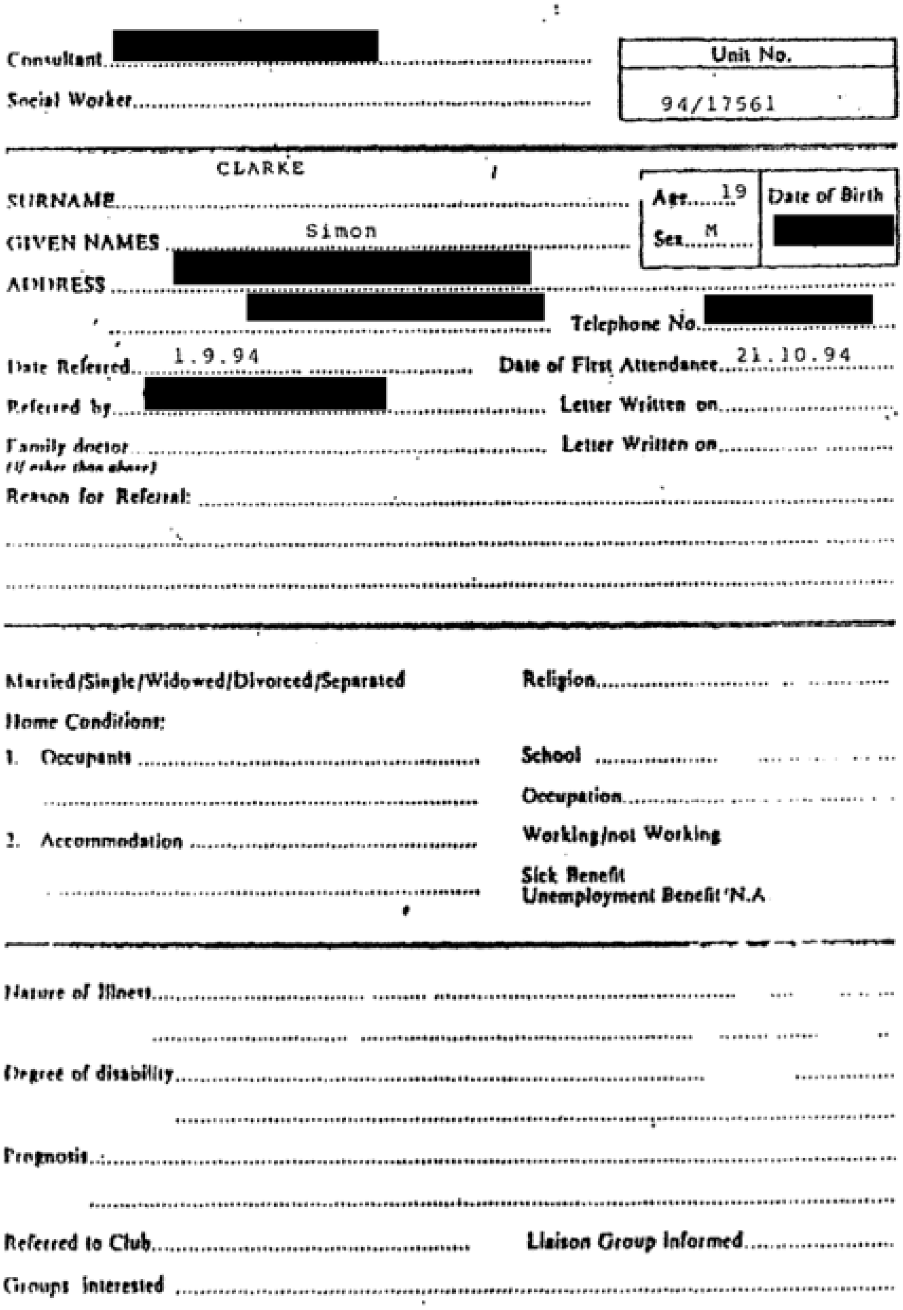
Reflection

There is a sinister edge here, with symbolic echoes of the biblical fall through the apples falling.

My immediate reaction to reading these accounts was anger at my mother and the GP. It hurt to see myself described as having a personality disorder; it is as if my very personhood was placed in question. It also hurt to see my mother's account concerning her comparisons with my brothers and retrospective analysis of my upbringing that attributes my difficulties to flaws in my psychological make-up.

On the other hand, I also felt desperately sad for her. Even though many people have commented on the apparent lack of emotion displayed by my mother throughout the diary, I got a sense of her desperation and helplessness.

Document 1.1. Referral form to psychiatric services.



Consultant [redacted]

Social Worker

Unit No.

94/17561

SURNAME CLARKE

GIVEN NAMES Simon

Age 19

Sex M

Date of Birth [redacted]

ADDRESS [redacted]

[redacted]

Telephone No. [redacted]

Date Referred 1.9.94

Date of First Attendance 21.10.94

Referred by [redacted]

Letter Written on

Family doctor
(If other than above)

Letter Written on

Reason for Referral:

Married/Single/Widowed/Divorced/Separated

Religion

Home Conditions:

1. Occupants

School

Occupation

2. Accommodation

Working/not Working

Sick Benefit
Unemployment Benefit N.A

Nature of Illness

Degree of disability

Prognosis

Referred to Club

Liaison Group Informed

Groups interested

Part 2. Assessment

Following the GP referral, I was offered an appointment with the psychiatrist. In this section, I met with the psychiatrist for an initial assessment, describing my feeling of ‘despair’ and isolation. A nurse was also present, which appeared to exacerbate rather than alleviate my sense of isolation. Following the meeting, the psychiatrist provided a report summarising his impressions, most notably my use of the word ‘despair’, which the psychiatrist treated in terms of a diagnostic category similar to depression. Concluding his report, the psychiatrist diagnosed me with “Inadequate P.D. with H/0 drug addiction Anxiety state & some social inadequacies”, whilst also recommending treatment at the Day Hospital. My mother’s voice was absent in this section.

Part 2: Assessment

Simon	Mother	Clinical Team	Reflection
You are ushered into the room by the tall, willowy nurse with long, blond hair. She is pale and looks insubstantial. She is wearing jeans and a white blouse. You think she looks tired and fed up. You don’t think she likes you very much. But then you think that about everyone at the moment. The doctor sits behind his desk and the nurse stands behind him. Tap, tap, tap, goes her foot. Click, click, click goes his pen. The doctor does not look up, as if his heavy black spectacles are weighing his face down to the notes. The sunlight glances from the dark brown dome of his balding head, scorching yellow, blue and then red patterns across your		12/9/94 Ref. by G.P. for assessment Saw his G.P. & asked that he wants to see a psycho-analyst, (or psychotherapist as he told me now) Problem > Lacking lack of sensitivity, emotional flatness – i.e. lacks any sense of creativity, no motivation, no energy & no longer experiences pleasure or joy, feeling depressed → Sleep poor with EMW, better in the morning but gets worse as the day goes on (But patient also says the he becomes more despaired) in the morning for about ½ hr, gets better during the day but again despaired just before going to bed until he sleeps ~ ½ 1 hr at about 11pm & gets up at 9am, then starts work at 10am) felt suicidal & needed urgent appt <u>Med</u> :- Prozac 10 mg pres. By G.P. 1/5 ~ ago but he has not	Whilst the last section dealt with the GP referral to the psychiatrist, this section continues at the first psychiatric assessment following the referral. I have included this section because it was my first point of contact with the psychiatric system and so represents a crucial stage in the career of a psychiatric inpatient. I did not know what to expect prior to the meeting as most of my knowledge of psychiatry had been informed by reading anti-psychiatry texts from the 1960s. My mother’s diary is silent on this encounter and her diary does not continue until over a week later when the admission process begins. It was also one of the more emotive memories of the time, mainly for negative reasons. I remember that the psychiatrist barely made eye contact with me throughout the whole interview and spoke very poor English.

Simon

eyes. They do not fade away like they are supposed to.

The doctor asks you what the problem is.

I am in despair, you say.

The doctor asks how long have you been depressed.

You correct him. I am not depressed, you tell him. I am in despair.

Despair? OK, he says.

A few seconds pause.

How often are you … depre … despairing?

I don’t understand, you reply.

How many times a day are you feeling despaired?

Slight pause and you say three times; you are not sure why.

The metaphysical significance of three then occurs to you immediately. *The unholy trinity*.

The nurse rolls her eyes behind the doctor. You assume that she is rolling her eyes at you.

Mother

Clinical Team

taken, does not think he is depressed

Although patient says, although he had anxiety for about 1 ½ yr, the above mentioned symptoms are for the past 1/2 . It started from drugs:

Marijuana → Felt relaxed & happy started 2 yrs ago – smoking daily (n-3 jt) → started 1/12 go because he felt despaired every time he started a joint – for about 6 hours

(2-3 months ago he had change of feelings with marijuana; personally happy but about 3/12 ago have anxious)

L.S.D. – took 12 times; last 1 yr ago (total 12 times in one yr) Wanted to enjoy its effects, found new experience – ecstatic which was enjoyable. 2f in a frightening experience so he stopped it.

No other drugs used.

Also has visual problem – image of light or anything like a

Reflection

I don’t remember the nurse as being particularly friendly either, although I now think that she was probably rolling her eyes at the doctor and not at me. I did not find the process remotely helpful at all.

There are several things that really strike me about this piece as I reflect on it now. The first is that the psychiatrist genuinely does appear to want to use my language. His, and the GP’s, term ‘depression’ is substituted with my term ‘despair’. In the report following (Documents 2.1.1 and 2.1.2), the psychiatrist writes that I used this phrase ‘fairly insistently’, implying an agency that I cannot remember having at the time. However, despite using my term, the psychiatrist then proceeds to describe ‘despair’ in terms of frequency and duration as one would depression, implying that his use of the patient

Part 2: Assessment

Simon

You must really be pissing them off. It feels like a waste of everyone's time, this.

The doctor asks you more questions:

How long have you felt like this?

What have you been doing with yourself?

When did you finish college? How are you finding your job?

When do you notice you were despairing?

You mumble your way through.

What difference is this going to make?

Scant offerings.

Somehow it feels like something crucial is being missed.

He asks whether there is a history of mental illness in your family.

You say no. Then you remember your mother's father, who died before you were born.

Mother

Clinical Team

[illegible] fades away gradually (whenever he sees any light) – longer than before.

<u>Mental</u> orientated TPP

Cognitive state sates intact

<u>MOOD</u> Anxious or despaired "loss of hope for future"

Doesn't look depressed

Always thinking about death (for 1/12) but wouldn't kill himself

Why "no future"; partially worthless. "I want to go on living". Told his mother about despair feeling 1/12 ago * She got upset later on as patient's dad told him (she didn't show herself) [illegible] √ (have [illegible]). Doesn't enjoy life. No tiredness Sleep (as above). Normal dreams, sometime wakes up but sleeps again soon

Appetite √ , . lunch √, home

No loss of weight.

Feels empty of [illegible] <u>but lost</u> things are real

No hallucinations (v. N.P.) Thinks

Reflection

language is merely superficial. There is no further questioning as to what I meant by 'despair', which strikes me as curious. There are also some other odd phraseologies and use of language where the meaning is not quite clear, for example, when the patient is described as feeling "partially worthless". There is also the first mention of the visual disturbances that would later be diagnosed as 'palinopsia' and used in support for a diagnosis of schizophrenia. Interestingly, here, there is no mention of psychosis whatsoever: my difficulties are put down to 'social inadequacies' and 'anxiety'.

The other notable feature is the mention of schooling, which appears to be an important recurrent feature of all the medical assessments. It does not seem to be a factor immediately relevant

Simon

Well, my Grandfather used to beat my Grandmother, my mum and her sisters, so he can’t have been very happy, could he?

The Doctor nods.

A short while later he concludes the interview.

He says some stuff which you don’t remember.

There is a lot you don’t remember.

You are not holding things in very well anymore. There is too much in here already.

Well Mr Clarke, thank you for coming today. We will refer you to the day hospital immediately. Do you have any questions?

You reply in the negative.

The Doctor pushes a small plastic container across the desk towards you. You notice the container is laden with little red pills.

The Doctor looks up at you for the first time.

Mother

Clinical Team

he is mentally ill & needs to talk about current situation Lives with parents F49 √ [illegible] bus driver M50 √ (nurse in community. Closer. Bassington)

Sib – 2b – Malesh 18 √ - - David 15 √

Maternal G. Father used to be physically violent to patient M & their sister otherwise no mental illness in family.

Been working as a kitchen porter since July .94) → Effenwick

Personal Born FBH, later birth (forceps delivery)

Happy childhood. Had whooping cough for few months (4 yr old)

School – left 18 3 GCSE 1 ‘A’ level

good relation, no truancy.

College – 1 yr English & sociology <u>but</u> left

→ C grade for English but failed sociology (doesn't do it again)

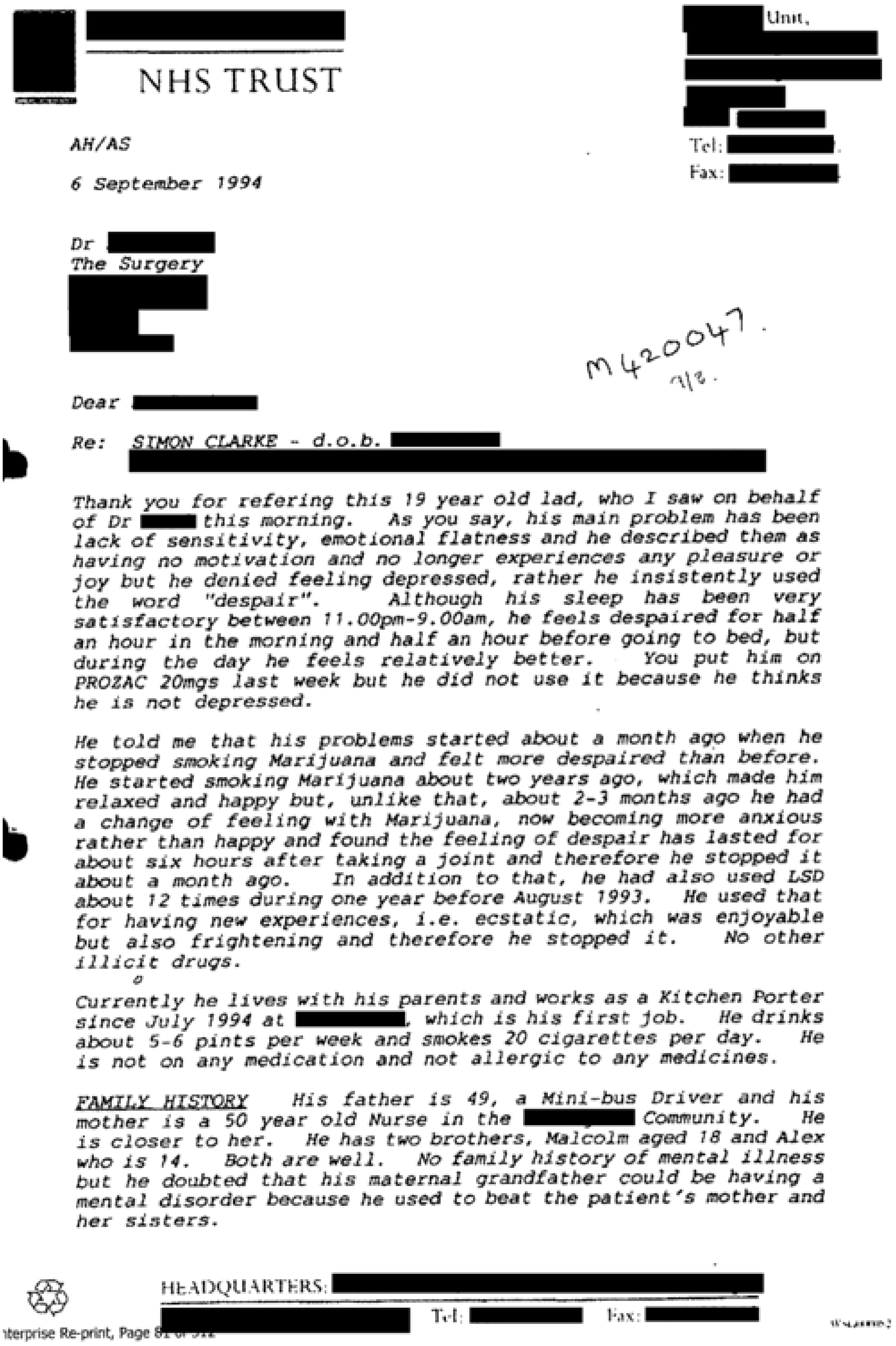
Reflection

to my own complaints, so it is curious when questions about schooling re-occur consistently. In fact, one feature of this, and subsequent, psychiatric assessments is the apparent need to collect huge amounts of information about the patient’s life that do not seem immediately relevant to the immediate situation, as if collecting information for information’s sake is an unconscious and automatic feature of institutional praxis.

Altogether, my first impressions of psychiatry did not meet my fears of an efficient and repressive machine that was driven to stamp on any signs of deviance, which I had picked up from Laing, Goffman and others but, rather, a tired, somewhat lackadaisical institution, where the staff were either disinterested, not that well trained, or just burnt-out.

Simon	Mother	Clinical Team	Reflection
These are for you, he says. He smiles. These are for your…despair.		1st job <u>the</u> current one Thinking of going to night college to improve qualif [illegible] ?1st G.F. → Never had a G.F. "shy" Just social talking only Despair – 5-6 times/wk Smoking – 20 cig daily No without drugs for 1/12 Dx Inadequate P.D. with H/0 drug addiction Anxiety state & some social inadequacies Needs to attend D.H. for group discussion, social skills, etc.	At this point, I was so far out in my own concerns that I think it would have been very difficult for the staff to have reached me anyway without significant energy and time, neither of which they possessed. The psychiatrist's recommendation of 'social skills training' and 'group discussion' at the Day Hospital (DH) does seem strange, especially given the psychotic breakdown that was to follow. The original request for psychotherapy, whilst acknowledged, is not explored further. Some of the nonsense written in the report following this (Documents 2.1.1 and 2.1.2) is unintentionally funny ('this lad is having inadequate personality').

Document 2.1.1. Psychiatrist's report following first assessment, page 1.



[redacted] [redacted]
NHS TRUST

[redacted] Unit,
[redacted]
Tel: [redacted]
Fax: [redacted]

AH/AS

6 September 1994

Dr [redacted]
The Surgery
[redacted]

M420047.
9/8.

Dear [redacted]

Re: SIMON CLARKE - d.o.b. [redacted]
[redacted]

Thank you for refering this 19 year old lad, who I saw on behalf of Dr [redacted] *this morning. As you say, his main problem has been lack of sensitivity, emotional flatness and he described them as having no motivation and no longer experiences any pleasure or joy but he denied feeling depressed, rather he insistently used the word "despair". Although his sleep has been very satisfactory between 11.00pm-9.00am, he feels despaired for half an hour in the morning and half an hour before going to bed, but during the day he feels relatively better. You put him on PROZAC 20mgs last week but he did not use it because he thinks he is not depressed.*

He told me that his problems started about a month ago when he stopped smoking Marijuana and felt more despaired than before. He started smoking Marijuana about two years ago, which made him relaxed and happy but, unlike that, about 2-3 months ago he had a change of feeling with Marijuana, now becoming more anxious rather than happy and found the feeling of despair has lasted for about six hours after taking a joint and therefore he stopped it about a month ago. In addition to that, he had also used LSD about 12 times during one year before August 1993. He used that for having new experiences, i.e. ecstatic, which was enjoyable but also frightening and therefore he stopped it. No other illicit drugs.

Currently he lives with his parents and works as a Kitchen Porter since July 1994 at [redacted]*, which is his first job. He drinks about 5-6 pints per week and smokes 20 cigarettes per day. He is not on any medication and not allergic to any medicines.*

FAMILY HISTORY His father is 49, a Mini-bus Driver and his mother is a 50 year old Nurse in the [redacted] *Community. He is closer to her. He has two brothers, Malcolm aged 18 and Alex who is 14. Both are well. No family history of mental illness but he doubted that his maternal grandfather could be having a mental disorder because he used to beat the patient's mother and her sisters.*

HEADQUARTERS: [redacted]
[redacted] Tel: [redacted] Fax: [redacted]

Document 2.1.2. Psychiatrist's report following first assessment, page 1.

[redacted]
NHS TRUST

Page 2

6 September 1994

Re: SIMON CLARKE

PERSONAL HISTORY The patient was born at [redacted]. It was rather a late birth and forceps delivery. He described his childhood as happy, apart from having Whooping Cough for a few months at the age of 4. He left school at the age of 18, obtained three GCSEs and one 'A' level. No problems in school and he did not play truant. He attended College for one year and obtained a Certificate in English but failed in Sociology which he does not intend to do again. However, he is interested to acquire two more 'A' levels and one more GCSE and wants to join Night College for that purpose.

The above-mentioned is his first and only job. He told me that he never had a girlfriend because he is shy but talks to the girls socially.

MENTAL STATE EXAMINATION His cognitive state is intact. Moodwise he feels anxious and in despair. This anxiety has been for the past 1½ years but more so for the past one month. He said this despair is because he has lost hope for his future. He also felt partially worthless but commented that he would not kill himself because he wants to live. He felt a bit guilty that he told his mother about his feelings about a month ago and she was upset later on, as his father told him. He takes interest in his household activities and work and does not feel tired. His sleep is normal, he gets normal dreams and sometimes wakes up at midnight for a moment and sleeps again. His appetite is satisfactory, no loss of weight. He feels empty and depersonalised but there are no feeling of derealisation. There are no hallucinations but he said that images of things like people, lights etc. remain longer in his mind than before, i.e. up to a couple of seconds (this is after he sees something).

This 19 year old lad is having inadequate personality with a history of drug addiction and anxiety state as well as some social inadequacies.

He needs some group discussions and social skills training which could be adequately arranged in the Day Hospital at [redacted]. I have referred his case to the staff there, who will see him on the 7th September 1994. I have not prescribed any medication for him.

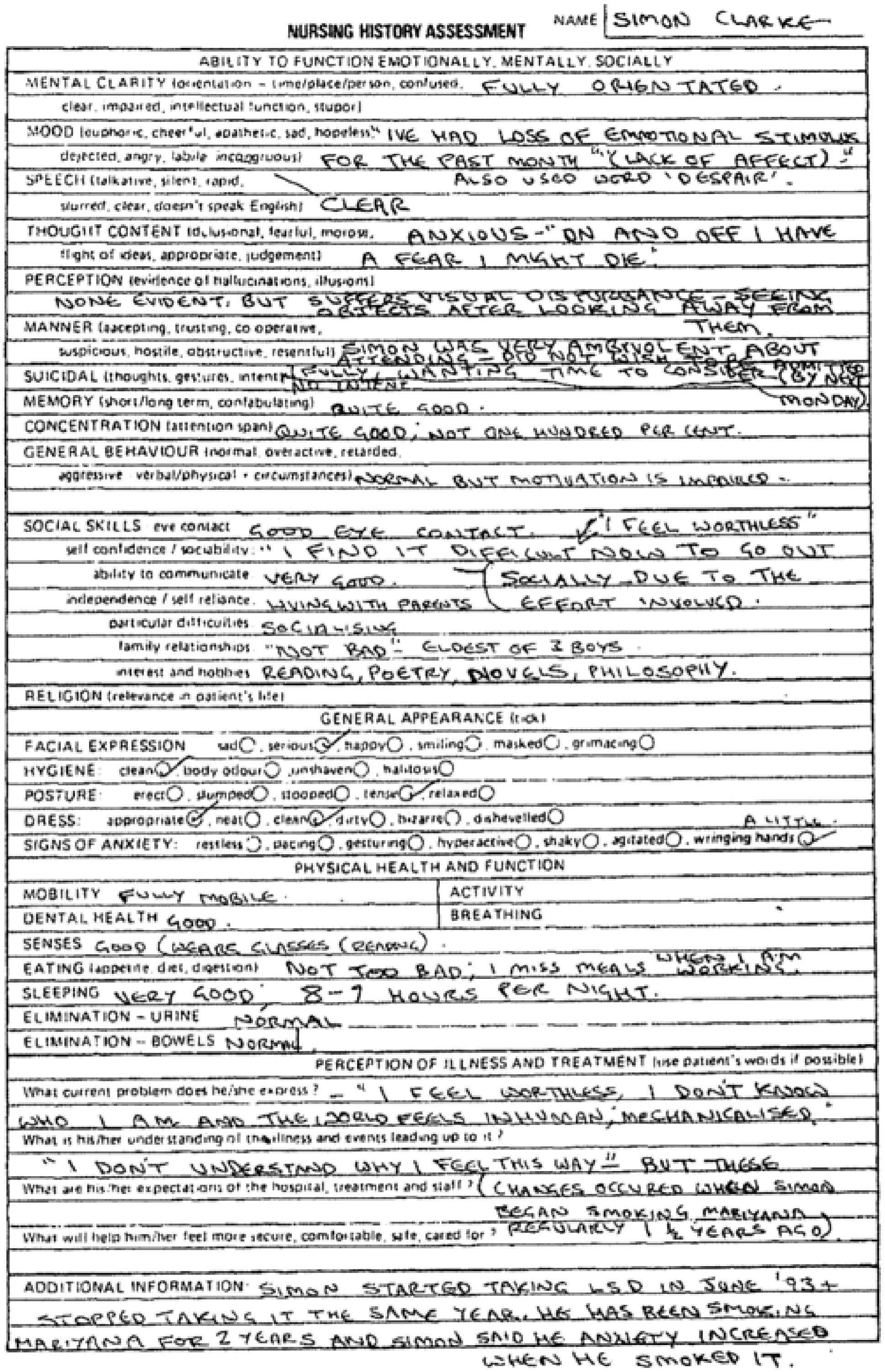
Yours sincerely

[redacted]

Dr A [redacted]
Locum Registrar in Psychiatry to Dr D [redacted]

c.c. Day Hospital

Document 2.2. Nursing history assessment



NURSING HISTORY ASSESSMENT NAME SIMON CLARKE

ABILITY TO FUNCTION EMOTIONALLY, MENTALLY, SOCIALLY

MENTAL CLARITY (orientation – time/place/person, confused, clear, impaired, intellectual function, stupor) FULLY ORIENTATED.

MOOD (euphoric, cheerful, apathetic, sad, hopeless, dejected, angry, labile incongruous) "IVE HAD LOSS OF EMOTIONAL STIMULUS FOR THE PAST MONTH" "(LACK OF AFFECT)." ALSO USED WORD 'DESPAIR'.

SPEECH (talkative, silent, rapid, slurred, clear, doesn't speak English) CLEAR

THOUGHT CONTENT (delusional, fearful, morose, flight of ideas, appropriate, judgement) ANXIOUS – "ON AND OFF I HAVE A FEAR I MIGHT DIE."

PERCEPTION (evidence of hallucinations, illusions) NONE EVIDENT, BUT SUFFERS VISUAL DISTURBANCE – SEEING OBJECTS AFTER LOOKING AWAY FROM THEM.

MANNER (accepting, trusting, co operative, suspicious, hostile, obstructive, resentful) SIMON WAS VERY AMBIVOLENT ABOUT ATTENDING – DID NOT WISH TO BE ADMITTED FULLY, WANTING TIME TO CONSIDER (BY NEXT MONDAY).

SUICIDAL (thoughts, gestures, intent) NO INTENT

MEMORY (short/long term, confabulating) QUITE GOOD.

CONCENTRATION (attention span) QUITE GOOD; NOT ONE HUNDRED PER CENT.

GENERAL BEHAVIOUR (normal, overactive, retarded, aggressive – verbal/physical + circumstances) NORMAL BUT MOTIVATION IS IMPAIRED.

SOCIAL SKILLS eye contact GOOD EYE CONTACT. "I FEEL WORTHLESS"

self confidence / sociability: "I FIND IT DIFFICULT NOW TO GO OUT SOCIALLY DUE TO THE EFFORT INVOLVED."

ability to communicate VERY GOOD.

independence / self reliance. LIVING WITH PARENTS

particular difficulties SOCIALISING

family relationships "NOT BAD" – ELDEST OF 3 BOYS.

interest and hobbies READING, POETRY, NOVELS, PHILOSOPHY.

RELIGION (relevance in patient's life)

GENERAL APPEARANCE (tick)

FACIAL EXPRESSION sad ○, serious ☑, happy ○, smiling ○, masked ○, grimacing ○

HYGIENE: clean ☑, body odour ○, unshaven ○, halitosis ○

POSTURE: erect ○, slumped ○, stooped ○, tense ☑, relaxed ○

DRESS: appropriate ☑, neat ○, clean ☑, dirty ○, bizarre ○, dishevelled ○

SIGNS OF ANXIETY: restless ○, pacing ○, gesturing ○, hyperactive ○, shaky ○, agitated ○, wringing hands ☑ A LITTLE.

PHYSICAL HEALTH AND FUNCTION

MOBILITY FULLY MOBILE.	ACTIVITY
DENTAL HEALTH GOOD.	BREATHING

SENSES GOOD (WEARS GLASSES (READING)).

EATING (appetite, diet, digestion) NOT TOO BAD; "I MISS MEALS WHEN I AM WORKING."

SLEEPING VERY GOOD, 8-9 HOURS PER NIGHT.

ELIMINATION – URINE NORMAL

ELIMINATION – BOWELS NORMAL.

PERCEPTION OF ILLNESS AND TREATMENT (use patient's words if possible)

What current problem does he/she express? – "I FEEL WORTHLESS, I DON'T KNOW WHO I AM AND THE WORLD FEELS INHUMAN, MECHANICALISED."

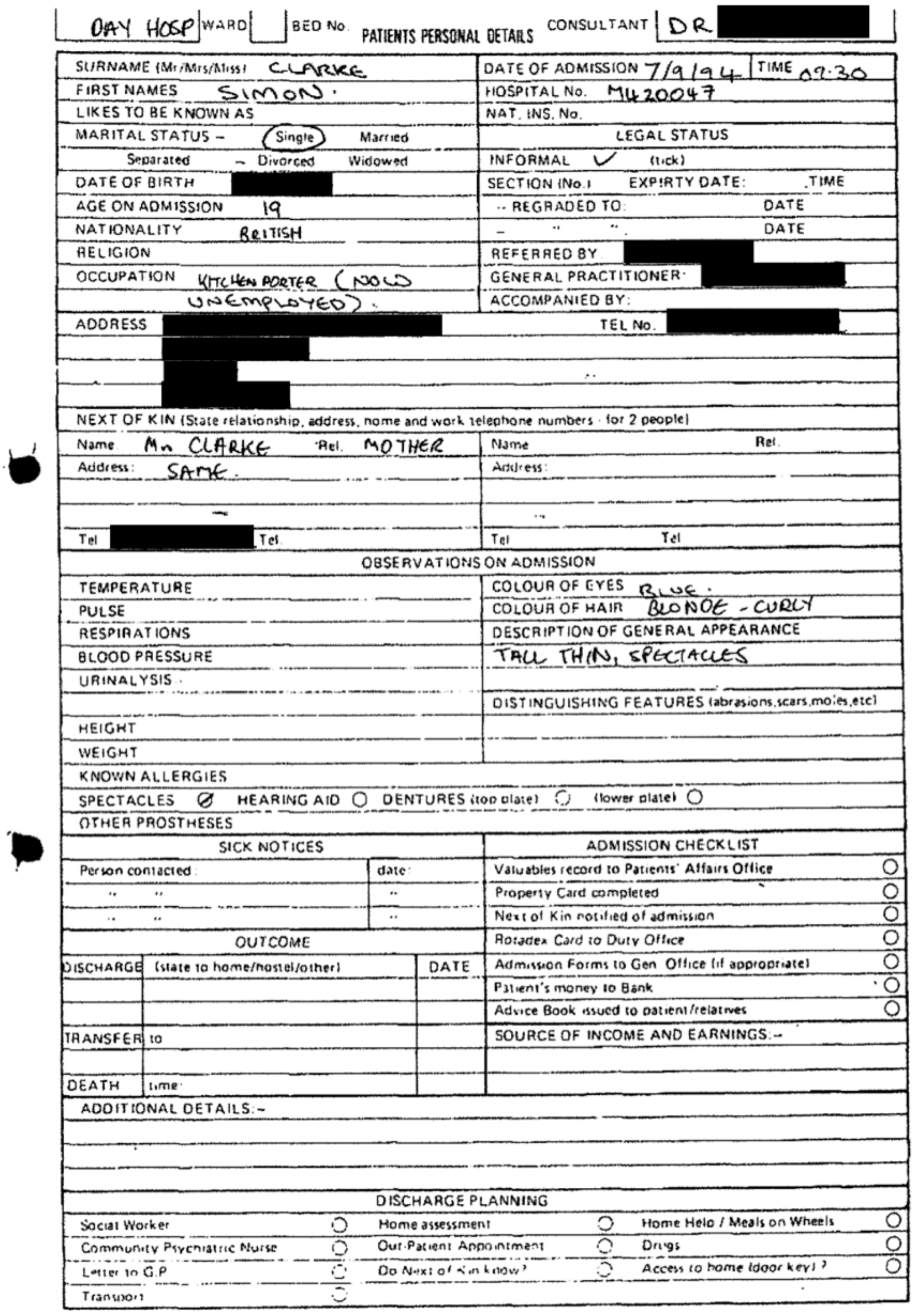
What is his/her understanding of the illness and events leading up to it? "I DON'T UNDERSTAND WHY I FEEL THIS WAY" – BUT THESE (CHANGES OCCURED WHEN SIMON BEGAN SMOKING MARIYANA REGULARLY 1½ YEARS AGO).

What are his/her expectations of the hospital, treatment and staff?

What will help him/her feel more secure, comfortable, safe, cared for?

ADDITIONAL INFORMATION: SIMON STARTED TAKING LSD IN JUNE '93 + STOPPED TAKING IT THE SAME YEAR. HE HAS BEEN SMOKING MARIYANA FOR 2 YEARS AND SIMON SAID HE ANXIETY INCREASED WHEN HE SMOKED IT.

Document 2.3. Day hospital admission form.



DAY HOSP | WARD | BED No. **PATIENTS PERSONAL DETAILS** CONSULTANT DR [redacted]

SURNAME (Mr/Mrs/Miss) CLARKE
FIRST NAMES SIMON.
LIKES TO BE KNOWN AS
MARITAL STATUS – [✓ Single] Married
Separated – Divorced Widowed
DATE OF BIRTH [redacted]
AGE ON ADMISSION 19
NATIONALITY BRITISH
RELIGION
OCCUPATION KITCHEN PORTER (NOW UNEMPLOYED).

DATE OF ADMISSION 7/9/94 TIME 09·30
HOSPITAL No. M420047
NAT. INS. No.
LEGAL STATUS
INFORMAL ✓ (tick)
SECTION (No.) EXPIRTY DATE: TIME
– REGRADED TO: DATE
– " " DATE
REFERRED BY [redacted]
GENERAL PRACTITIONER: [redacted]
ACCOMPANIED BY:

ADDRESS [redacted] TEL No. [redacted]

NEXT OF KIN (State relationship, address, home and work telephone numbers - for 2 people)
Name Mrs CLARKE Rel. MOTHER
Address: SAME.
Tel [redacted] Tel

Name Rel.
Address:
Tel Tel

OBSERVATIONS ON ADMISSION

TEMPERATURE
PULSE
RESPIRATIONS
BLOOD PRESSURE
URINALYSIS
HEIGHT
WEIGHT

COLOUR OF EYES BLUE.
COLOUR OF HAIR BLONDE - CURLY
DESCRIPTION OF GENERAL APPEARANCE
TALL THIN, SPECTACLES
DISTINGUISHING FEATURES (abrasions, scars, moles, etc)

KNOWN ALLERGIES
SPECTACLES ⊘ HEARING AID ○ DENTURES (top plate) ○ (lower plate) ○
OTHER PROSTHESES

SICK NOTICES

Person contacted:	date:
" "	"
" "	"

OUTCOME

DISCHARGE	(state to home/hostel/other)	DATE
TRANSFER	to	
DEATH	time:	

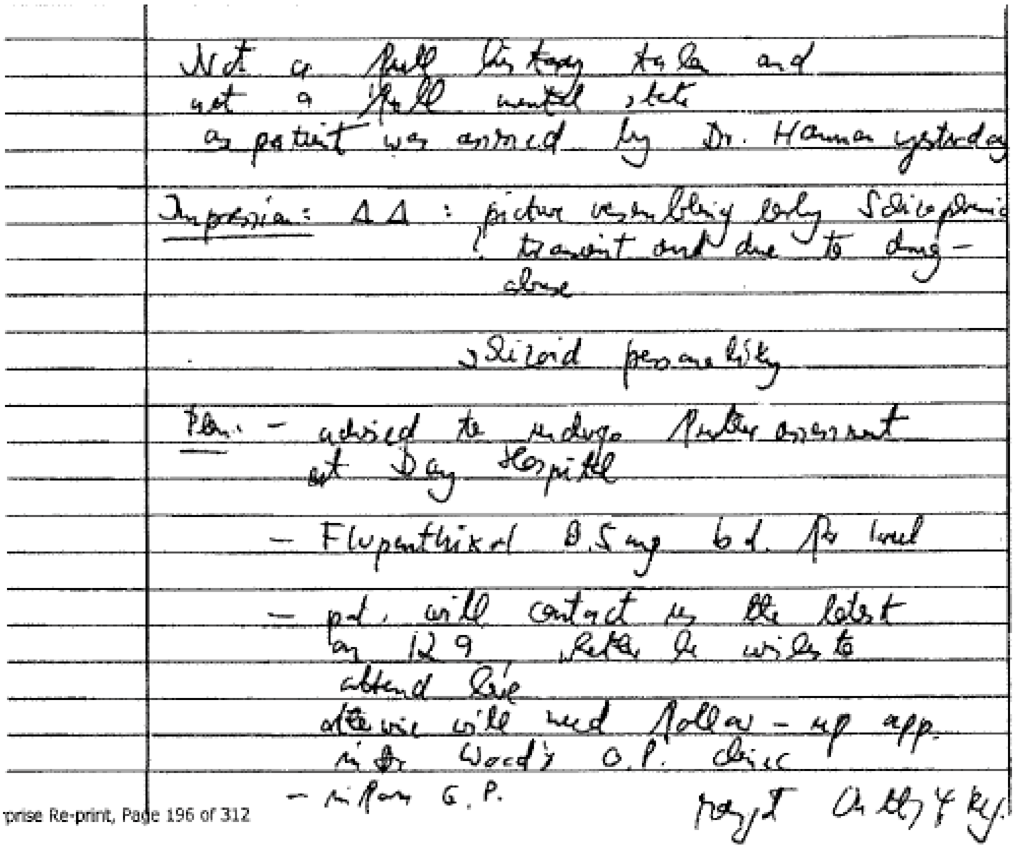
ADMISSION CHECKLIST
Valuables record to Patients' Affairs Office ○
Property Card completed ○
Next of Kin notified of admission ○
Rotadex Card to Duty Office ○
Admission Forms to Gen. Office (if appropriate) ○
Patient's money to Bank ○
Advice Book issued to patient/relatives ○
SOURCE OF INCOME AND EARNINGS:–

ADDITIONAL DETAILS:–

DISCHARGE PLANNING

Social Worker	○	Home assessment	○	Home Help / Meals on Wheels	○
Community Psychiatric Nurse	○	Out-Patient Appointment	○	Drugs	○
Letter to G.P	○	Do Next of Kin know?	○	Access to home (door key)?	○
Transport	○				

Document 2.4. Section of clinical notes from follow-up assessment with psychiatrist on 7th September 1994



Not a full history taken and
not a full mental state
as patient was assessed by Dr. Hanna yesterday

Impression: ΔΔ: picture resembling early Schizophrenia
? transient one due to drug-
abuse

Schizoid personality

Plan: - advised to undergo further assessment
at Day Hospital

- Flupenthixol 0.5mg bd. for week

- pt. will contact us the latest
on 12 9 whether he wishes to
attend [illegible]
otherwise will need follow-up app.
in Dr. Wood's O.P. clinic
- inform G.P.

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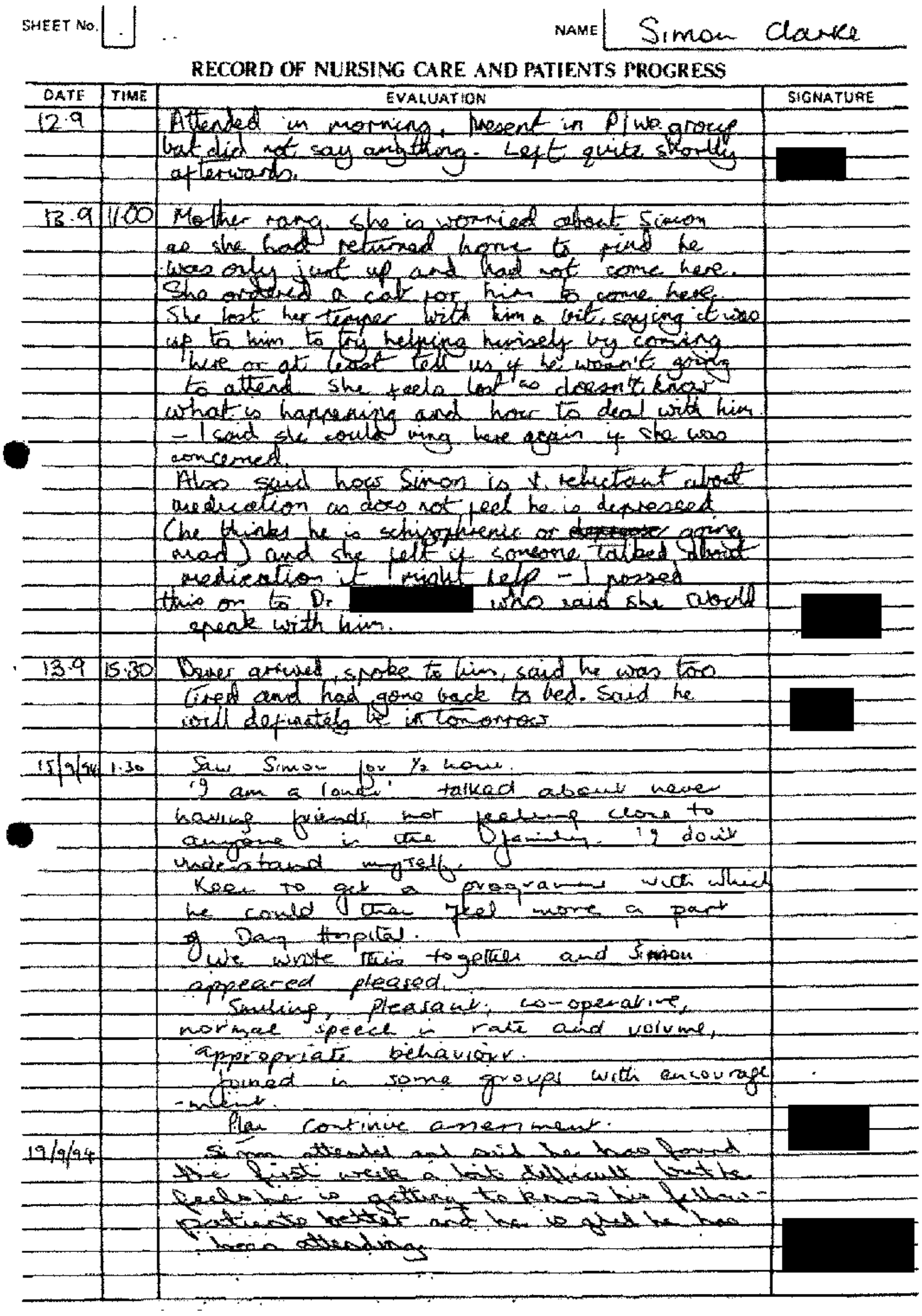
Document 2.5. Day Hospital nursing record form.



SHEET No.

NAME Simon Clarke

RECORD OF NURSING CARE AND PATIENTS PROGRESS

DATE	TIME	EVALUATION	SIGNATURE
12.9		Attended in morning. Present in P/WE group but did not say anything. Left quite shortly afterwards.	[redacted]
13.9	11.00	Mother rang, she is worried about Simon as she had returned home to find he was only just up and had not come here. She ordered a cab for him to come here. She lost her temper with him a bit, saying it was up to him to try helping himself by coming here or at least tell us if he wasn't going to attend. She feels lost as doesn't know what is happening and how to deal with him. – I said she could ring here again if she was concerned. Also said how Simon is v. reluctant about medication as does not feel he is depressed (he thinks he is schizophrenic or ~~[illegible]~~ going mad) and she felt if someone talked about medication it might help – I passed this on to Dr [redacted] who said she would speak with him.	[redacted]
13.9	15.30	Driver arrived, spoke to him, said he was too tired and had gone back to bed. Said he will definitely be in tomorrow	[redacted]
15/9/94	1.30	Saw Simon for ½ hour. 'I am a loner' talked about never having friends, not feeling close to anyone in the family. 'I don't understand myself.' Keen to get a programme with which he could then feel more a part of Day Hospital. We wrote this together and Simon appeared pleased. Smiling, pleasant, co-operative, normal speech in rate and volume, appropriate behaviour. Joined in some groups with encourage-ment. Plan continue assessment.	[redacted]
19/9/94		Simon attended and said he has found the first week a bit difficult but he feels he is getting to know his fellow-patients better and he is glad he has been attending.	[redacted]

Part 3. Ward Round

Since the assessment in Part 2, I had been attending the Day Hospital sporadically for almost two weeks. Feelings of overwhelming anxiety and fear, along with a heightened sense of signification, had reached a point where I believed I was being sent to the inpatient ward to be killed and eaten. During the ward round, I struggled to contain my anxiety, which was exacerbated by stories from other patients about their experiences of being inpatients and negative experiences with the psychiatrist. Soon after the ward round began, I walked out. I was then interviewed by another psychiatrist in a separate room. The psychiatrist asked me whether I would consider being an inpatient and then promptly left the room. I interpreted this negatively and left the hospital in panic. Immediately following the ward round, the medical team discussed their concerns and fears that I might self-harm. They diagnosed me with ‘probable’ early schizophrenia and recommended voluntary detention under threat of section in the event of non-compliance. My mother’s diary continued again at the point where I returned home. She described me as looking ‘disturbed’ and ‘anxious’ and expressed her concerns about my presentation. That night, I stayed up smoking cigarettes and drinking coffee, terrified the police would turn up and take me to the inpatient unit, holding a knife to stab myself when they came. The stress became too much and I experienced a total psychological collapse. The next morning, my mother contacted the Day Hospital over the phone to express her concerns. Later that day, she left work to go to the Day Hospital to meet the medical team face to face. At the meeting, they told her their concerns about my ‘unpredictability’ and ‘risk of self-harm’. Whilst my mother was at the Day Hospital, I cut my arm with the knife and set fire to my t-shirt. On returning home, my mother persuaded me to come into the hospital voluntarily as an inpatient, although the medical notes indicated that involuntary detention would be used if I refused to come in voluntarily.

Part 3: Ward Round

Simon

You are waiting for your first ward round. Throughout the week the other patients in the day hospital have told you stories about this Dr Carver. They say he enjoys winding patients up. They tell you that the ward round is humiliating. They also tell you stories of being raped and physically abused in the inpatient ward. All you can think about is the significance of the doctor’s name and how this also fits together somehow. This is how it will happen, you think. Everything is building to this*.*

O golden child the world will kill and eat.

From the waiting room a cheerful nurse calls you in. She smiles pleasantly as she ushers you into a small room. The room is packed with people – at least seven or eight. You weren’t expecting this many people. The meeting starts without delay and already you can barely keep it

Mother

Clinical Team

20.9.94 Team discussion:
Need to look into <u>family dynamics</u>
? Started smoking marijuana after death of grandfather
also note

Needs independent information

21.9.94 W.R. Dr Cuthbert
Presentation
? Do you see yourself as having a psychotic problem
Just a little bit down
Had friends at school
GCSE’s English, Literature, History
A-levels English and History but 2 fails “because of drugs and stuff”
Left 6th form summer 1992
College Autumn 92 – summer 93
A-levels C for English and D for sociology

Reflection

Following the assessment, and as the DH nursing notes in Document 2.5 above indicates, I only sporadically attended meetings at the DH. The meetings mostly consisted in older people talking about their preoccupations and struggles, usually with alcohol and relationships. These struggles were very different to mine. I could not relate to them and their apparent disappointment with life. I felt like I was just about hanging onto my sanity. After a week at the DH, I was called in for a ward round with the psychiatrist. As my account indicates, this psychiatrist was not popular with the other patients in the DH. Reflecting on this account now, I am not sure what degree these conversations would have primed my own expectations of the meeting. By this time, my delusion had solidified into a belief that I was being driven into the inpatient unit

Part 3: Ward Round

Simon

together. Two officious-looking middle-aged men in suits at the head (doctors you assume) ask you questions.

One of the doctors leads. What’s the problem? What have you been doing with yourself then, eh? How long since you finished college? When was that then? How did you do? I mean, what were your grades like? What’s the plan for the future?

You are barely keeping it together. The fear is intense and overwhelming. You cannot tell a coherent narrative. You keep contradicting yourself. You become so anxious you can barely talk. The two psychiatrists smile and throw each other knowing glances. There is cold amusement in their eyes. One of the nurses rolls her eyes at you. You have had enough. You mutter something in a quiet, barely audible, mumble. You walk out.

Mother

Clinical Team

Since then works in Effenwick as a kitchen porter
Most of his friends unemployed

“I just feel lonely”

<u>walks out</u>; when asked about the last ward round he said “Dr Cuthbert is too slick”
Interviewed by Dr Gilbert

“sad about being sad”
Interviewed on his own = perplexed
thoughts disappeared
“mind goes blank”
me and other
palinposia confirmed
thoughts about killing himself; but not current

<u>Impressions</u>: probable early stage of schizophrenia, Simon’s presentation is quite worrying as he appears to be quite

Reflection

by demonic entities as a kind of ritual sacrifice. It is perhaps not surprising that the piece is dominated by a strong sense of fear and terror. When thinking about the encounter now, it baffles me that this frightened, psychotic and paranoid young man, not much more than a child really, was put in a situation whereby he was subjected to interrogation in a room full of strangers. Indeed, the overriding sense from the clinical notes is the medical team’s primary concern was safety and risk. I can understand the concern here, particularly as there had been changes to mental health policy and following a high-profile murder case by a psychiatric patient only two years’ prior. I can also see how my behaviour would likely be perceived as unpredictable and potentially problematic. No clinicians would want to feel responsible for a

Part 3: Ward Round

Simon

The other doctor (the quiet one) follows you out. You chat in a nearby room. The doctor asks you what’s wrong (we were only asking you questions, he says).

The doctor asks you whether you will consider being an inpatient. The self-assurance in the doctor’s blue-grey eyes seems to imply that the decision has already been made. You can’t keep your eyes away from the figure of the dark, hulking Victorian asylum with the barred windows that shimmer in the afternoon sun through the window opposite you.

No, you tell the doctor, I don’t want to be an inpatient.

Suddenly and inexplicably the quiet doctor leaves the room where you were talking. Was it something you said? You are not sure why he has left the room and whether you should wait for him to come back. What happens now?

Mother

Clinical Team

unpredictable

Risk of serious self harm

<u>Plan</u>:
- try on Trifluoperazine 10mg nocte concurrent with Procyclidine 5mg bd
- Simon’s parents need to be seen regardless of his refusal for further independent information and to share with them our worries
- May be sectionable if not attends regularly at Day Hospital and refuses inpatient treatment

21.9.94 Seen by Dr Cuthbert and team today. Simon was a little suspicious before entering the room and anxious. At first answered Dr willingly but as the questions continued to be asked of him, he suddenly got up and I spoke to him to try to encourage him to return but was unwilling to

Reflection

patient’s death, not least for the possible ramifications that this could have in terms of career and livelihood if an investigation were to judge staff as being professionally negligent. Even considering this however, I cannot see what purpose a meeting like this would serve. From a risk management perspective, it almost failed – my stress over whether I would be admitted led directly to a breakdown, leading to some very risky behaviour. From a clinical perspective, no new information was gained from the encounter, except in the sense of post-hoc justifications for detainment. To my mind reading it now, there is something almost unpleasantly macho about the encounter. At this point someone might raise a question of the accuracy of my own perceptions, especially as I was experiencing a psychotic break.

Simon	Mother	Clinical Team	Reflection
You open the door to the corridor and see the doctor running back to the ward round room. You don't know what to do. You are scared. Will they drag you into the ward with straightjackets? Is that what happens here? There is a brief moment of hesitation before you walk out of the hospital. On the way out, you bump into an elderly patient who recognises you from the day hospital. The man asks if you are OK. I'm going to be an inpatient, you reply. The other man says nothing but swallows, then looks down. He seems to understand what this means. The warm September sun on your front porch is all encompassing. You are in despair. This is it now. All you have is this moment: the one, unfailing, unremitting sense of crushing despair, without hope of abatement or reprieve. It is final		do so. Advised not to leave. Dr Cuthbert spoke to him as he returned to the interview room. Dr Cuthbert asked more questions. Simon appeared very uncomfortable suggested to be seen by only one person. Seen by Dr Gilbert. (He) reported him as being very perplexed & he said that he had no autonomy when talking to people. He describes no abnormalities in sleep, appetite, weight, no auditory hallucinations, mind just blank. He denies suicidal thoughts at present but admitted that he had contemplated it recently. Dr Cuthbert & Dr Gilbert said that the "projectory images" described by Simon could be "palenoposia" often seen schizophrenic in patients. Dr Gilbert felt that Simon was a high suicide risk and admission should be considered. Simon also refused admission when seen by Dr Gilbert.	They may question whether the psychiatrists were behaving as unpleasantly as they were depicted here, and whether this was just not part of my overall paranoia. My response to this is that the account has tried to capture something of the intimidation that these types of social encounters engender. To focus on the empirical details of who said, or did, what would seem to me to miss the point. After all, there is no way to verify the accuracy of either accounts: memories are unreliable, clinical notes are never really neutral. Rather, the significance appears to me that the unintended consequences of an overly heavy approach to risk management actually results in worse risky behaviour. Interestingly, there does not appear to be serious risk issues in the assessment as I had denied any suicidal intent and

Part 3: Ward Round

Simon

and it is total. You would kill yourself if that would make a difference. You know that it won’t.

Slowly, like aspirin dissolving in water, your consciousness dissolves.

Scattered impressions: head feels on fire; a knife; arm cold as clay; four scratches. Visions of dragons and faces laughing at you in the trees; hatred poured into you. It consumes you. The overwhelming sense of horror.

And then nothing for a while, until morning, when you have been transformed. There are feelings of release. Your brothers walk past, unaware, it seems, of the transformation in you. You take a lighter to your t-shirt, watching the fabric dissolve in a flurry of sparks. You throw the flaming bundled ball that used to be a t-shirt onto the front porch. The fire alarm squeals in protest. Your brother brushes past you

Mother

Simon came home from the day centre yesterday very disturbed and anxious. He eventually told me that he had a meeting with the Drs and other people which made him feel intimidated. They asked him to come in as an inpatient. This obviously frightened him – he said he didn't want to be in a ward of mad people.

The rest of the evening he spent drinking tea and chain smoking – very distracted – losing track of any conversation – unable to concentrate.

He refused to let me go back to the hospital with him the next day. I had planned to go there anyway – but didn't want him to catch me there and go behind his back.

I went to work and phoned the day centre – spoke to DM – she said she would arrange for Dr to see me elsewhere – I told her Simon

Clinical Team

22.9.94. Phone call from Simon’s mother this am. She is concerned about the sudden deterioration. Came home yesterday was very preoccupied. She talked about suggestion made by Dr Gilbert about admission as inpatient & told mother he did not want to come as afraid he would be with people who are mad & also older than him. He slept very little, pacing up and down and smoking over 60 cigarettes, but was still up at 7 am today. Since August she has seen an apparent change in him. Before this he would have strong opinions & would express them well now he is very passive. He isolated himself from the rest of the family. Mother would like to talk to a doctor.

11:00 hrs Simon did not come to the day hospital but his mother came. Seen jointly with Dr Q. Mrs Clarke was sent home from work

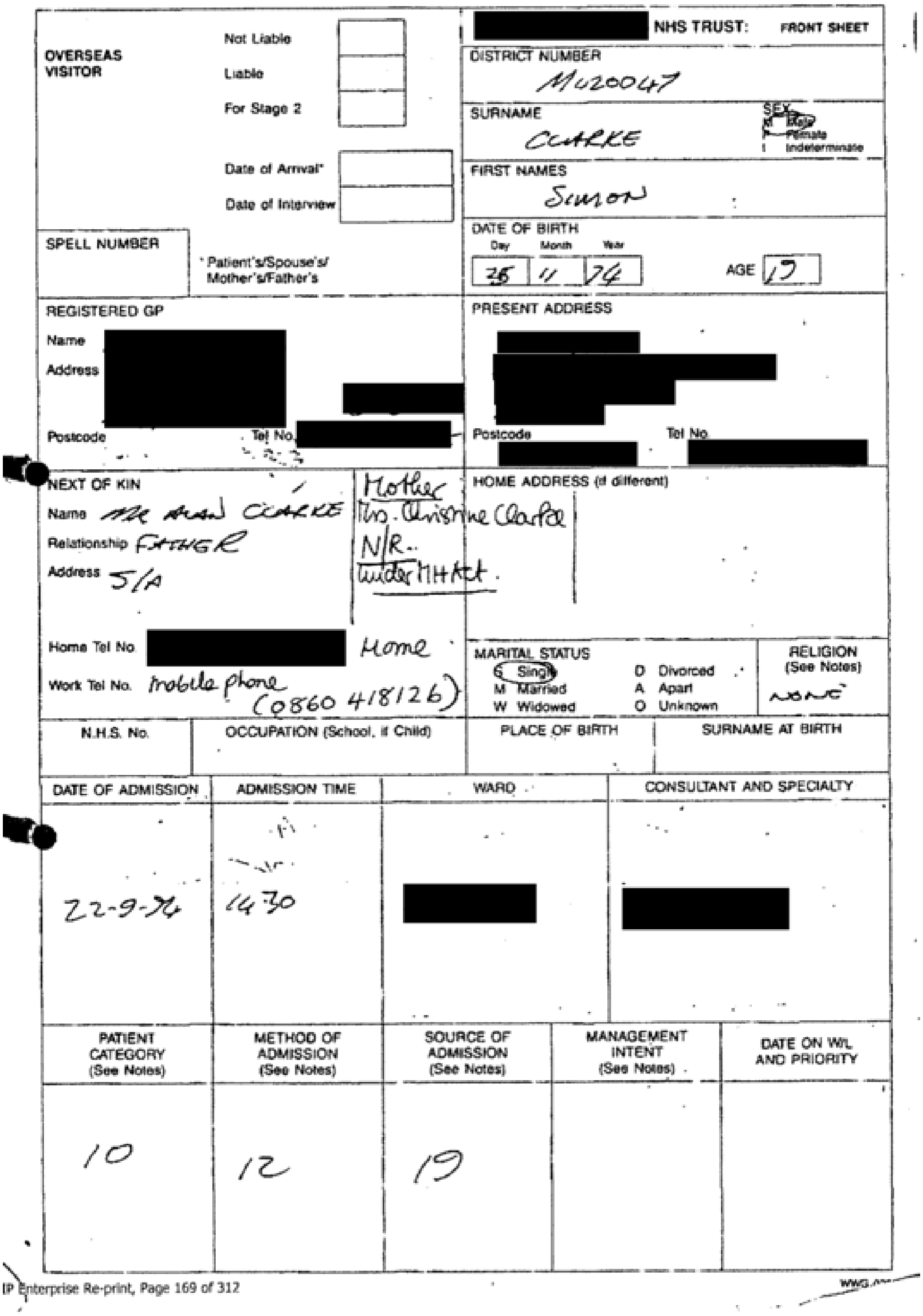
Reflection

there was no indication from anything I had said previously to suggest I was a risk to others.

Another interpretation of my behaviour in the ward round relates perhaps to the social context and power: the doctors can strip patients of their rights, on sometimes very little pretext, and this, coupled with how ward rounds are organised in terms of both structure and style, makes for a very frightening experience. Walking out, therefore, may represent an understandable response which, nevertheless, would also be contravening the social expectations of the encounter and result in some form of sanction.

Simon	Mother	Clinical Team	Reflection
quickly and puts the fire out. He throws you a nervous glance. What the fuck, Si? You put all your books in a carboard box and take them out to the back garden, by the rubbish bins. Discussions. You have to go to hospital, your parents tell you. We can't cope with you here anymore. You barely register any of this. You have touched genius, or God, or something. It no longer matters.	would be in late. Unable to work I went home – Simon still very anxious – refused to go to the day centre – so I went Spoke to Dr and Derry. They told when interviewed Simon was unable to concentrate and because of suicidal thoughts they felt he was unpredictable. She did say that he had not planned how to do it which was a good sign. I told her Simon was worse and would not come in voluntarily. When I came home Simon had burnt his tee shirt and had scratches on his arm. Realised that he had to go in which at first he refused to do – eventually agreed.	(district nurse) as she was too distressed. Simon was still at home, looking in a world of his own, not acknowledging her when she spoke to him. Afraid of coming into day hospital. Mrs Clarke is obviously very distressed by the situation. She has been the support for Simon as Simon is not able or willing to talk to Father. Mother is very concerned about his unpredictability and lives in fear he might harm himself. She took him to see a male counsellor when he came off "DRugs", but Simon could not relate to him. Admission offered. 14:00 – Mother phoned. Has agreed to come in voluntarily to hospital. Had burnt shirts & cigarettes? Scratches on limb. For admission to AII	As the entry on 13/9 of Document 2.5 indicates, my mother was driving my attendance at the DH. Even now, it does hurt to see how she orchestrated the admission by the constant phone calls and by meeting with the staff separately. Although her anxiety is very palpable, I am left wondering whether the admission would have happened if she had been more self-contained. Perhaps however this expectation is somewhat unfair: how is one supposed to act when your child starts to display such behaviour? It was, more than anything else, I sign she had come to the end of her tether.

Document 3.1. Admission form.



[redacted] **NHS TRUST:** **FRONT SHEET**

OVERSEAS VISITOR

Not Liable ☐
Liable ☐
For Stage 2 ☐

Date of Arrival* ☐
Date of Interview ☐

SPELL NUMBER

* Patient's/Spouse's/Mother's/Father's

DISTRICT NUMBER M420047

SURNAME CLARKE

SEX [✓ M Male] F Female I Indeterminate

FIRST NAMES Simon

DATE OF BIRTH Day 25 Month 11 Year 74

AGE 19

REGISTERED GP
Name [redacted]
Address [redacted]
Postcode
Tel No. [redacted]

PRESENT ADDRESS
[redacted]
Postcode [redacted]
Tel No [redacted]

NEXT OF KIN
Name MR ALAN CLARKE
Relationship FATHER
Address S/A

Mother
Mrs. Christine Clarke
N/R..
under MH Act.

Home Tel No [redacted] Home
Work Tel No. mobile phone (0860 418126)

HOME ADDRESS (if different)

MARITAL STATUS
[✓ S Single] M Married W Widowed
D Divorced A Apart O Unknown

RELIGION (See Notes) NONE

N.H.S. No.	OCCUPATION (School, if Child)	PLACE OF BIRTH	SURNAME AT BIRTH

DATE OF ADMISSION	ADMISSION TIME	WARD	CONSULTANT AND SPECIALTY
22-9-94	1430	[redacted]	[redacted]

PATIENT CATEGORY (See Notes)	METHOD OF ADMISSION (See Notes)	SOURCE OF ADMISSION (See Notes)	MANAGEMENT INTENT (See Notes)	DATE ON W/L AND PRIORITY
10	12	19		

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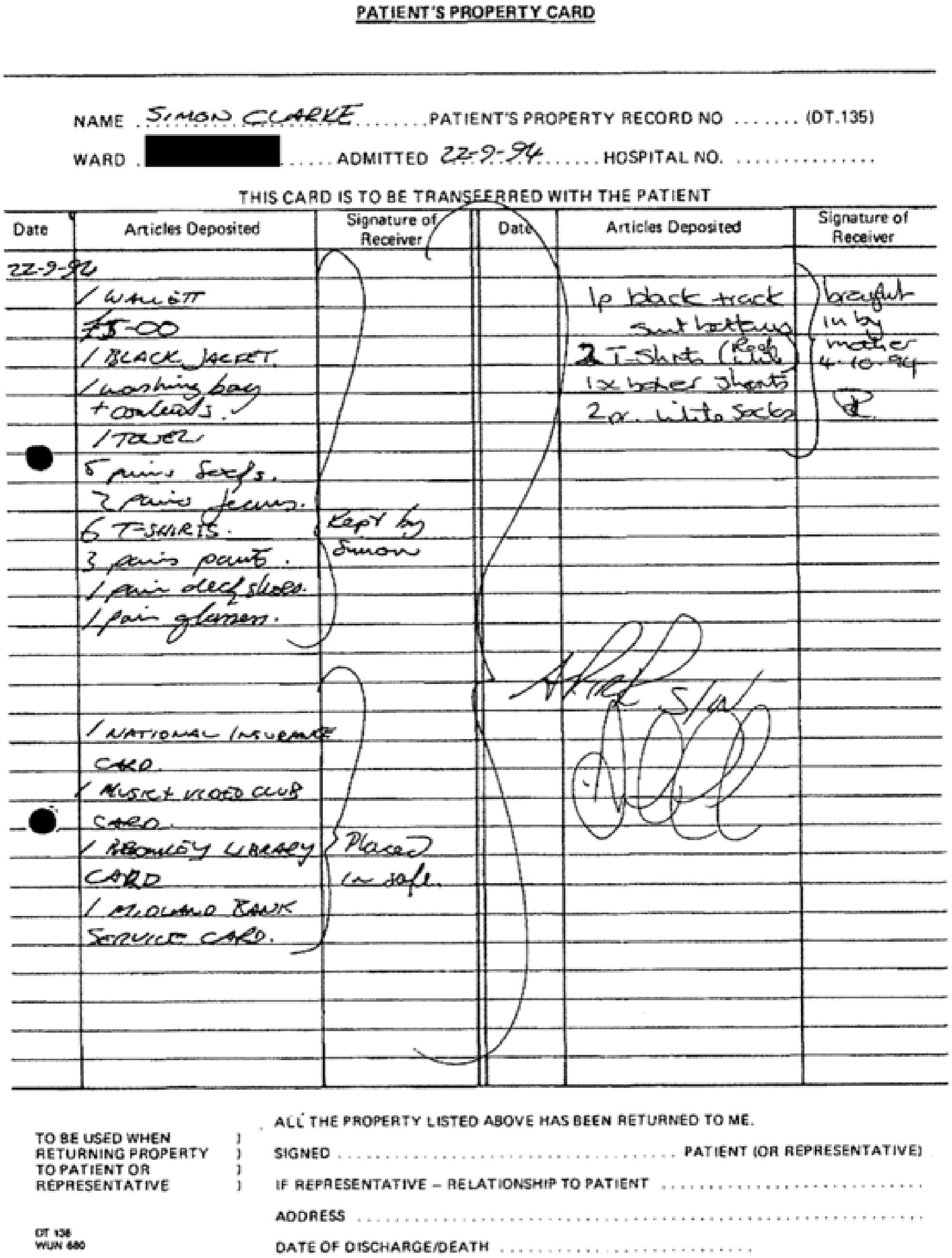
Document 3.2. Patient property card.



PATIENT'S PROPERTY CARD

NAME SIMON CLARKE ....PATIENT'S PROPERTY RECORD NO .... (DT.135)

WARD [redacted] .....ADMITTED 22-9-94 ......HOSPITAL NO. ....

THIS CARD IS TO BE TRANSFERRED WITH THE PATIENT

Date	Articles Deposited	Signature of Receiver	Date	Articles Deposited	Signature of Receiver
22-9-92					
	1 WALLETT			1p black track	brought
	£5-00			suit bottoms	in by
	1 BLACK JACKET.			2 T-Shirts (Red White)	mother 4-10-94
	1 washing bag			1x boxer shorts	
	+ contents.			2 pr. white socks	
	1 TOWEL				
	5 pairs socks.				
	2 pairs jeans.				
	6 T-SHIRTS.	Kept by Simon			
	3 pairs pants.				
	1 pair deck shoes.				
	1 pair glasses.				
	1 NATIONAL INSURANCE				
	CARD.				
	1 MUSIC + VIDEO CLUB				
	CARD.				
	1 BROMLEY LIBRARY	Placed in safe.			
	CARD				
	1 MIDLAND BANK				
	SERVICE CARD.				

TO BE USED WHEN RETURNING PROPERTY TO PATIENT OR REPRESENTATIVE

ALL THE PROPERTY LISTED ABOVE HAS BEEN RETURNED TO ME.

SIGNED .... PATIENT (OR REPRESENTATIVE)

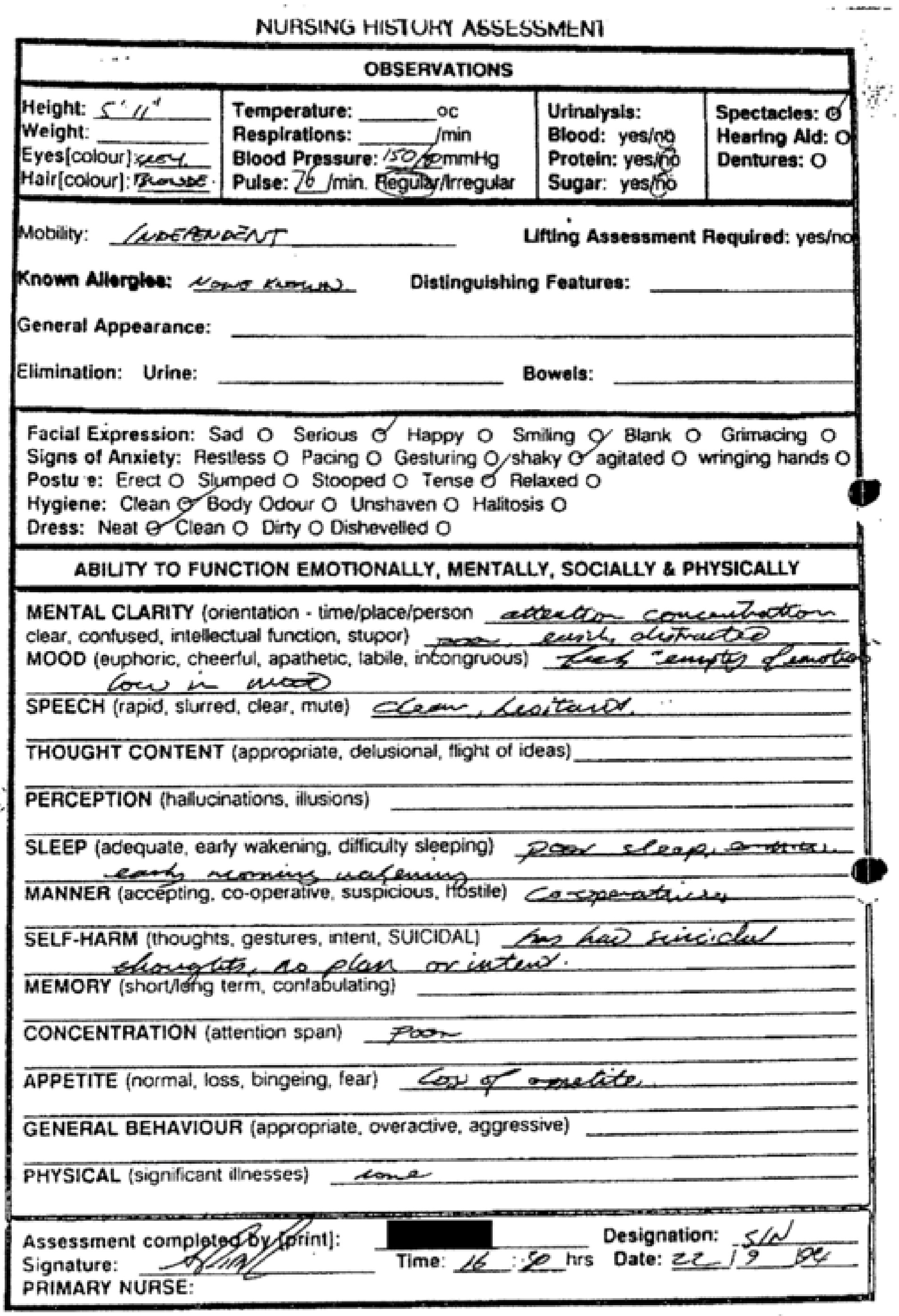
IF REPRESENTATIVE – RELATIONSHIP TO PATIENT ....

ADDRESS ....

DATE OF DISCHARGE/DEATH ....

DT 136
WUN 680

Document 3.3. Nursing history assessment.



NURSING HISTORY ASSESSMENT

OBSERVATIONS

Height: 5'11" Weight: ______ Eyes[colour]: grey Hair[colour]: blonde	**Temperature:** ______ oc **Respirations:** ______ /min **Blood Pressure:** 150/[illegible] mmHg **Pulse:** 76 /min. [✓ Regular]/Irregular	**Urinalysis:** **Blood:** yes/[✓ no] **Protein:** yes/[✓ no] **Sugar:** yes/[✓ no]	**Spectacles:** ☑ **Hearing Aid:** ○ **Dentures:** ○

Mobility: INDEPENDENT **Lifting Assessment Required:** yes/no

Known Allergies: NONE KNOWN **Distinguishing Features:** ______

General Appearance: ______

Elimination: Urine: ______ **Bowels:** ______

Facial Expression: Sad ○ Serious ☑ Happy ○ Smiling ☑ Blank ○ Grimacing ○
Signs of Anxiety: Restless ○ Pacing ○ Gesturing ○/shaky ☑ agitated ○ wringing hands ○
Posture: Erect ○ Slumped ○ Stooped ○ Tense ☑ Relaxed ○
Hygiene: Clean ☑ Body Odour ○ Unshaven ○ Halitosis ○
Dress: Neat ☑ Clean ○ Dirty ○ Dishevelled ○

ABILITY TO FUNCTION EMOTIONALLY, MENTALLY, SOCIALLY & PHYSICALLY

MENTAL CLARITY (orientation - time/place/person clear, confused, intellectual function, stupor) attention concentration poor, easily distracted

MOOD (euphoric, cheerful, apathetic, labile, incongruous) feels "empty" of emotion low in mood

SPEECH (rapid, slurred, clear, mute) clear, hesitant.

THOUGHT CONTENT (appropriate, delusional, flight of ideas) ______

PERCEPTION (hallucinations, illusions) ______

SLEEP (adequate, early wakening, difficulty sleeping) poor sleep, [illegible] early morning wakening

MANNER (accepting, co-operative, suspicious, hostile) Co-operative

SELF-HARM (thoughts, gestures, intent, SUICIDAL) has had suicidal thoughts, no plan or intent.

MEMORY (short/long term, confabulating) ______

CONCENTRATION (attention span) Poor

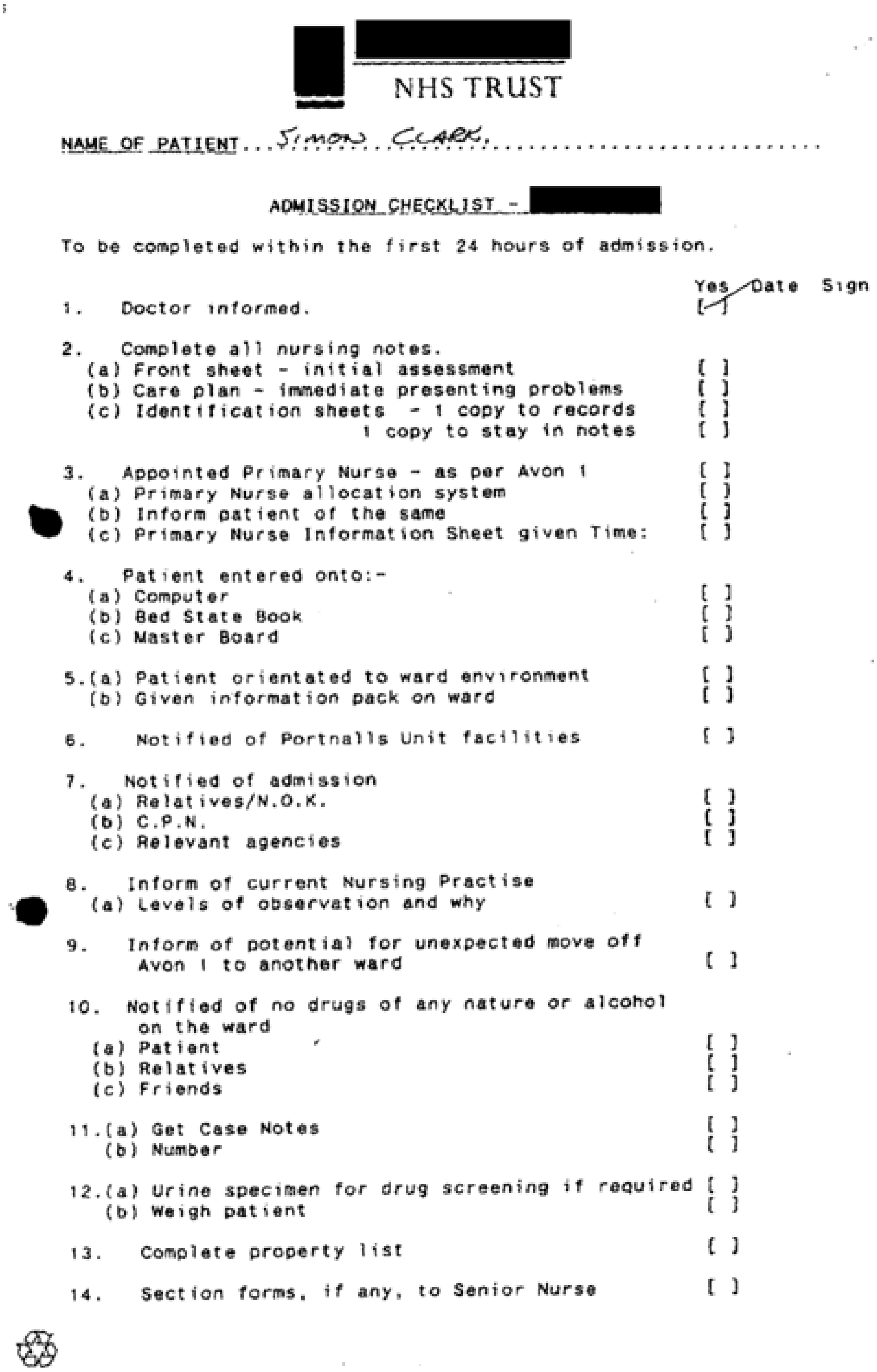
APPETITE (normal, loss, bingeing, fear) Loss of appetite.

GENERAL BEHAVIOUR (appropriate, overactive, aggressive) ______

PHYSICAL (significant illnesses) none

Assessment completed by [print]: [redacted] Designation: S/N
Signature: Time: 16 : 50 hrs Date: 22 / 9 / 94
PRIMARY NURSE:

Document 3.4. Admission checklist.



[redacted] NHS TRUST

NAME OF PATIENT...Simon Clark.............................

ADMISSION CHECKLIST - [redacted]

To be completed within the first 24 hours of admission.

Yes Date Sign

1. Doctor informed. [✓]

2. Complete all nursing notes.
  (a) Front sheet - initial assessment [ ]
  (b) Care plan - immediate presenting problems [ ]
  (c) Identification sheets - 1 copy to records [ ]
      1 copy to stay in notes [ ]

3. Appointed Primary Nurse - as per Avon 1 [ ]
  (a) Primary Nurse allocation system [ ]
  (b) Inform patient of the same [ ]
  (c) Primary Nurse Information Sheet given Time: [ ]

4. Patient entered onto:-
  (a) Computer [ ]
  (b) Bed State Book [ ]
  (c) Master Board [ ]

5.(a) Patient orientated to ward environment [ ]
  (b) Given information pack on ward [ ]

6. Notified of Portnalls Unit facilities [ ]

7. Notified of admission
  (a) Relatives/N.O.K. [ ]
  (b) C.P.N. [ ]
  (c) Relevant agencies [ ]

8. Inform of current Nursing Practise
  (a) Levels of observation and why [ ]

9. Inform of potential for unexpected move off Avon 1 to another ward [ ]

10. Notified of no drugs of any nature or alcohol on the ward
  (a) Patient [ ]
  (b) Relatives [ ]
  (c) Friends [ ]

11.(a) Get Case Notes [ ]
  (b) Number [ ]

12.(a) Urine specimen for drug screening if required [ ]
  (b) Weigh patient [ ]

13. Complete property list [ ]

14. Section forms, if any, to Senior Nurse [ ]

Part 4. Admission

Since the assessment in Part 2, I had been attending the Day Hospital sporadically for almost two weeks. Feelings of overwhelming anxiety and fear, along with a heightened sense of signification, had reached a point where I believed I was being sent to the inpatient ward to be killed and eaten. During the ward round, I struggled to contain my anxiety, which was exacerbated by stories from other patients about their experiences of being inpatients and negative experiences with the psychiatrist. Soon after the ward round began, I walked out. I was then interviewed by another psychiatrist in a separate room. The psychiatrist asked me whether I would consider being an inpatient and then promptly left the room. I interpreted this negatively and left the hospital in panic. Immediately following the ward round, the medical team discussed their concerns and fears that I might self-harm. They diagnosed me with ‘probable’ early schizophrenia and recommended voluntary detention under threat of section in the event of non-compliance. My mother’s diary continued again at the point where I returned home. She described me as looking ‘disturbed’ and ‘anxious’ and expressed her concerns about my presentation. That night, I stayed up smoking cigarettes and drinking coffee, terrified the police would turn up and take me to the inpatient unit, holding a knife to stab myself when they came. The stress became too much and I experienced a total psychological collapse. The next morning, my mother contacted the Day Hospital over the phone to express her concerns. Later that day, she left work to go to the Day Hospital to meet the medical team face to face. At the meeting, they told her their concerns about my ‘unpredictability’ and ‘risk of self-harm’. Whilst my mother was at the Day Hospital, I cut my arm with the knife and set fire to my t-shirt. On returning home, my mother persuaded me to come into the hospital voluntarily as an inpatient, although the medical notes indicated that involuntary detention would be used if I refused to come in voluntarily.

Part 4: Admission

Simon

They pack you into a car, on the way to the hospital. You are an observer to your experience. Passive. You talk to the doctor. Bald, middle-aged, tired-looking. He asks you a series of questions. You say that there is nothing wrong with you and you are not sure why you are here. He throws you a baffled look. He does not look bothered.
You are exhausted. You are a buried corpse. You go straight to bed. When you wake, it is dark. You walk past the glass-fronted, fishbowl nurse’s station to the lounge. Several young women are there. They have dance music blaring out. You sit and talk to them. One young woman is wearing only a bra and is dancing furiously. The other women start to taunt you. The woman who is dancing falls between your legs and starts to try and unzip your trousers. A nurse comes in,

Mother

James and I took him to Avon 2 ward – admitted by ben – had already looked around The ward and felt comfortable about it even though it looks like a tip. Spoke to Esme who was reassuring .

Spoke to the admitting DR. who asked a lot of questions about him.
Afterwards I asked for hope or indication he said the there is cause for concern. Leaving him in other peoples hands was awful

25.9.94 Richard and I visited Simon Saturday Friday night. It was a shock to see him. He was in the kitchen making tea and smoking. We sat in the kitchenette all evening He chainsmoked and drank tea. He looked dishevelled, restless, unco-ordinated. He never initiated conversation, just smiled and answered when we spoke to him. The only positive thing he

Clinical Team

22/9/94 HOPC Px presented to G.P. 2/12 ago requesting psychotherapy he was sent to OPD & referred to DAY HOSPITAL 2/mdc anxiety feelings lasting 5 minutes, heart beating fast, thoughts rapid not able to identify particular thought.
Also for 5 months “loss of imagination”, unhappiness loss of interests. Insight – doesn't know why he’s here, thinking if he should go, but doesn't need much persuasion to stay.
School 5-18 no social/discipline problems enjoyed exams GCSE?

Interviewed Mo.
Normal childhood but recently reported bullied & hated school Gradual decline in personality since 6th form in school greatly [illegible] last 2/12 loss of motivation, difficult to get pt up in morning loss in interest & self appearance.

Reflection

If the breakdown represented something of a nightmare, the admission would herald in a different, and worse, kind of nightmare. My symptoms shifted from paranoid ideas of eternal damnation, to criminal patients and conspiracies of theft and framing.

Even now, I ask myself a series questions about this aspect of the narrative, such as the inevitably of the transition to hospital and whether there was a time in the process whereby the experience could have been avoided. Other questions also occur to me now. For example, why did my mother appear to push so hard for this outcome knowing, as a nurse, what inpatient units can be like. My father’s voice is largely absent, only appearing sporadically. I understand, and have been told time and again by different

Simon

scolds the patients angrily, which they ignore, and then leaves. You are becoming increasingly agitated. What’s the matter? They say. We’re not going to eat you. You freak out. Of course they are, you think, that is why you were sent here. You back off. They walk past you, up the stairs to their rooms. Sad, one of them says as she walks past. You go back to your room in terror. As you lie on the bed looking up at the old Victorian ceiling and bay window, you have an overwhelming and crushing sense of déjà vu, that this will be the place that you will die and you have known this your whole life.

They take turns freaking you out. One patient hands you a book called ‘The Lucky Loser’. Another time, you come into the lounge and four LPs have been taken out of their covers, the vinyl laid out

Mother

expressed was when I asked him if I could be present when DR Furbois sees him Monday and he said no. The DR at The Day Centre had said that he never wanted me present.

We spoke to two other patients there – they had spoken to Simon during the day. He says he feels safe there. That had been a worry to him when first asked to come in – he said “you get raped in there”. He did voice his fears to ben who reassured him.

Richard and I felt distraught when we left, we felt we had lost him and felt so down, the future looked bleak. It’s like a bereavement, you’ve lost your son – he is there in body but [he’ll or will] never be the same again. He has so much going for him but he cannot see that, and wouldn't believe us if he told him. Richard cried – only the

Clinical Team

lack of socialising (never had girlfriend)

Reading all night, psychology & philosophy & depressing stuff eg Jim Morrison Normally more close to Fa in recent times has turned to Mo for reassurance etc.
Has said odd things, eg “I feel the whole world of philosophy is on my shoulders” He is worried that he is going mad, despairing,
Imp 19 yr old m blunting of affect, loss of volition/self care. Despairing, increasing interest in psychology / philosophy, isolating self, day dreaming. Now mild thought disorder No persecutions or hallucinations ? Paranoid schizophrenia ? schizoid personality disorder ?? affective disorder **X** Admin close obs **X**
Consider section 5(2) if wants to discharge self as set fire to self Friday & lacerations to foreman and has suicidal ideation.

Reflection

people, of how difficult it is for carers emotionally and, also, how overwhelming the whole process is for them. Despite knowing this, I still feel hurt and angry at my parents. There is still a part of me that feels it could have been avoided, however unjustifiable.

The question of my treatment by some of the other patients also raises questions for me now. I was clearly subjected to some quite sadistic bullying, perhaps even psychological torture, and there are suggestions in my account that I was not the only victim of this type of abuse. Such examples reinforce, I think, the overall sense of a lack of containment, refuge and asylum. It is difficult to see how this would be an appropriate place for a disturbed, confused and distressed young person. Other questions come to my mind from

Simon

on top of the covers in a quadrant. The Four Zoas, you think, from Blake. They can read your mind. Then it occurs to you: they will steal all our money and frame us as paedophiles.

You take a knife from the kitchen. You have had enough. There is only one way out of this. You stab yourself several times in the head with it. The knife is blunt. It only makes shallow indentations in your skull. Your head hurts.

Everything is significant. It all comes back to you. In the crowded lounge, it is overwhelming.

Your parents walk in. The patient you are sitting next to turns to you and says, you didn't think he'd look up there, did you?

Mother

the second time I have ever seen him cry. He said that the qualities Simon has depth, knowledge, will benefit him later, but he can't see that now, we said a lot of things – blaming, all negative. There seems to be nothing positive we can do but just be there.
When we went back Saturday, Ana said he had slept a lot during the day. When we saw him, I nearly broke down – he looked so doped up. However he ate all the food I had brought him and orange drink, and although he didn't initiate any conversation he did seem a little bit more aware.

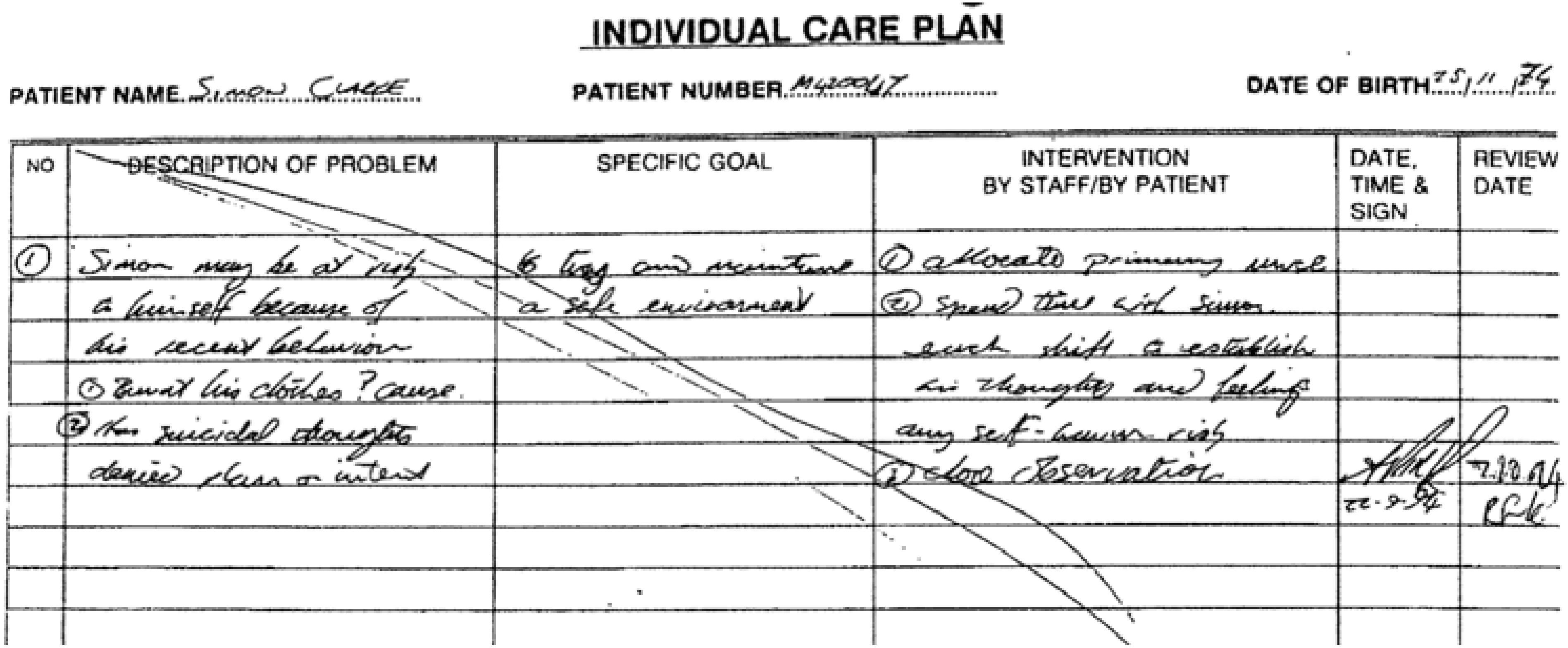
Clinical Team

23/9/94 Nursing 0605 Simon who was admitted yesterday, sat quietly in the midst of fellow patients, until around 2205 hours, when he became very agitated. With the easy accessibility of knife on the ward, he got hold of a knife he was pacing up and down the kitchen, presumably pondering whether or not to harm himself. Unable to find his prescription card is a replacement card was done by Dr Vera. Approached him calmly and requested him to come for his medication. Without any hesitation, he put the knife down and came and took his prescribed medication. Settled around midnight and slept well. Remains on close observation.

Reflection

how the ward is represented here. I remember many of the nurses being superficially nice and caring. Some were clearly cynical and burnt-out; others tired and harassed. Only one or two of the nurses were genuinely unpleasant or threatening. It seems like all the people here – patients, staff, carers – are floundering in one way or another. It leads me to question what the actual function of the ward really is, and to wonder whether this function has actually become lost, obscured or confused.

Document 4.1. Patient care plan.

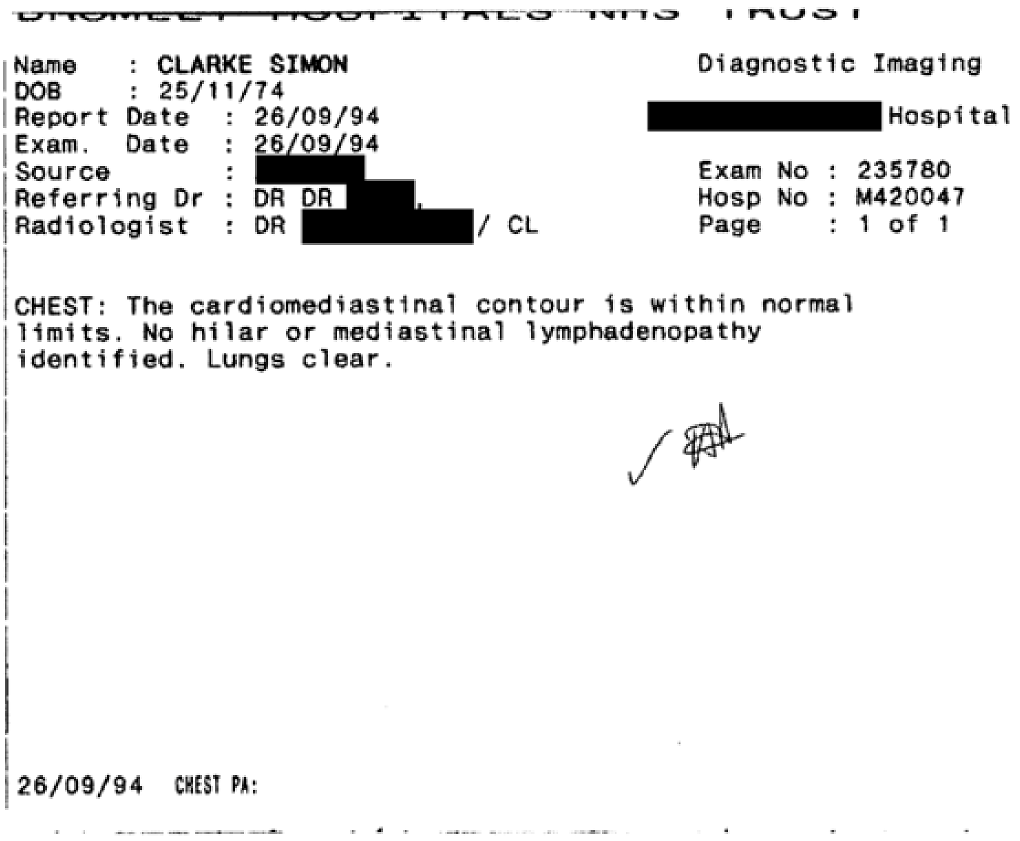


INDIVIDUAL CARE PLAN

PATIENT NAME. Simon Clarke **PATIENT NUMBER.** M420047 **DATE OF BIRTH** 25/11/74

NO	DESCRIPTION OF PROBLEM	SPECIFIC GOAL	INTERVENTION BY STAFF/BY PATIENT	DATE, TIME & SIGN	REVIEW DATE
①	Simon may be at risk	to try and maintain	① allocate primary nurse		
	to himself because of	a safe environment	② spend time with Simon.		
	his recent behaviour		each shift to establish		
	① burnt his clothes? cause.		his thoughts and feelings		
	② has suicidal thoughts		any self-harm risk		
	denied plans or intent		③ close observation		7.10.94
				22.9.94	

Document 4.2. Results of X-ray.



Name : **CLARKE SIMON**
DOB : 25/11/74
Report Date : 26/09/94
Exam. Date : 26/09/94
Source : [redacted]
Referring Dr : DR DR [redacted],
Radiologist : DR [redacted] / CL

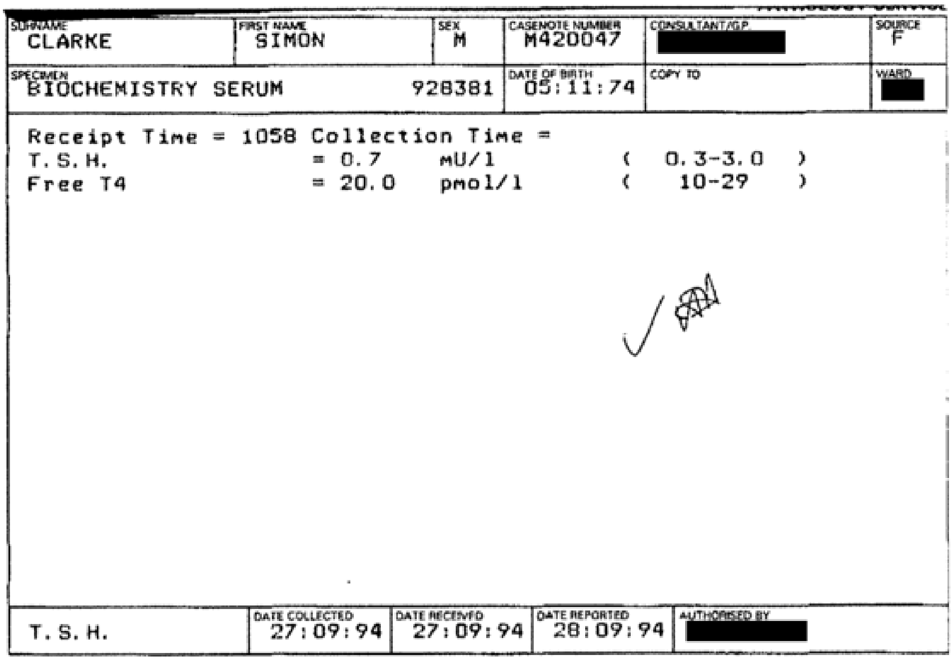
Diagnostic Imaging
[redacted] Hospital

Exam No : 235780
Hosp No : M420047
Page : 1 of 1

CHEST: The cardiomediastinal contour is within normal limits. No hilar or mediastinal lymphadenopathy identified. Lungs clear.

26/09/94 CHEST PA:

Document 4.3. Analysis of patient's blood sample.

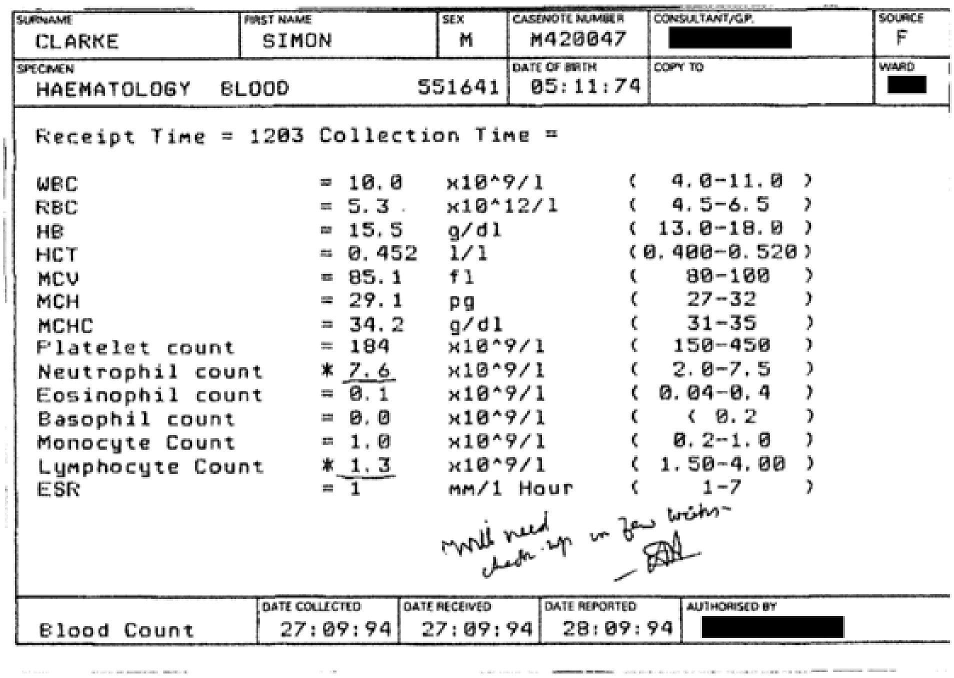


SURNAME CLARKE	FIRST NAME SIMON	SEX M	CASENOTE NUMBER M420047	CONSULTANT/G.P. [redacted]	SOURCE F
SPECIMEN BIOCHEMISTRY SERUM 928381			DATE OF BIRTH 05:11:74	COPY TO	WARD [redacted]

```
Receipt Time = 1058 Collection Time =
T.S.H.                = 0.7    mU/l         (  0.3-3.0  )
Free T4               = 20.0   pmol/l       (   10-29   )
```

T.S.H.	DATE COLLECTED 27:09:94	DATE RECEIVED 27:09:94	DATE REPORTED 28:09:94	AUTHORISED BY [redacted]

Document 4.4. Patient's blood count.



SURNAME CLARKE	FIRST NAME SIMON	SEX M	CASENOTE NUMBER M420047	CONSULTANT/G.P. [redacted]	SOURCE F
SPECIMEN HAEMATOLOGY BLOOD 551641			DATE OF BIRTH 05:11:74	COPY TO	WARD [redacted]

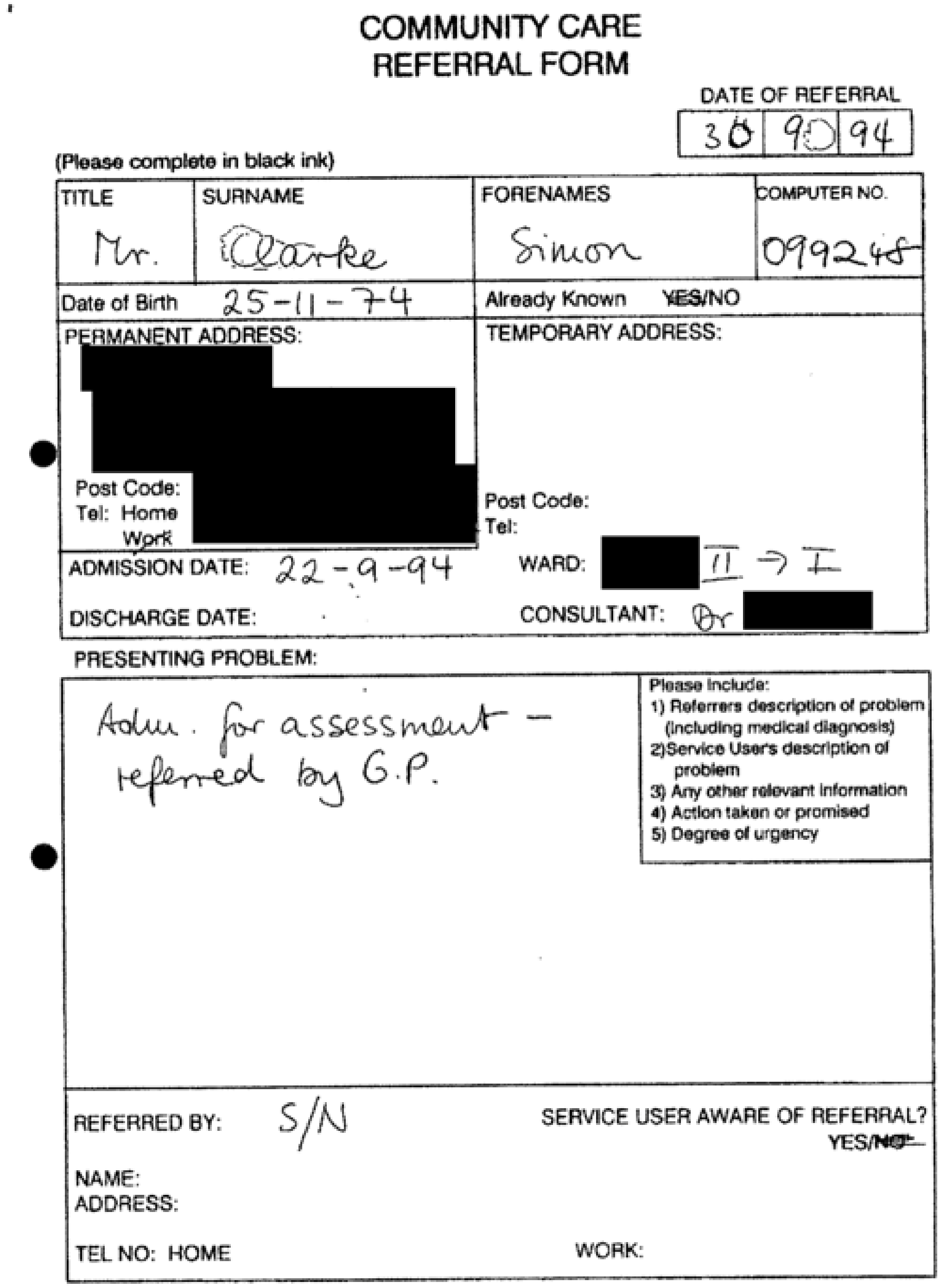
```
Receipt Time = 1203 Collection Time =

WBC                   = 10.0   x10^9/l      (   4.0-11.0  )
RBC                   = 5.3    x10^12/l     (   4.5-6.5   )
HB                    = 15.5   g/dl         (  13.0-18.0  )
HCT                   = 0.452  l/l          (0.400-0.520)
MCV                   = 85.1   fl           (    80-100   )
MCH                   = 29.1   pg           (    27-32    )
MCHC                  = 34.2   g/dl         (    31-35    )
Platelet count        = 184    x10^9/l      (   150-450   )
Neutrophil count      * 7.6    x10^9/l      (   2.0-7.5   )
Eosinophil count      = 0.1    x10^9/l      (  0.04-0.4   )
Basophil count        = 0.0    x10^9/l      (    < 0.2    )
Monocyte Count        = 1.0    x10^9/l      (   0.2-1.0   )
Lymphocyte Count      * 1.3    x10^9/l      (  1.50-4.00  )
ESR                   = 1      mm/l Hour    (     1-7     )
```

Will need check-up in few weeks

Blood Count	DATE COLLECTED 27:09:94	DATE RECEIVED 27:09:94	DATE REPORTED 28:09:94	AUTHORISED BY [redacted]

Document 4.5. Referral form to community care.



COMMUNITY CARE
REFERRAL FORM

DATE OF REFERRAL

30	9	94

(Please complete in black ink)

TITLE Mr.	SURNAME Clarke	FORENAMES Simon	COMPUTER NO. 099248

Date of Birth 25-11-74

Already Known ~~YES~~/NO

PERMANENT ADDRESS:
[redacted]
Post Code:
Tel: Home
Work

TEMPORARY ADDRESS:
Post Code:
Tel:

ADMISSION DATE: 22-9-94

WARD: [redacted] II → I

DISCHARGE DATE:

CONSULTANT: Dr [redacted]

PRESENTING PROBLEM:

Adm. for assessment – referred by G.P.

Please include:
1) Referrers description of problem (including medical diagnosis)
2) Service User's description of problem
3) Any other relevant information
4) Action taken or promised
5) Degree of urgency

REFERRED BY: S/N

SERVICE USER AWARE OF REFERRAL? YES/~~NO~~

NAME:
ADDRESS:

TEL NO: HOME

WORK:

Part 5. Transfer

As my situation on the ward intensified, I noticed that other patients were also being bullied. Totally overwhelmed, I left the ward to walk the five miles home. My parents returned me to the ward. I ran away again early next morning, trying to walk home on a dangerous rain-swept road in the dark. My dad and brother pull up in their car and return me once again to the ward. Back on the ward, a nurse tricked me into entering the Psychiatric Intensive Care Unit, recorded by staff as an official transfer. A recommendation is made for involuntary detention. My mother’s account was once again silent during this part of the narrative

Part 5: Transfer

Simon

Everything is kicking off. People shouting, laughing, crying. The same group of patients winding up other patients with glee, and then watching them unravel. You can’t take it anymore, so you leave the ward, to go home.

You walk the 5 miles from the hospital to home. Cars go by hissing insults. The small point of light in front of your vision holds your focus. When you get home, your parents tell you that you must be in hospital. They drive you back there.

In the morning, you walk home in your slippers, in the dark, in the rain. There is no pavement, so you walk on the road, your sodden footwear slipping on the wet asphalt. Cars and buses and trucks pass; some beep their horns, others shout from the window at you. One car coming

Mother

Clinical Team

2-10-94 Nursing 14.00 Have tried to talk to Simon this morning, he will talk about general topics & when asked about his thoughts and feelings he refused to answer. Seems preoccupied with his thoughts, restless at times. ON CLOSE OBSERVATION

2.10.94 Simon returned to the ward accompanied by his parents. Request to know why Simon was slightly upset when he turned up at his house this evening. Explained to them that Simon was distressed when observing another patient’s disturbed behaviour. Reassured Simon’s parents. Remains on close observation.

3-10-94 NURSING 07.30 Found to be missing from the ward at 07.15 was seen by night staff at 07.00. attempts to contact parents

Reflection

The documents preceding included blood tests, blood samples and x-rays. They indicate the extent to which the patient’s body is subjected to analysis and inspection, even though some of this data does not seem relevant. It also suggests the institutional impetus towards data gathering, even if this is of little apparent relevance to the patient’s immediate problem. I remember having to attend test after test, with little or no explanation as to why these were being conducted, or their relevance. A vacuum of explanation only provides further fuel to paranoia.

Upon reading these sections again, it felt somehow discordant that the precision of data offered by these measurements contrasted sharply with the chaos of life on the ward. Whilst the medical staff may have been

Simon	Mother	Clinical Team	Reflection
the opposite way crosses lanes and comes to a stop right in front of you, so you can't walk any further. The rain criss-crosses the headlights. Someone gets out the passenger's side – it's your brother. Si what are you doing? Your Dad also gets out, leaving the car engine running, the window wipers scraping furiously in the downpour. Come on Si, get in. You do so, and your Dad sets off. Quickly, you realise, back to the hospital. Dad, just take me home, please take me home. Sorry, son, you need to be there. It's killing us, but you need to go back. You need to be there. The creepy old nurse with the drooping grey moustache comes up to you. Everything is kicking off again and you are waiting by the ward exit. This is the third time you have tried to run. Are you going or not, Simon? You shake		at 07.25 but no answer. Will try again. 3-10-94 NURSING 07.40 Contacted parents at home, informed that Simon has gone morning. They will contact the ward if he arrives at home. 3\10\94 Nursing 13.59 Simon returned to the ward with his parents at 08.17 hrs. His mother requested if she could stay with him until seen by Dr. Furbois this p.m. Remains subdued, not wishing to talk to staff. Has made no attempts to leave the ward. 3 10 94 15:00 Dr. Furbois W.R. Parents seen. Simon seen with them : he's clearly psychotically ill. Simon then left us. He – no insight ? partial: says he's depressed with some peculiar experiences – delusions	able to tell me the exact composition of my blood, biochemistry and the structural health of my respiratory system, they seem unable to know how to manage the psychological distress at a very basic level. This is not an attack on staff on the ward. I think in most cases they were genuinely trying to help, and the ward environment was clearly understaffed and underfunded. Most of the staff were friendly and, as the nursing notes indicate, I was recalcitrant and withdrawn. However, the ward was simply not conducive in any way to providing a place of sanctuary or care. Worse, as the nursing notes indicate, behaviour which might seem understandable given the social context such as walking home from a chaotic and threatening ward, is then used as an indication of illness and as a justification for further restrictions.

Part 5: Transfer

Simon

your head. He sighs and locks the door, shaking his head as he does. Come with me, he says. You come to the door with reinforced glass panels. Now Simon, he says, since you’ve been here, I’ve come to see you more as a friend than a patient. He unlocks the door. If you’d like to come through here for a minute so we can have a chat? You feel he is being deliberately insincere, like he is playing a role, but you are not sure what to do. There is a large patient standing by the door watching everything kick off, almost with satisfaction. You say ‘jump’, he says ‘how high’ eh, Dave? He says with a laugh. The nurse nods noncommittedly, leads you to the bottom of the stairs where there is another reinforced glass door. You think he is going to try and beat you up, so you get ready to run. He opens the door and you dash through. You stop.

Mother

Clinical Team

and hallucinations
Parents –
ILL 12/12 ago after drug abuse : counsellor: college resit plus kitchen porter
Has GCSEs plus A-level English
3.10.94 RTA not [illegible]
Parents told diff. diagnosis & management.
Px - not to leave hospital
- Woodbrook <u>ONE</u> if necessary
- Sec 5(2) if needed

3/10/94 nursing 20 00 hrs Simon was transferred from Woodbrook II and placed on close observations.
I’ve informed Simon’s brother about his transfer and he will tell Simon’s parents.
Simon told me he doesn't feel suicidal at the moment, but has done a few attempts. [illegible] hearing voices. Says he hasn't been happy for two years. He

Reflection

These restrictions may be justified on the basis of the clinical evidence, and perhaps justifiable concerns about safety and risk, but it still seems to me now that walking out of the ward was an understandable response. It was also a reflection of how bad things must have been on the ward that I would take such extreme measures to my own safety to escape. The section concludes with my transfer to the Psychiatric Intensive Care Unit (PICU) and may represent one the greatest divergence of patient and clinical accounts in this thesis. The PICU was located directly underneath the ward I was admitted to, and was locked at all times; in most cases, the PICU is reserved for what are considered the most distressed or risky patients. The suggestion from the nursing notes is that this was part of a plan, albeit a plan that was changed.

Part 5: Transfer

Simon	Mother	Clinical Team	Reflection
You are in a locked ward. No way out. The nurse laughs to himself, satisfied it seems, as he returns back through the glass door. They are all witches. They have replaced the real staff. You're all witches, you accuse them. No, we're not, says one older, somewhat grizzled nurse, who does look a bit witchlike. You notice she is wearing a pendant shaped like a five-pointed star. What's that then you say, pointing at the pendant. She appears to be thrown by the question. Earth mother…or something, she says. You're witches! You're all witches! You start shouting. They keep giving you this orange liquid. By the fourth or fifth one you start to feel weird and spaced. As the nurses lead you away to your room, you see the nurse taking her pendant off.		hopes that the change of medication will help him. Close observations continued. 3/10/94 9.50pm The patient bed to be moved downstairs to Woodbrook I – a risk of absconding - Diagnosed psychotically ill by the consultant - Refusing medication & trying to leave the ward without medical advice. - Advised section 5(2) if needed. * already * I feel he is a risk to himself/others if allowed to leave Put on section 5(2)	My account suggests it was the action of one lone nurse acting out of what seemed to me to be a sadistic delight in punishing. That the nurse who instituted this was one of the few nurses I remember as being genuinely unpleasant probably creates an even greater sense of dissonance. Like the biological data, the notes provide an impression of certainty; an impression that is perhaps illusory, but certainly negated by my account. The explanation in the nursing notes that I was 'trying to leave the ward without medical advice' seems to be a familiar double-bind that many psychiatric patients are put in: invited to come in voluntarily, but then threatened with involuntary detention should they then want to leave. What is the psychological effect of such a bind?

Document 5.1. Mental Health Act 1983 Section 5(2) forms

Report on hospital in-patient

Form 12

Mental Health Act 1983
Section 5 (2)

(name of hospital or mental nursing home in which the patient is)

To the Managers of [redacted]

I [redacted] am

delete the phrase which does not apply

~~the registered medical practitioner~~

✓the nominee of the registered medical practitioner

in charge of the treatment of

(full name of patient) SIMON CLARKE

who is an in-patient in this hospital and not at present liable to be detained under the Mental Health Act 1983. I hereby report, for the purposes of section 5(2) of the Act, that it appears to me that an application ought to be made under Part II of the Act for this patient's admission to hospital for the following reasons:-

(Reasons should indicate why informal treatment is no longer appropriate)

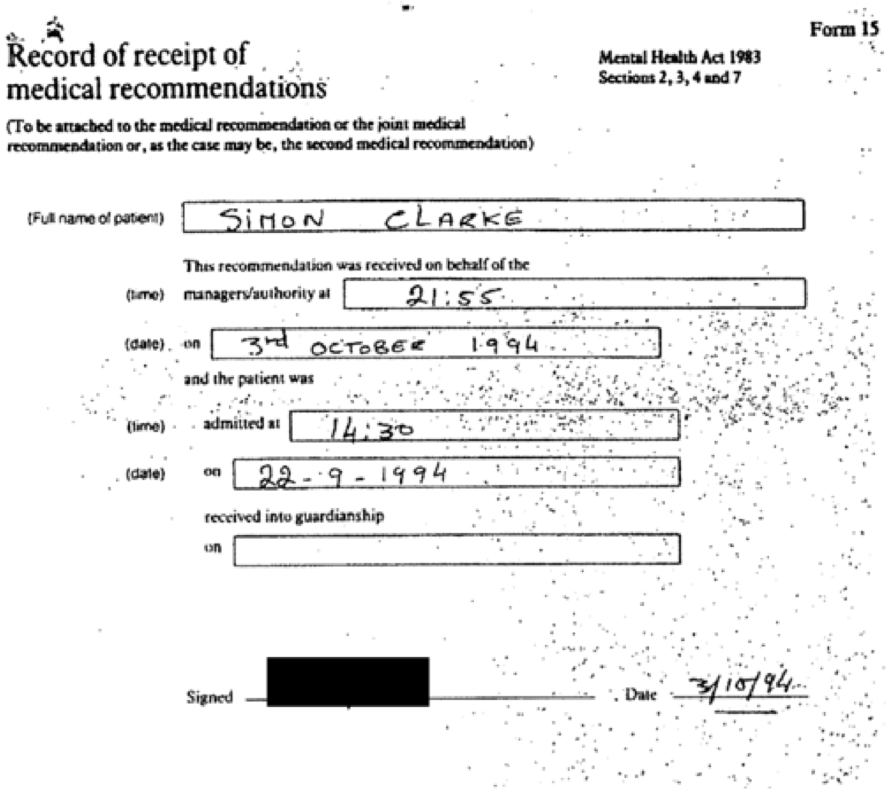
The patient is psychotic, having delusions of persecution & is thought disordered. He is refusing medication & trying to leave the ward without medical advice and can be a danger to himself.

Signed [redacted]

Date 03/10/94

Time 09.55pm

Document 5.2. Record of medical recommendation for Section 5(2).



Form 15

Record of receipt of medical recommendations

Mental Health Act 1983
Sections 2, 3, 4 and 7

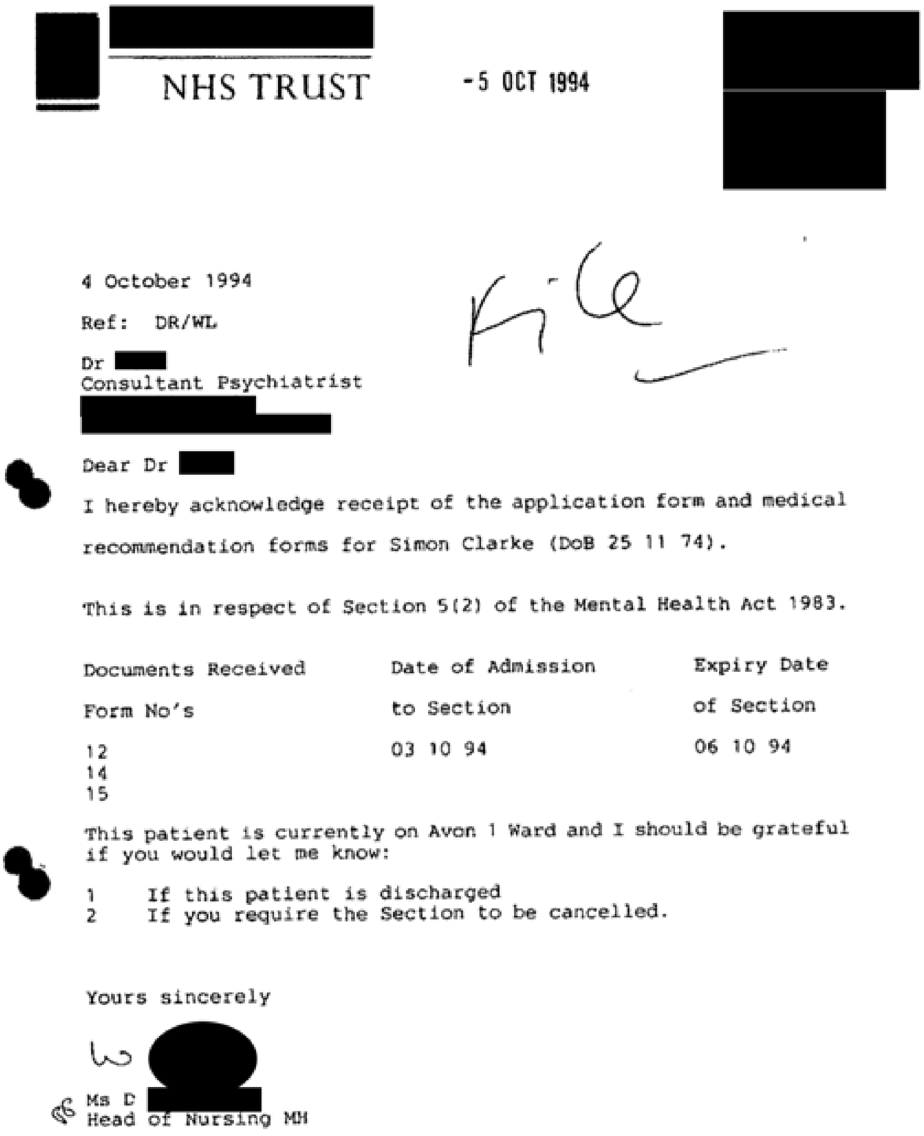
(To be attached to the medical recommendation or the joint medical recommendation or, as the case may be, the second medical recommendation)

(Full name of patient) SIMON CLARKE

This recommendation was received on behalf of the
(time) managers/authority at 21:55
(date) on 3rd OCTOBER 1994
and the patient was
(time) admitted at 14:30
(date) on 22-9-1994
received into guardianship
on

Signed [redacted] Date 3/10/94

Document 5.3. Letter from Head of Nursing confirming receipt of Section 5(2) papers.



[redacted] [redacted]
NHS TRUST

[redacted]

-5 OCT 1994

File

4 October 1994

Ref: DR/WL

Dr [redacted]
Consultant Psychiatrist
[redacted]

Dear Dr [redacted]

I hereby acknowledge receipt of the application form and medical recommendation forms for Simon Clarke (DoB 25 11 74).

This is in respect of Section 5(2) of the Mental Health Act 1983.

Documents Received Form No's	Date of Admission to Section	Expiry Date of Section
12 14 15	03 10 94	06 10 94

This patient is currently on Avon 1 Ward and I should be grateful if you would let me know:

1 If this patient is discharged
2 If you require the Section to be cancelled.

Yours sincerely

[redacted]

Ms D [redacted]
Head of Nursing MH

Document 5.4. Section 132 forms.

Form 14

Record of admission

(To be attached to the application for admission or report)

Mental Health Act 1983
Sections 2, 3, 4 and 5(2)

(Name of hospital or mental nursing home) [redacted] HOSPITAL

(full name of patient) SIMON CLARKE

The patient named above was

(complete (a) or (b))

(a) admitted to this hospital in pursuance of this application on

(date)

(b) already in this hospital on the date of the application or report and the application or report was received by me on behalf of the managers on

(date) 03-10-1994.

The patient was given information in accordance with section 132 of the Act on

(date) 03-10-1994 Verbally & written. [redacted]

delete the phrase which does not apply

The patient's nearest relative

The person authorised to exercise the functions of the nearest relative

was informed of the patient's admission on

(date) 4-10-94

The local social services authority of the area where the patient resided immediately before admission is

(name of authority) [redacted]

That authority was advised of the patient's admission on

(date) 4-10-94

Signed [redacted]
on behalf of the managers

Date 4-10-94

Part 6. Intensive Care

Having been transferred to a locked ward with restricted leave, I struggled to adapt to life on the ward, even though the environment was less chaotic. I strongly believed that there were several conspiracies going on in the ward. The application to detain me under Section 3 of the 1983 Mental Health Act was processed. Some strange events occurring on the ward fuelled my already heightened paranoia.

Part 6: Intensive Care

Simon

Everything happens so fast. Activity, people rushing back and forth, police, ambulance, doctors, nurses. Comings and goings. Every person passing means something. Are you in trouble? Is this when they will transfer you to prison? You are interviewed countless times by some people you know, and others you don't. They tell you are going to be ‘sectioned’. You think that means you will be carved up into little pieces.

And then nothing happens for long periods of time and the ward feels almost empty. At these times, you wonder if you’ve been left alone and the world outside has gone post-Apocalyptic. And here you are, the last human being alive, wandering the corridors of a derelict psychiatric unit, until the end of time.

Mother

Clinical Team

4.10.94 Nursing 12.50hrs. I spent some time with Simon encouraging him to “talk”. He was reticent and reluctant to engage in conversation but he described himself as being “shy” by nature. He spoke a little about “going crazy” but would not elaborate. I advised him to approach the nurses should he want to talk about anything (not necessarily Ψ symptoms etc) or should he feel that he just wants some company. Remains on close observation.

4.10.94 Nursing 20.15hrs Simon was assessed by Dr Jose this pm who completed a medical recommendation for section 3. He was visited by his parents who seem very supportive (particularly mother). I spent more time with Simon and his mother together who appeared to need self support. Apparently Simon was repeatedly asking his mother to

Reflection

As the documents between this and the preceding section indicate, the institutional wheels had now been set in motion for the process of applying for detainment under the Mental Health Act. The latter forms were for Section 5(2) that allows the ward to hold a patient for 72 hours whilst the application for a longer-term section (usually Section 2 or 3) are being processed.

Reading this now, I can see that the nurses were genuinely trying to help. The excerpts do not just read like an exercise in bureaucratic recording or institutional self-reifying, but an honest attempt to describe the process of trying to help a patient who is resisting every attempt to be open about their experiences. When the nurse says that the diagnosis is less important than treating the symptoms, this feels

Simon

You are holding onto this one book. If you could only get out without being murdered or transferred to prison, it may have been worth it. You think that the whole of philosophy, poetry and art is an elaborate coded system to protect humanity from itself. Certain people throughout time have been able to encode these hidden messages and then pass then onwards. You believe that a spiritual temple of this knowledge is being built surreptitiously and that Wittgenstein’s first work provides the scaffolding that will put all of this coding together. However, the other patients in the ward are only bent on destruction. They can't be allowed to mine your thoughts that far, or they will destroy humanity and everything will be lost.

Mother

Clinical Team

take him home and she was becoming quite upset explained that the responsibility of deciding any leave or discharge has now been taken away from Simon and his mother and placed with the doctors here. I again explained the need for Simon to talk with us about his thoughts/feelings etc. He became embarrassed and reluctant, and he agreed that his mother could tell me what he had previously told her – she spoke of persecutory ideas re police chasing the family in connection with a paedophile ring (he claims to understand these thoughts or “abnormal”. Mrs Clarke requested that Simon has been reading a lot of psychological literature recently and had diagnosed himself as “schizoid.” – reiterated importance of repeating symptoms as they occur so we can treat them and lessened importance of diagnosis. Remains on close observation.

Reflection

believable; there are extensive references to different methods used to try and get me to be open including reassurance, persuasion and explanation. Indeed, when the nurse describes the restriction of leave following my attempt to leave the ward, the tone jars with most of the other excerpts.

What the nurse possibly did not know was the impossible situation that a patient on the ward can be in when invited to talk about their symptoms with staff. I knew my symptoms were incredibly bizarre and would be perceived by staff as further evidence of psychosis. Even then, I knew that whilst individual nurses might have good intentions, the information could be used in all sorts of ways. As I genuinely believed that there was a conspiracy to do me harm, talking more openly about my paranoia was, paradoxically,

Simon

Four of the other male patients you think are the ringleaders come down from the ward upstairs and meet in the lounge here. You hover at the corridor, out of sight, in order to hear what they are saying. But there's one book he's still keeping from us, says the leader, as the others laugh. Wittgenstein's *Tractatus Logico-Philosophicus,* your mind confesses involuntarily. They laugh. You fall into your room in complete despair.

The nurses are generally very nice and try to coax information out from you. You try not to tell them anything but sometimes it just slips out. Every piece of new information you give them throws you into a despair of panic. What did you do that for? How will they use that against you?

Mother

Clinical Team

Nursing 6/10/94 1230. Appeared a little brighter this am. Requested that he goes out for a walk. On returning to ward he became extremely reluctant and placed his foot on the door and refused to come in. Given his previous suicidal attempt, informed Simon further escorted walks with nursing or his family will be suspended till reviewed on Sunday. Simon is still at risk. <u>Resumed close observation</u>.

6/10/94 ASW :- Assessment and Section 3 applied for.

7.10.94 Nursing 13.20 I spent here with Simon this morning explaining to him that he needs to tell staff about his experiences & also explained that the restrictions enforced were for his safety. He states he feels that there is a plot against him and that he is being punished. He can't elaborate on

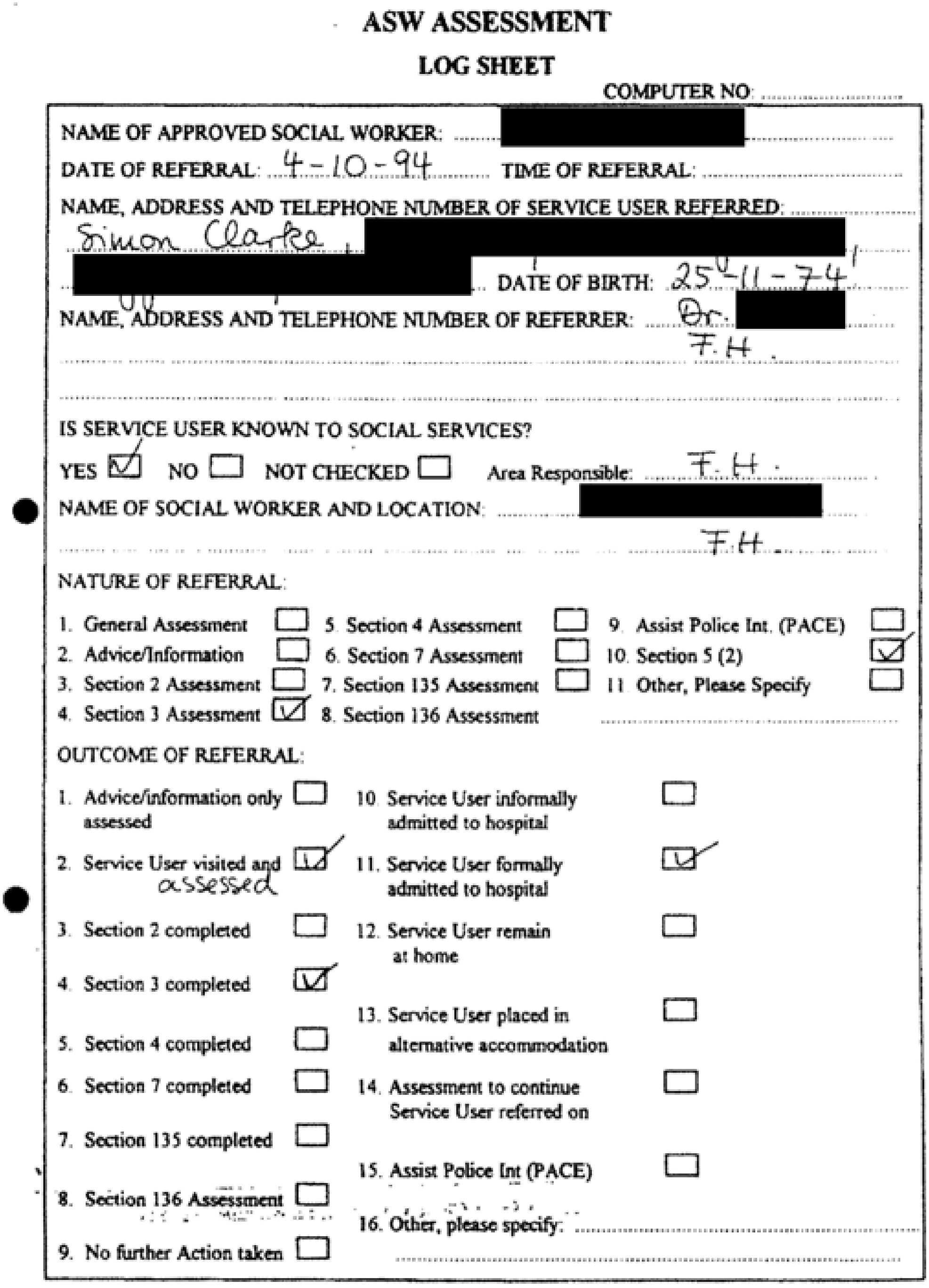
Reflection

likely to make me more paranoid. I think mental health staff do not always appreciate the impact that it has on a person's subjectivity. In other words, to know that once you have said something it will be recorded and, once recorded, you then lose control of how that information may be used about you in future. Added to this concern, many of my thoughts were disturbing even to me and would have resulted in significant shame and humiliation if they were shared. Finally, and as the last patient excerpt shows, genuinely strange things *do* happen on a psychiatric ward. Such incidents are obviously not recorded in the notes. The overlap between institutional strangeness and personal paranoia is not fixed or straightforward. Sometimes neither the paranoid, nor the common-sense explanations, appear to fit.

Part 6: Intensive Care

Simon	Mother	Clinical Team	Reflection
Your eyes are being withdrawn into your skull like a winch which is being slowly wound by them, pulling the stalks into the sockets. You cannot see reality if they are pulled back just a fraction. You wonder if this is why you have always had problems. You are up and around the ward, because you can’t sleep. The night staff follow you around, pissed off. You come to a table surrounded by staff. They are trying to get you to take these pills. You refuse; they keep insisting. They are watching you, with expectation. You eventually cave and take the pills. They turn to the only other patient in the room, congratulate him and shake his hand. Welcome back, they say.		this “feeling” he had but he can acknowledge it could be connected with his mental state. I asked him about the lacerating and burning he did on 23.9.94. He stated he felt “dead” and he was checking if this was true. He said his emotions were flat he didn't feel himself hence the feelings of “deadness”. Simon did appear willing to talk but it was obvious he found it hard to trust me enough to talk of all his experience. Apparently he felt he was under surveillance last night by a group of doctors he found it difficult to accept this might not have happened.	The nurses’ compassion for my mother’s distress is also palpable and references to her distress are mentioned several times by proxy in the nurses’ accounts. My mother’s voice is silent throughout this section, and was for the last one. This strikes me as curious. When she originally gave me the diary for the research, she said she kept it for the purposes of emotional containment. I am guessing that this was probably one of the most distressing episodes for her and so it does seem curious that there is no comment here. Perhaps she was too distressed, emotionally and physically exhausted, or even overwhelmed, to record anything.

Document 6.1. Approved Social Worker assessment log sheet.



ASW ASSESSMENT

LOG SHEET

COMPUTER NO: ....

NAME OF APPROVED SOCIAL WORKER: [redacted]

DATE OF REFERRAL: 4-10-94 TIME OF REFERRAL: ....

NAME, ADDRESS AND TELEPHONE NUMBER OF SERVICE USER REFERRED:

Simon Clarke, [redacted]

[redacted] DATE OF BIRTH: 25-11-74

NAME, ADDRESS AND TELEPHONE NUMBER OF REFERRER: Dr. [redacted]

F.H.

IS SERVICE USER KNOWN TO SOCIAL SERVICES?

YES ☑ NO ☐ NOT CHECKED ☐ Area Responsible: F.H.

NAME OF SOCIAL WORKER AND LOCATION: [redacted]

F.H.

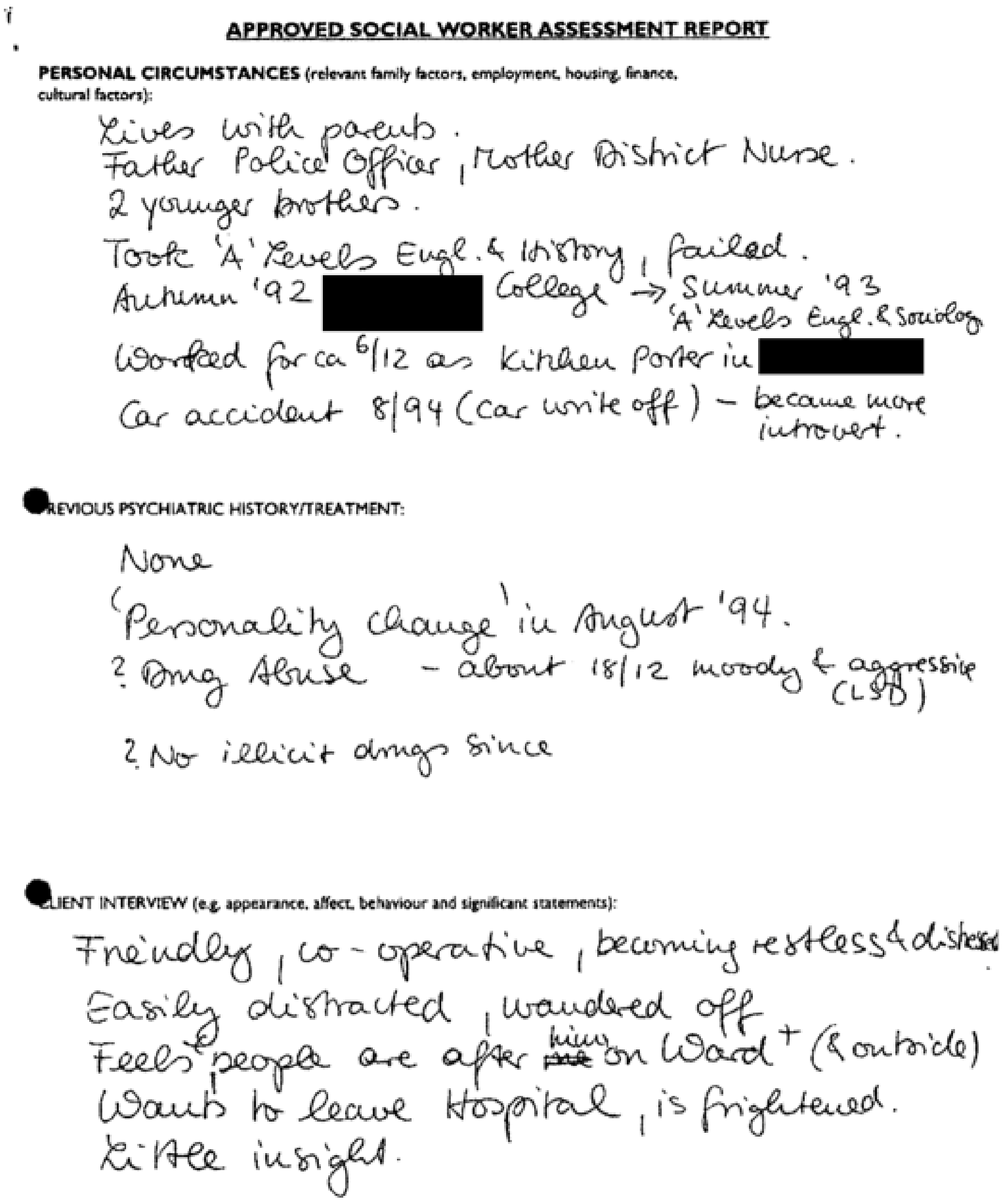
NATURE OF REFERRAL:

1. General Assessment ☐
2. Advice/Information ☐
3. Section 2 Assessment ☐
4. Section 3 Assessment ☑
5. Section 4 Assessment ☐
6. Section 7 Assessment ☐
7. Section 135 Assessment ☐
8. Section 136 Assessment
9. Assist Police Int. (PACE) ☐
10. Section 5 (2) ☑
11. Other, Please Specify ☐ ....

OUTCOME OF REFERRAL:

1. Advice/information only assessed ☐
2. Service User visited and assessed ☑
3. Section 2 completed ☐
4. Section 3 completed ☑
5. Section 4 completed ☐
6. Section 7 completed ☐
7. Section 135 completed ☐
8. Section 136 Assessment ☐
9. No further Action taken ☐
10. Service User informally admitted to hospital ☐
11. Service User formally admitted to hospital ☑
12. Service User remain at home ☐
13. Service User placed in alternative accommodation ☐
14. Assessment to continue Service User referred on ☐
15. Assist Police Int (PACE) ☐
16. Other, please specify: ....

Document 6.2.1. Approved Social Worker assessment report, page 1.



APPROVED SOCIAL WORKER ASSESSMENT REPORT

PERSONAL CIRCUMSTANCES (relevant family factors, employment, housing, finance, cultural factors):

Lives with parents.
Father Police Officer, Mother District Nurse.
2 younger brothers.
Took 'A' Levels Engl. & History, failed.
Autumn '92 [redacted] College → Summer '93
'A' Levels Engl. & Sociology
Worked for ca 6/12 as Kitchen Porter in [redacted]
Car accident 8/94 (car write off) – became more introvert.

REVIOUS PSYCHIATRIC HISTORY/TREATMENT:

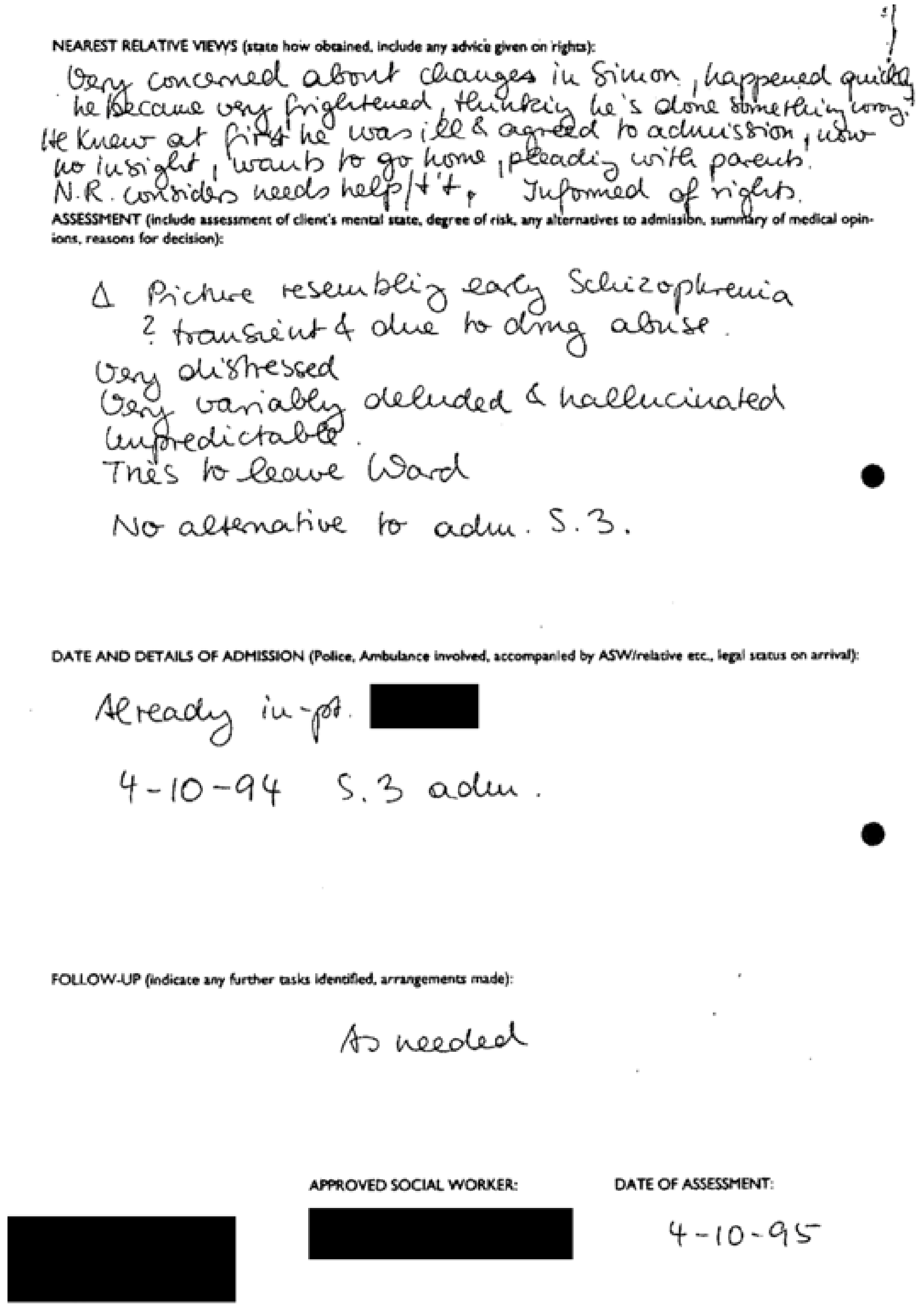
None
'Personality change' in August '94.
? Drug Abuse – about 18/12 moody & aggressive
(LSD)

? No illicit drugs since

LIENT INTERVIEW (e.g. appearance, affect, behaviour and significant statements):

Friendly, co-operative, becoming restless & distressed.
Easily distracted, wandered off
Feels people are after ~~[illegible]~~ him on Ward + (& outside)
Wants to leave Hospital, is frightened.
Little insight.

Document 6.2.2 Approved Social Worker assessment report, page 2.



NEAREST RELATIVE VIEWS (state how obtained, include any advice given on rights):

Very concerned about changes in Simon, happened quickly
he became very frightened, thinking he's done something wrong.
He knew at first he was ill & agreed to admission, now
no insight, wants to go home, pleading with parents.
N.R. considers needs help/t't, Informed of rights.

ASSESSMENT (include assessment of client's mental state, degree of risk, any alternatives to admission, summary of medical opinions, reasons for decision):

Δ Picture resembling early Schizophrenia
? transient & due to drug abuse.
Very distressed
Very variably deluded & hallucinated
Unpredictable.
Tries to leave Ward

No alternative to adm. S.3.

DATE AND DETAILS OF ADMISSION (Police, Ambulance involved, accompanied by ASW/relative etc., legal status on arrival):

Already in-pt. [redacted]

4-10-94 S.3 adm.

FOLLOW-UP (indicate any further tasks identified, arrangements made):

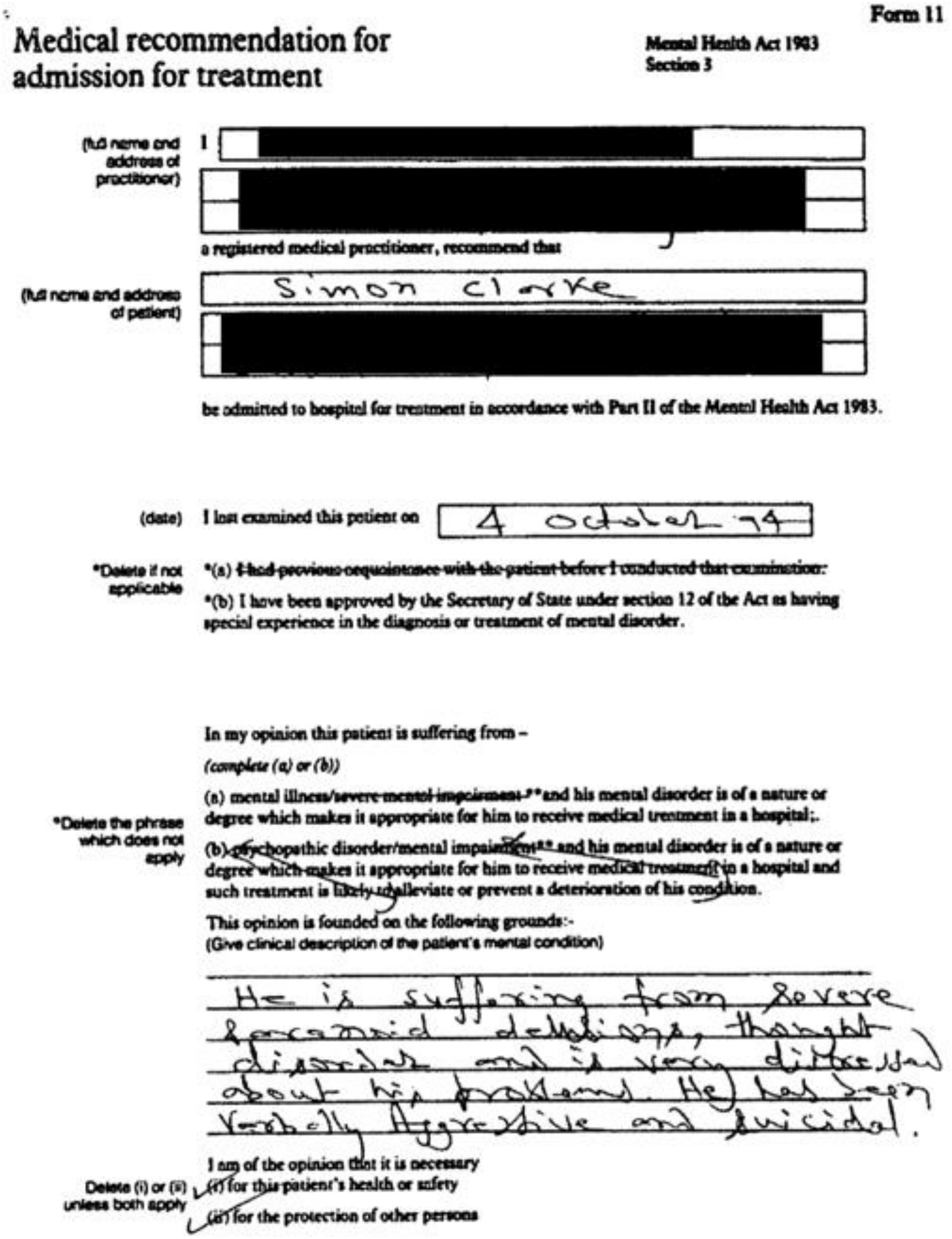
As needed

[redacted]

APPROVED SOCIAL WORKER: [redacted]

DATE OF ASSESSMENT: 4-10-95

Document 6.3.1. Medical recommendation for treatment under Section 3 of the 1983 Mental Health Act (Section 12 approved doctor), page 1.



Form 11

Medical recommendation for admission for treatment

Mental Health Act 1983
Section 3

(full name and address of practitioner) I [redacted]

[redacted]

a registered medical practitioner, recommend that

(full name and address of patient) Simon Clarke

[redacted]

be admitted to hospital for treatment in accordance with Part II of the Mental Health Act 1983.

(date) I last examined this patient on 4 October 94

*Delete if not applicable

*(a) ~~I had previous acquaintance with the patient before I conducted that examination.~~

*(b) I have been approved by the Secretary of State under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder.

In my opinion this patient is suffering from –

(complete (a) or (b))

*Delete the phrase which does not apply

(a) mental illness/~~severe mental impairment~~** and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital;.

(b) ~~psychopathic disorder/mental impairment** and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital and such treatment is likely to alleviate or prevent a deterioration of his condition.~~

This opinion is founded on the following grounds:-
(Give clinical description of the patient's mental condition)

He is suffering from severe paranoid delusions, thought disorder and is very distressed about his problems. He has been verbally aggressive and suicidal.

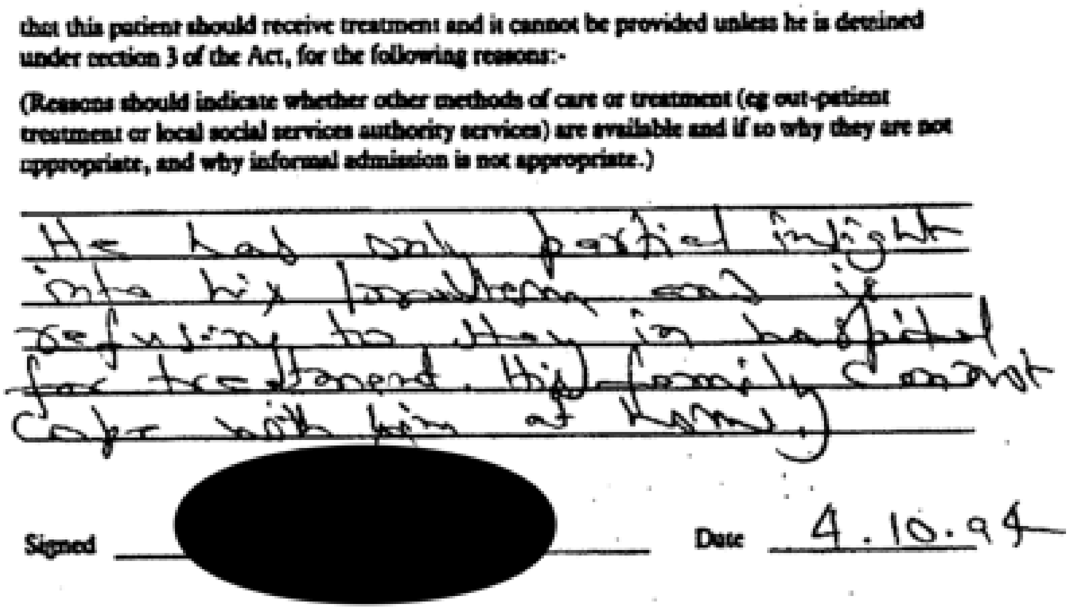
I am of the opinion that it is necessary

Delete (i) or (ii) unless both apply

✓ (i) for this patient's health or safety

✓ (ii) for the protection of other persons

Document 6.3.2. Medical recommendation for treatment under Section 3 of the 1983 Mental Health Act (Section 12 approved doctor), page 2.



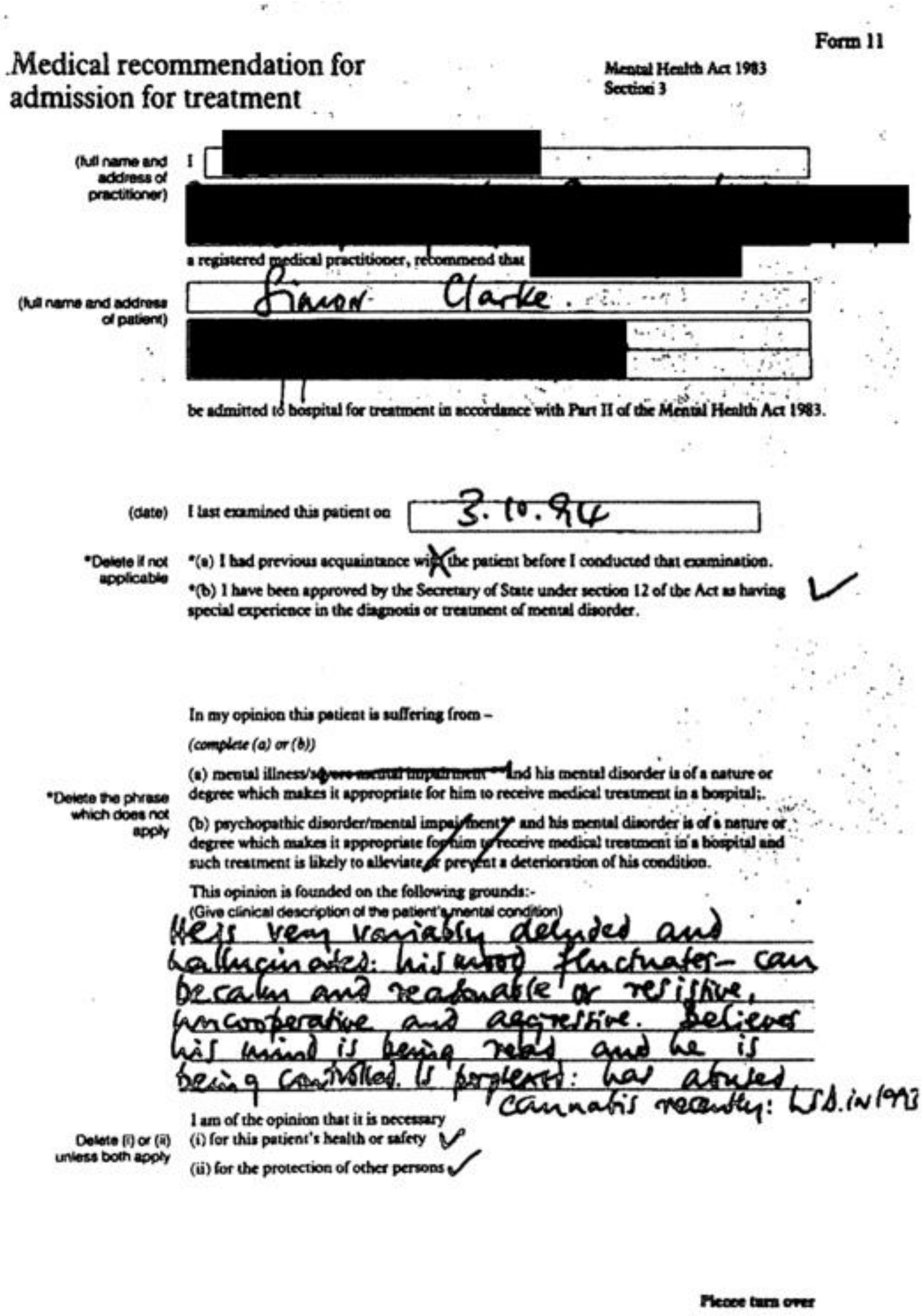
that this patient should receive treatment and it cannot be provided unless he is detained under section 3 of the Act, for the following reasons:-

(Reasons should indicate whether other methods of care or treatment (eg out-patient treatment or local social services authority services) are available and if so why they are not appropriate, and why informal admission is not appropriate.)

He has only partial insight
into his problem and is
refusing to stay in hospital
for treatment. His family cannot
cope with him at home.

Signed [redacted] Date 4.10.94

Document 6.4.1. Medical recommendation for treatment under Section 3 of the 1983 Mental Health Act (Consultant Psychiatrist), page 1.



Form 11

Medical recommendation for admission for treatment

Mental Health Act 1983
Section 3

(full name and address of practitioner) I [redacted]

[redacted]

a registered medical practitioner, recommend that [redacted]

(full name and address of patient) Simon Clarke.

[redacted]

be admitted to hospital for treatment in accordance with Part II of the Mental Health Act 1983.

(date) I last examined this patient on 3.10.94

*Delete if not applicable

*(a) I had previous acquaintance with the patient before I conducted that examination.

*(b) I have been approved by the Secretary of State under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder. ✓

In my opinion this patient is suffering from –

(complete (a) or (b))

*Delete the phrase which does not apply

(a) mental illness/~~severe mental impairment~~* and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital;.

(b) psychopathic disorder/mental impairment* and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital and such treatment is likely to alleviate or prevent a deterioration of his condition.

This opinion is founded on the following grounds:-
(Give clinical description of the patient's mental condition)

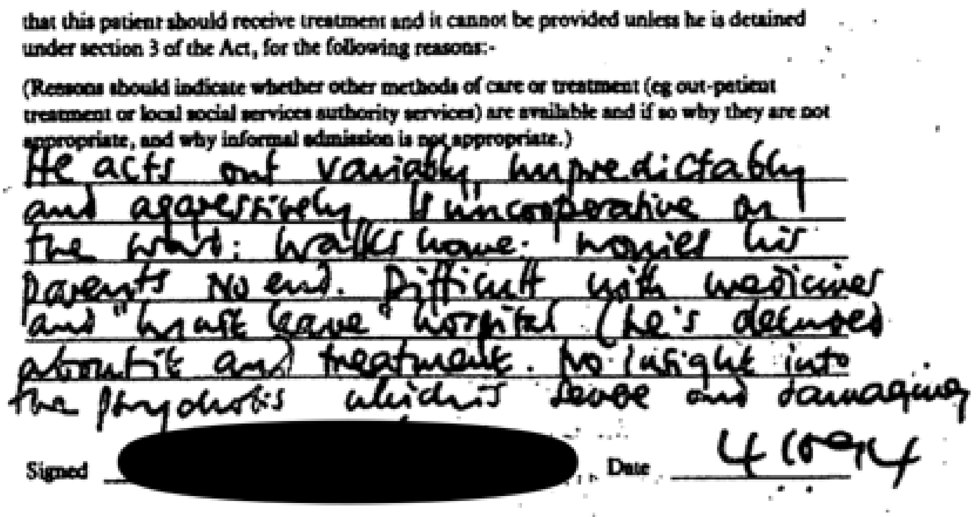
He is very variably deluded and hallucinated: his mood fluctuates – can be calm and reasonable or resistive, uncooperative and aggressive. Believes his mind is being read and he is being controlled. Is perplexed: has abused cannabis recently: LSD. in 1993

Delete (i) or (ii) unless both apply

I am of the opinion that it is necessary
(i) for this patient's health or safety ✓
(ii) for the protection of other persons ✓

Please turn over

Document 6.4.2. Medical recommendation for treatment under Section 3 of the 1983 Mental Health Act (Consultant Psychiatrist), page 2.



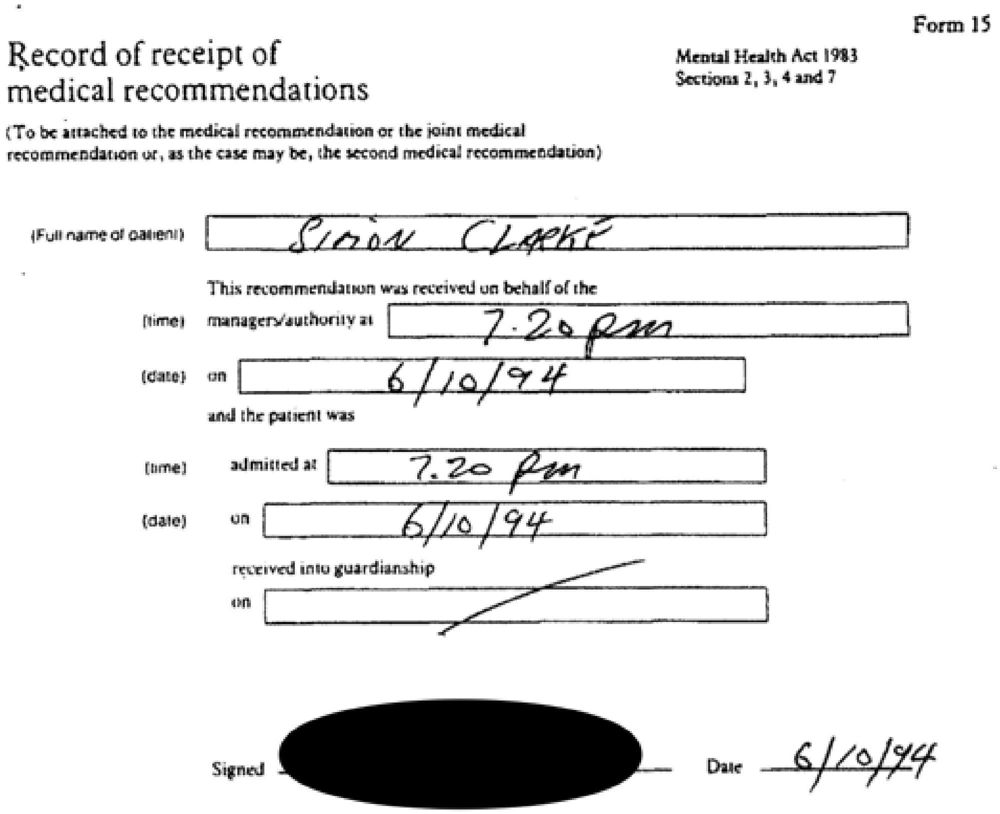
that this patient should receive treatment and it cannot be provided unless he is detained under section 3 of the Act, for the following reasons:-

(Reasons should indicate whether other methods of care or treatment (eg out-patient treatment or local social services authority services) are available and if so why they are not appropriate, and why informal admission is not appropriate.)

He acts out variably, unpredictably and aggressively, is uncooperative on the ward: walks home. Worries his parents no end. Difficult with medicines and "wants leave" hospital (he's deluded about it and treatment). No insight into the psychosis which is severe and damaging

Signed [redacted] Date 4/10/94

Document 6.5.1. Record of receipt of medical recommendations under Section 3 of the 1983 Mental Health Act, page 1.



Form 15

Record of receipt of medical recommendations

Mental Health Act 1983
Sections 2, 3, 4 and 7

(To be attached to the medical recommendation or the joint medical recommendation or, as the case may be, the second medical recommendation)

(Full name of patient) SIMON CLARKE

This recommendation was received on behalf of the

(time) managers/authority at 7.20 pm

(date) on 6/10/94

and the patient was

(time) admitted at 7.20 pm

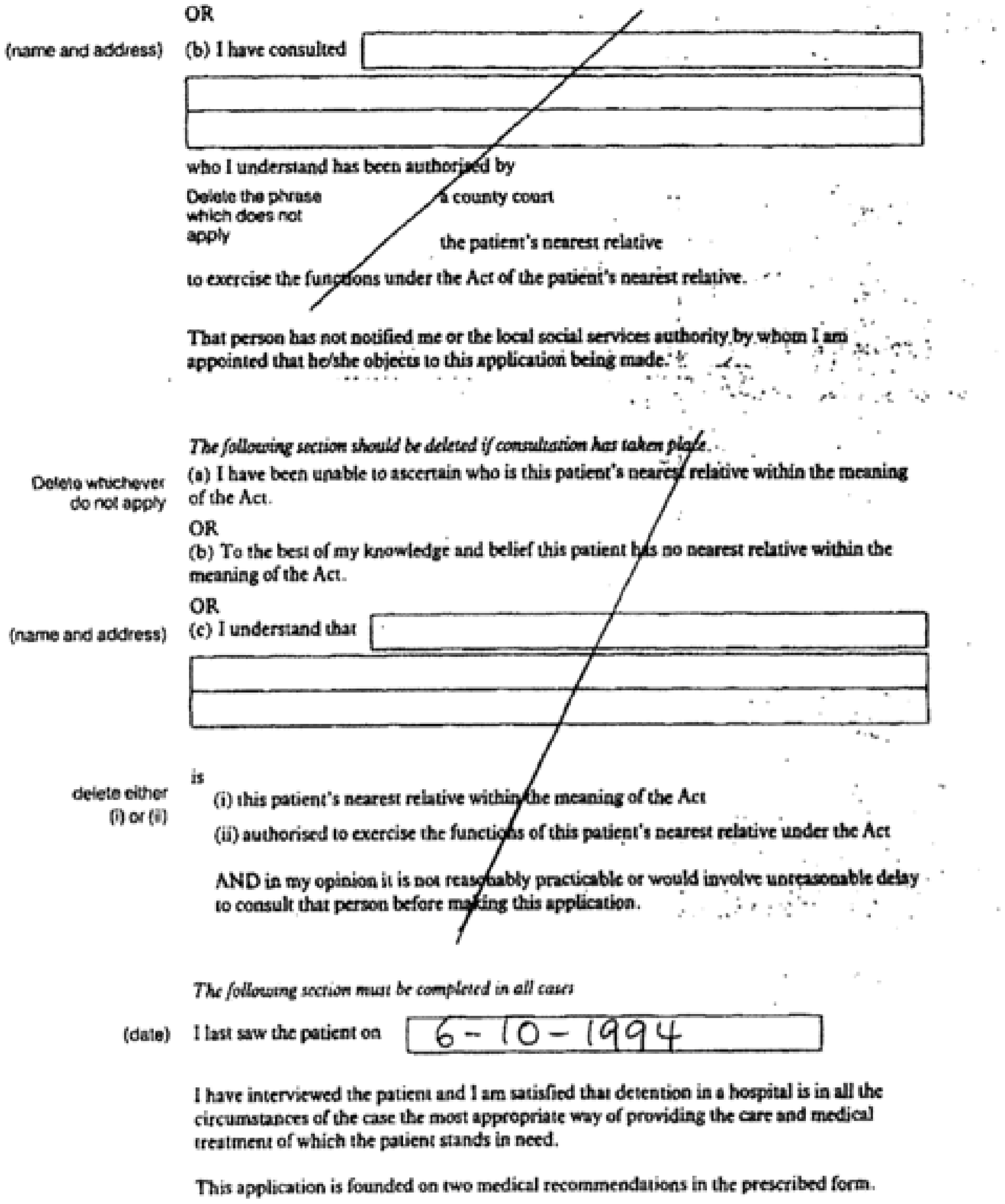
(date) on 6/10/94

received into guardianship

on

Signed [redacted] Date 6/10/94

Document 6.5.2. Record of receipt of medical recommendations under Section 3 of the 1983 Mental Health Act, page 2.



OR

(name and address) ~~(b) I have consulted~~

~~who I understand has been authorised by~~

Delete the phrase which does not apply

~~a county court~~

~~the patient's nearest relative~~

~~to exercise the functions under the Act of the patient's nearest relative.~~

That person has not notified me or the local social services authority by whom I am appointed that he/she objects to this application being made.

~~*The following section should be deleted if consultation has taken place.*~~

Delete whichever do not apply

~~(a) I have been unable to ascertain who is this patient's nearest relative within the meaning of the Act.~~

~~OR~~

~~(b) To the best of my knowledge and belief this patient has no nearest relative within the meaning of the Act.~~

~~OR~~

(name and address) ~~(c) I understand that~~

~~is~~

delete either (i) or (ii)

~~(i) this patient's nearest relative within the meaning of the Act~~

~~(ii) authorised to exercise the functions of this patient's nearest relative under the Act~~

~~AND in my opinion it is not reasonably practicable or would involve unreasonable delay to consult that person before making this application.~~

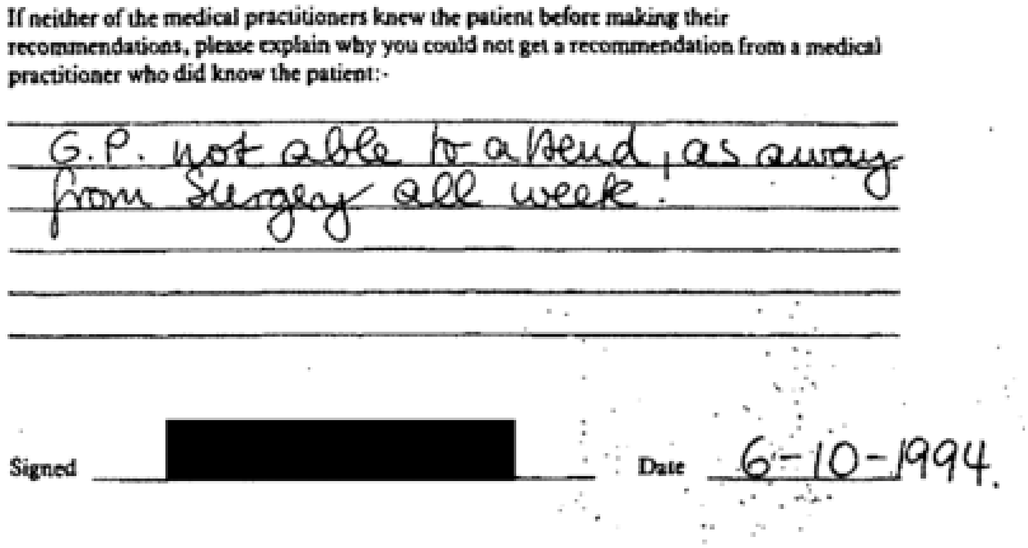
The following section must be completed in all cases

(date) I last saw the patient on 6 - 10 - 1994

I have interviewed the patient and I am satisfied that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

This application is founded on two medical recommendations in the prescribed form.

Document 6.5.3. Record of receipt of medical recommendations under Section 3 of the 1983 Mental Health Act, page 3.

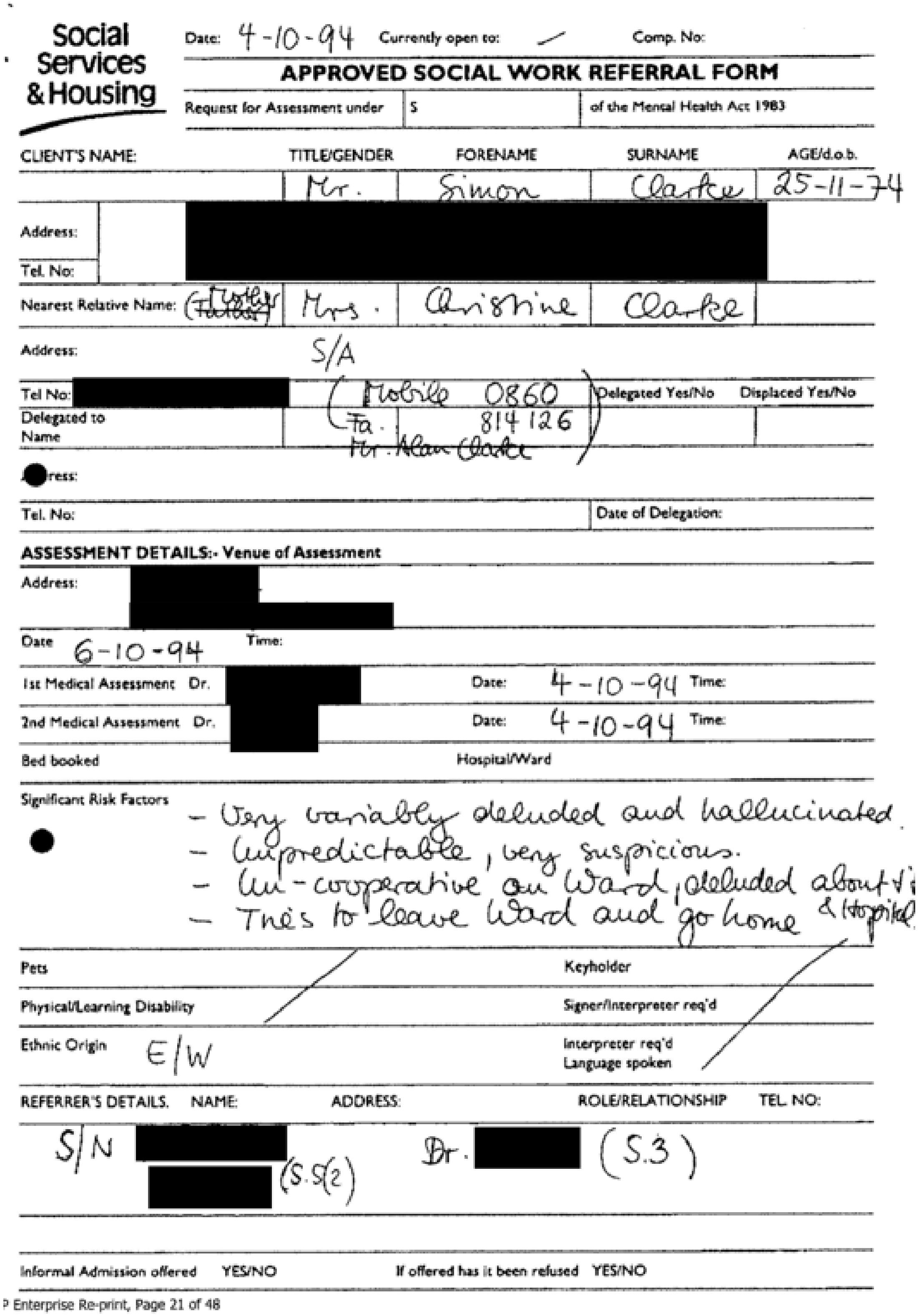


If neither of the medical practitioners knew the patient before making their recommendations, please explain why you could not get a recommendation from a medical practitioner who did know the patient:-

G.P. not able to attend, as away from Surgery all week!

Signed [redacted] **Date** 6-10-1994.

Document 6.6.1. Approved Social Worker referral form, page 1.



Social Services & Housing

Date: 4-10-94 Currently open to: — Comp. No:

APPROVED SOCIAL WORK REFERRAL FORM

Request for Assessment under S of the Mental Health Act 1983

CLIENT'S NAME:	TITLE/GENDER	FORENAME	SURNAME	AGE/d.o.b.
	Mr.	Simon	Clarke	25-11-74

Address: [redacted]
Tel. No:

Nearest Relative Name: (~~Father~~ Mother Mrs. Christine Clarke

Address: S/A

Tel No: [redacted] (Mobile 0860 / Fa. 814 126 / Mr. Alan Clarke) Delegated Yes/No Displaced Yes/No

Delegated to Name

[illegible]ress:

Tel. No: Date of Delegation:

ASSESSMENT DETAILS:- Venue of Assessment

Address: [redacted]

Date 6-10-94 Time:

1st Medical Assessment Dr. [redacted] Date: 4-10-94 Time:

2nd Medical Assessment Dr. [redacted] Date: 4-10-94 Time:

Bed booked Hospital/Ward

Significant Risk Factors
- Very variably deluded and hallucinated.
- Unpredictable, very suspicious.
- Un-cooperative on Ward, deluded about
- Tries to leave Ward and go home & Hospital

Pets Keyholder

Physical/Learning Disability Signer/Interpreter req'd

Ethnic Origin E/W Interpreter req'd Language spoken

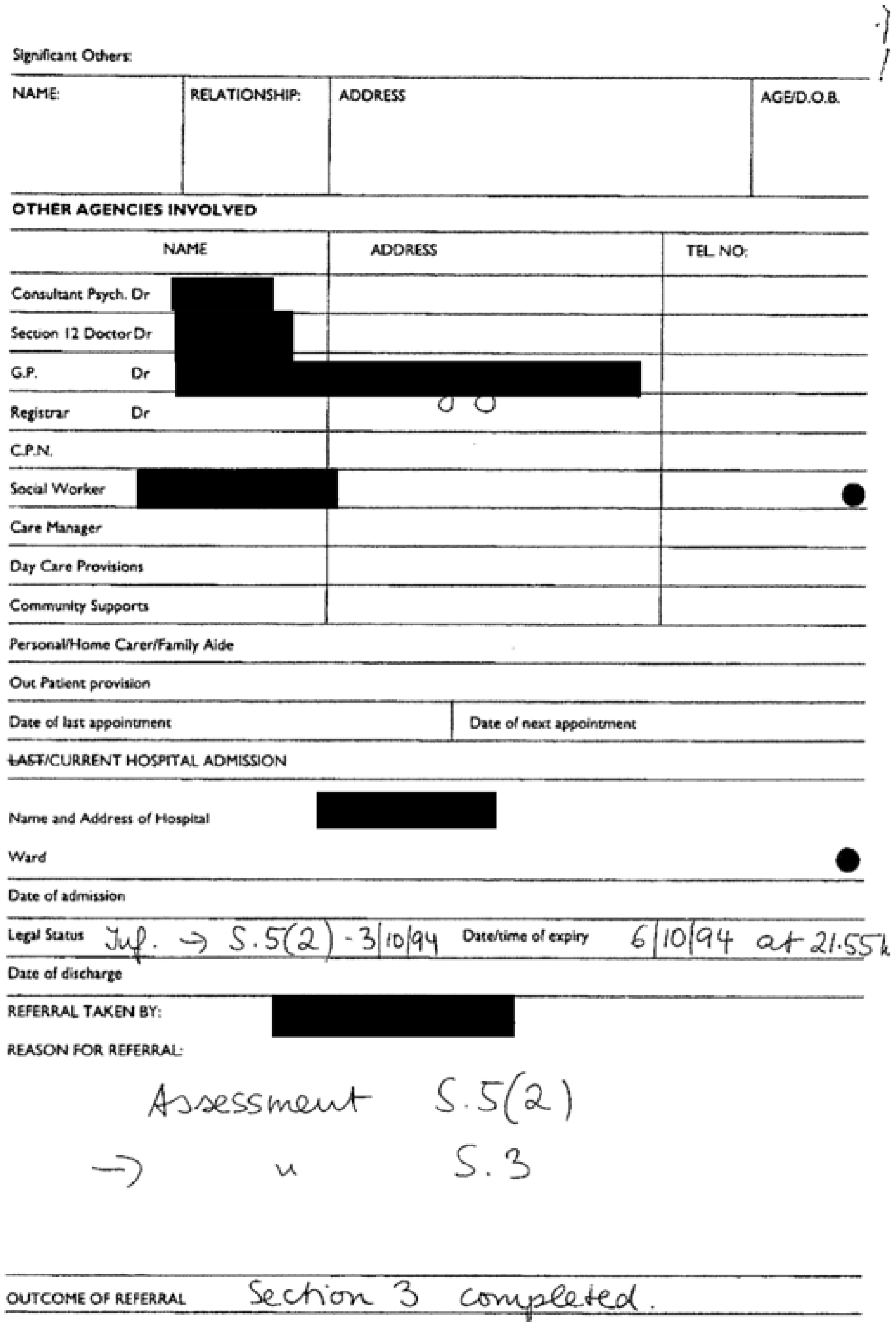
REFERRER'S DETAILS. NAME: ADDRESS: ROLE/RELATIONSHIP TEL. NO:

S/N [redacted] (S.5(2) Dr. [redacted] (S.3)

Informal Admission offered YES/NO If offered has it been refused YES/NO

P Enterprise Re-print, Page 21 of 48

Document 6.6.2. Approved Social Worker referral form, page 2.



Significant Others:

NAME:	RELATIONSHIP:	ADDRESS	AGE/D.O.B.

OTHER AGENCIES INVOLVED

	NAME	ADDRESS	TEL. NO:
Consultant Psych. Dr	[redacted]		
Section 12 Doctor Dr	[redacted]		
G.P. Dr	[redacted]	[redacted]	
Registrar Dr			
C.P.N.			
Social Worker	[redacted]		
Care Manager			
Day Care Provisions			
Community Supports			

Personal/Home Carer/Family Aide

Out Patient provision

Date of last appointment | Date of next appointment

~~LAST~~/CURRENT HOSPITAL ADMISSION

Name and Address of Hospital [redacted]

Ward

Date of admission

Legal Status Inf. → S.5(2) - 3/10/94 Date/time of expiry 6/10/94 at 21.55h

Date of discharge

REFERRAL TAKEN BY: [redacted]

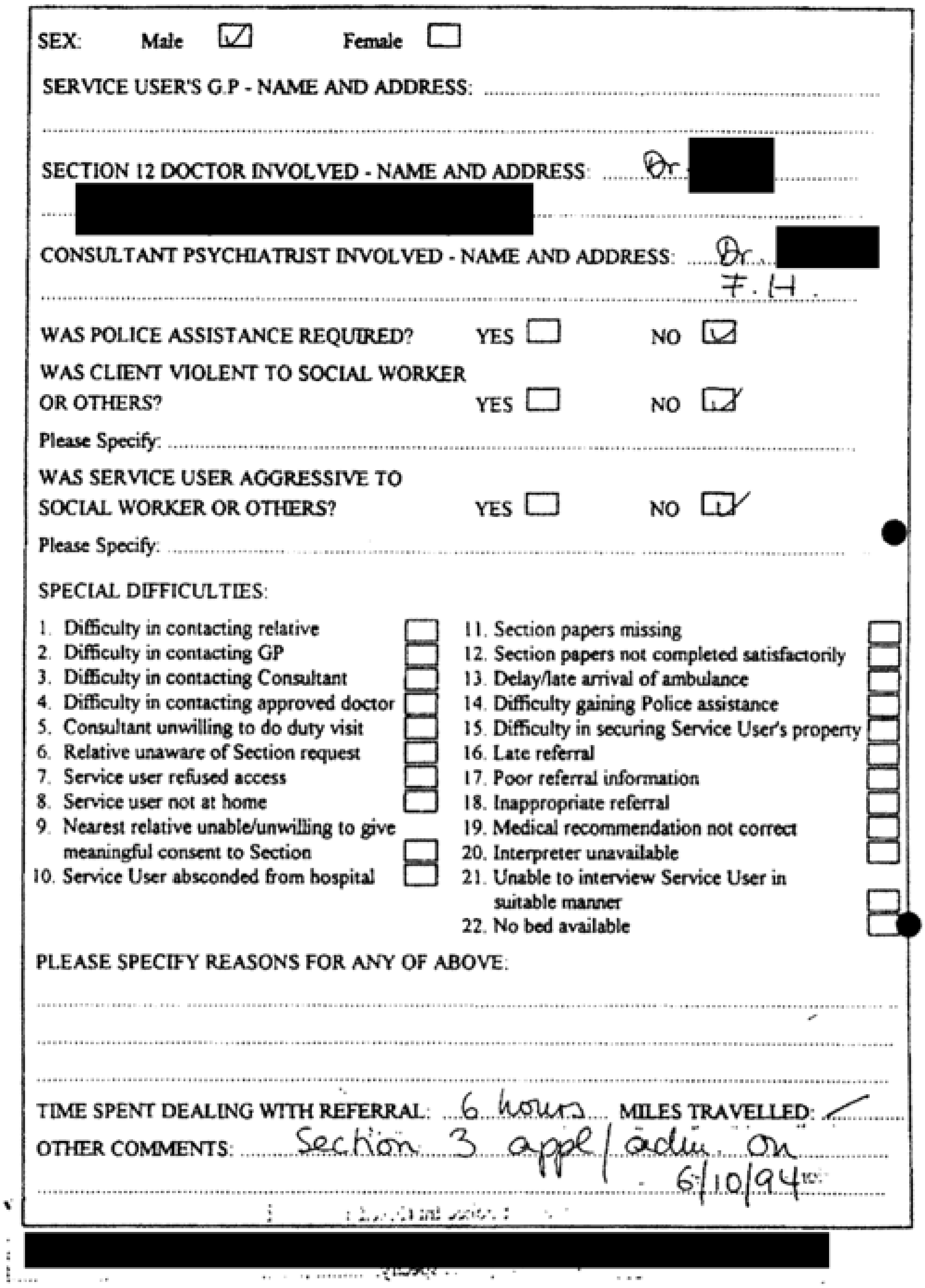
REASON FOR REFERRAL:

Assessment S.5(2)

→ " S.3

OUTCOME OF REFERRAL Section 3 completed.

Document 6.6.3. Approved Social Worker referral form, page 3.



SEX: Male ☑ Female ☐

SERVICE USER'S G.P - NAME AND ADDRESS:

SECTION 12 DOCTOR INVOLVED - NAME AND ADDRESS: Dr. [redacted]

[redacted]

CONSULTANT PSYCHIATRIST INVOLVED - NAME AND ADDRESS: Dr. [redacted]

F.H.

WAS POLICE ASSISTANCE REQUIRED? YES ☐ NO ☑

WAS CLIENT VIOLENT TO SOCIAL WORKER OR OTHERS? YES ☐ NO ☑

Please Specify:

WAS SERVICE USER AGGRESSIVE TO SOCIAL WORKER OR OTHERS? YES ☐ NO ☑

Please Specify:

SPECIAL DIFFICULTIES:

1. Difficulty in contacting relative ☐
2. Difficulty in contacting GP ☐
3. Difficulty in contacting Consultant ☐
4. Difficulty in contacting approved doctor ☐
5. Consultant unwilling to do duty visit ☐
6. Relative unaware of Section request ☐
7. Service user refused access ☐
8. Service user not at home ☐
9. Nearest relative unable/unwilling to give meaningful consent to Section ☐
10. Service User absconded from hospital ☐
11. Section papers missing ☐
12. Section papers not completed satisfactorily ☐
13. Delay/late arrival of ambulance ☐
14. Difficulty gaining Police assistance ☐
15. Difficulty in securing Service User's property ☐
16. Late referral ☐
17. Poor referral information ☐
18. Inappropriate referral ☐
19. Medical recommendation not correct ☐
20. Interpreter unavailable ☐
21. Unable to interview Service User in suitable manner ☐
22. No bed available ☐

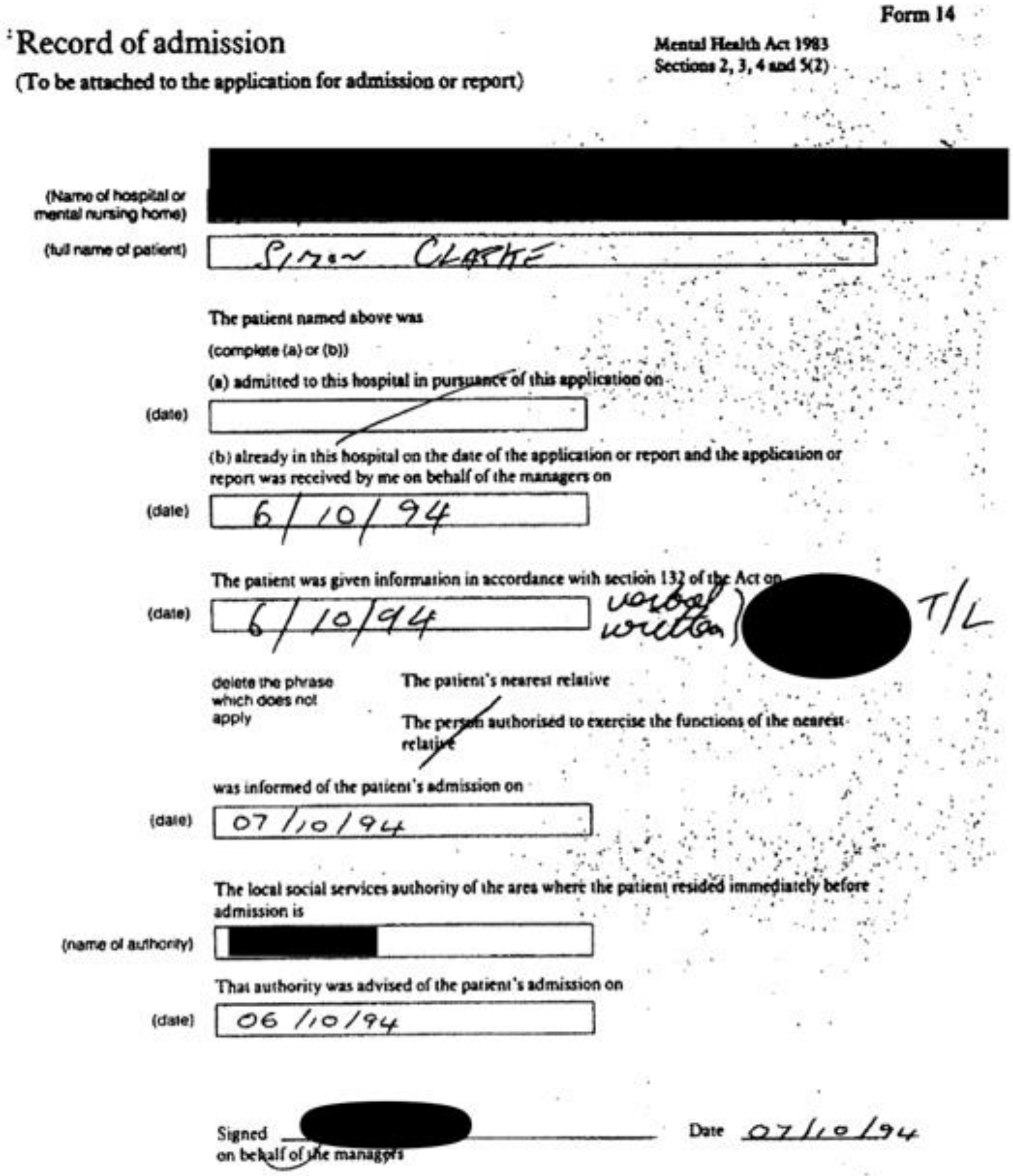
PLEASE SPECIFY REASONS FOR ANY OF ABOVE:

TIME SPENT DEALING WITH REFERRAL: 6 hours MILES TRAVELLED: /

OTHER COMMENTS: Section 3 appl/adm on 6/10/94

[redacted]

Document 6.7. Record of receipt of admission papers pertaining to Section 2 of the 1983 Mental Health Act.



Form 14

Record of admission

(To be attached to the application for admission or report)

Mental Health Act 1983
Sections 2, 3, 4 and 5(2)

(Name of hospital or mental nursing home) [redacted]

(full name of patient) Simon Clarke

The patient named above was

(complete (a) or (b))

~~(a) admitted to this hospital in pursuance of this application on~~

(date)

(b) already in this hospital on the date of the application or report and the application or report was received by me on behalf of the managers on

(date) 6/10/94

The patient was given information in accordance with section 132 of the Act on

(date) 6/10/94 verbal / written) [redacted] T/L

delete the phrase which does not apply

The patient's nearest relative

~~The person authorised to exercise the functions of the nearest relative~~

was informed of the patient's admission on

(date) 07/10/94

The local social services authority of the area where the patient resided immediately before admission is

(name of authority) [redacted]

That authority was advised of the patient's admission on

(date) 06/10/94

Signed [redacted]
on behalf of the managers

Date 07/10/94

Part 7. Leave

I was now under Section 3 of the 1983 Mental Health Act, but my mental state appeared to be improving. I was offered overnight leave for the first time, but this proved to be difficult as I struggled with the movement between ward and home life. A visit to my friend’s house further reinforced my sense of alienation and despair, especially when I realised they were unaware that I had been in hospital. At the end of this section, I tried to force my way off the ward and was forcibly secluded.

Part 7: Leave

Simon	Mother	Clinical Team	Reflection
You have been given leave for the first time. The world is now 'outside' and 'inside' - the hospital, and everywhere else. In the carpark, a woman takes a long lingering look at you, an expression of disgust on her face. On the way home in Dad's minibus Chris Tarrant on Capital Radio is laughing about how you are being framed by being linked with the National Front. When you get home, two neighbours are talking and laughing together. As you and Dad walk into the home they stop talking and watch you. You presume they are laughing at you. Hello Stranger! Says your friend's mum as she opens the door to let you in. Stan! She shouts. Stan! Simon's here! Send him up mum! Stan shouts in reply, with the usual irritation.	Oct Mon 17th – home good day.	17.10.94 Nursing 11:45 hrs. Simon was sleeping on his bed when I approached him – he says he only slept for 3-4 hours last night & the medication is sedating him heavily now. Conversation was fluent and involved equal interaction from Simon and myself. He intends asking Dr Furbois for weekend / overnight leave. Says his thoughts improved tremendously. "I used to think evil spirits were after me". He describes feeling initially relieved on admission as the distressing thoughts subsided. He seemed concerned that someone had mentioned a depot injection to him – he says he's worried about this and would prefer to take medication orally. 17.10.94 20.10 Nursing. Seen at the ward round appeared to cope well with the amount of people present and expressed himself	As the volume of documents between these sections indicate, the sectioning process is a substantial bureaucratic enterprise. The paperwork has to be signed off by three professionals, one Approved Social Worker (ASW) and two Section 12-approved doctors (usually psychiatrists), following a face-to-face assessment with the patient. The section applied for here was Section 3 under the MHA, which allows a patient to be held on a ward for at least 6 months. The process would have been conducted for the Section 5(2) and then repeated for the Section 3. That they did not apply for the shorter Section 2 (28 days) is perhaps a sign of their judgement to the severity of my symptoms. As my account indicates, not only was my immediate interpretation of 'section' very concrete and linked

Simon

When you get upstairs to Stan’s room, Stan is squatting by the window, as he usually does, smoking a reefer. Lenny is sitting by. They are listening to Pink Floyd. *We’re just two lost souls swimming in a fish bowl, year after year*. Hi Si! They both say, smiling profusely and throwing each other knowing glances. What you been up to? *Running over the same old ground. What have we found?* I’ve been in mental hospital, you reply. Their smiles freeze in their faces. *The same old fear*. Then the smiles melt, like wax, with expressions of shock, horror, and concern mingling together. *Wish you were here*. Shit, says Stan eventually. Fuck, Si, says Lenny after that. They look at you with a mixture of fear and pity. You try and make small talk with each other but it’s no use. After a short while you excuse yourself and leave. We all thought you’d found

Mother

Tue 18th – home 10am – 7pm

Wed. 19th – P. – slept 3hrs – P – slept 12 – 10 45

Thurs 20th – Stayed in room most of day – P – suspicious 10 – 7.30

Clinical Team

well. He can have weekend leave and can go out for escorted walks. Although Dr Furbois is aware that Simon feels drowsy he feels it would be wise to review medication next week. Dr Furbois will see Simon’s mother on Wednesday.

20\10\94 nursing 2015 Simons mother phoned. He had spent all day in his room on his bed still expressing paranoid ideas. Simon returned to the ward with his Father, appeared relaxed, said he hopes he is getting better but feels unsure.

N. report 21/10/94 Nursing 16.00 Message received from S/W Louise M. Simon mother rang Louise to reiterate that the Dad’s unable to cope presently with Simon at home. He “is very suspicious about letters coming into the home”. He has gone to his

Reflection

to my paranoia, the process felt like an almost endless round of interviews and questions by social workers, doctors, mental health advocates and nurses, asking the same questions and me giving the same (minimal) answers. Although the degree of bureaucratic checks and balances may be appropriate for a legal process that is perhaps more far-reaching in its removal of rights than any other UK legislation, the implications were lost to me at the time. It was just too overwhelming.

There is some indication of improvement: one nursing entry suggests that I had managed to get some distance from my paranoid ideas. However, on returning home for overnight leave for the first time, something clearly happened to throw me back off course. It may be that the appearance of improvement was

Simon

a woman, Stan tells you much later. We thought that’s why you’d disappeared.

Two of the patients in the ward like Pink Floyd and they are allowed to watch the concert live on TV. The concert you were supposed to go to, the only band you have ever really wanted to see. *When I was a child, I caught a fleeting glimpse. Out of the corner of my eye*. You can’t bear to watch it, so you go to your bed. *I turned to look but it was gone, I cannot put my finger on it now, the child is grown, the dream is gone*. They have turned the volume on the TV up full blast, so you can hear it, even though you have the pillow over your head to try and drown it out. *I have become comfortably numb*. You fucking wish.

Mother

Fri21 very agitated – Paranoia – slept often

Clinical Team

room, pulled the curtains and stayed in his room. His mother feels that he should come back to Woodbrook 1 in the morning and stay here till Monday’s ward round. But would like this message to be given by [illegible] following assessment tomorrow. They feel that he should not go the ‘Pink Floyd’ as it would be too stimulating. I have asked Louise relay the message that we are quite prepared for Simon to return for further assessment if things are difficult at home, as previously relayed to Mrs Clarke.

22/10/94 Nursing 2100. Phone call received from Simon’s mother. Simon had a good night sleep and was a lot brighter today. They felt that they could cope with him at home and he will return tomorrow between 17.00 hr and 1800 hrs. Simon was a lot less suspicious.

Reflection

a mere façade that crumbled easily when exposed to the realities. It could be that the visit with friends was too exposing, even humiliating. Whatever the reasons, the excerpt suggests that despite being located within the confines of the general hospital, the psychiatric hospital still retains the power to enforce a sense of separation. The boundaries may be structurally permeable, but less so psychologically for the patient.

Whilst the last section discussed the double-binds patients are often placed in with regards to discussing their ‘true’ symptoms with staff, another double-bind appears to be playing itself out with regards to the family. It is reported in the nursing notes that the family are unable to cope with me, yet this statement is revoked the next morning. I am reported as too ill to attend a Pink Floyd

Part 7: Leave

Simon	Mother	Clinical Team	Reflection
All of your time pacing up and down the corridor is trying to keep your thoughts together. Your consciousness is focussed on the white dot in from of you, which forms something of a cone. Your imagination is in overdrive trying to interpret what is happening, whilst these idiots hold you in here, oblivious. Reality is elsewhere, going on apart from you, being controlled by others around you, but you are left here, helpless. At times, the small, homeless old man walks with you on these corridor circuits. Don't worry Simon, he says, might never happen. Walk with me, he says. Just keep walking. Stops me from getting lost, he says.	SAT 22nd – slept late morning – slightly paranoia – went to football returned tired – depress slept – depressed – weary still slightly paranoia	Nursing 23/10/94 1700 Returned from leave. Phone message from his mother. Simon has been as usual sleeps till late morning. On arising is generally restless pacing the rooms and agitated. Very suspicious, eg. If mother is talking on the phone he would make arguments and also expressed paranoid ideas. Attended a football match when he felt uncomfortable being in a crowd and the urge to walk about → ? anxious / akathisia. He is according to his mother reluctant to take medication & mothers impression → poor compliance with oral medication on discharge. He went out on his own for 20 minutes today with the dog. No problems encountered. On return to the ward concerned that his paranoid ideas have not abated.	concert, yet a football match is deemed to be suitable. Presumably, the rationale for this was one of compliance and surveillance: I report less paranoia, so am rewarded with being able to stay; at the football match, I would be accompanied by my parents where, I assume, they could keep an eye on me. Reading my reflections now, I do wonder if this train of thought is slightly paranoid and is unfair on my parents. On this point, my mother's diary continues again after a silence of three entire weeks. When her last entry talked about her and my father's 'loss' and 'bereavement' of losing their son, it was almost as if the silence reflected that loss. However, in the interim her tone in the diary has changed: she is no longer expressing her own feelings or distress and pain. Indeed,

Part 7: Leave

Simon

You’ve been hanging around the door for days now, trying to make a go for it. Three nurses stand around you, far enough for personal space, near enough to make a grab. This has become almost a sort of game; you edge nearer, they roll their eyes and threaten the needle, you back off. You then edge nearer the door…and the whole processes repeats itself again. Today your mother left the ward in tears. One of the nurses says something as she leaves. You think it was “bitch”. This is a trigger. For the first time you get your arm in the door before the door is slammed shut on it. You grunt in pain. You are dragged back by three nurses. Two of them bend your wrists back on themselves, one on each side, and lead you up the corridor. The third holds your shoulders and guides from the back. You are forced down into a hunched

Mother

13th November
Last Two week Simon was put on Haliperodol as the weeks on Largactil had not worked plus he was on maximum dose. Ig daily.

He has been on haliperidol 2 weeks. Last week he was very agitated. When Dr Furbois saw him, he presented himself quite well and I don't think the Haliperidol was changed – the depot injection was brought forward though .

Clinical Team

29.10.94 Nursing 19.00 hrs.
Simon was visited by parents this afternoon. Shortly after they left simon tried to leave the ware, pushing past D/H/N Christina A as she allowed another patient to enter. Several nurses were needed to prevent Simon from leaving the ward, he would not/could not listen to reason & rational argument and was physically restrained using C & R techniques and taken to seclusion room 2 where he was given 100mg of chlorpromazine intra – muscularity. Seclusion commenced at 18:25hrs, bleep-holder, doctor, and next of kin informed.

Throughout “struggle” Simon was persistently resistant and it took a great deal of man-power and effort to restrain him; he looked incredible perplexed and seemed unable to comprehend why we are keeping

Reflection

the use of abbreviations such as ‘P’ for paranoia, the focus on medication changes, the reporting of symptoms with terms such as ‘depression’, make her diary read almost like medical notes. The frequent reporting in the clinical notes of conversations with my mother again suggest a constant stream of communication between the family and the ward, with my mother updating them continually on my symptoms and behaviour. It is almost as if the family had become an extension of the ward bi-proxy. This realisation makes me angry at my parents which, in turn, makes me feel guilty as my anger also feels unfair. It was a harrowing experience for me to read my mother’s diary, particularly the last section; it made me aware, in a very real way, the impact this time must have had on her and my father.

Simon

position as you are slowly shifted forward. Together, you look like an absurd crab shuffling along in a multi-layered human shell. You are screaming at them and they are shouting directions to each other across you. The shuffling human crab reaches the end of the corridor at the large wooden door view with the viewing portal and collapses in on itself on the blue vinyl mattress. The crab reconstitutes itself as a starfish, two arms spread wide and legs forced apart. Somehow the belt is whipped out and your trousers, off they come, and pants are pulled down. The only part of you that can move under their combined weight is your naked arse. At least one of them is laughing as it thrusts up and down, dry humping the mattress. The arse is quickly put out of its misery by the needle. Sensation is sucked up to the skull and the blood rush is red

Mother

This week he is not so agitated, more aware, but only of his paranoia Which seems to overwhelming him and he is unable to be distracted.

Clinical Team

him here – he did not seem particularly sensitive to restraint techniques and fought and fought incessantly.
Relevant documentation completed.

29-10-94 19.55hrs Nursing Seclusion terminated at 19.55hrs. Simon seems calmer. Dr Murgha contacted & asked to examine Simon. Mrs Clarke now informed that Simon is now out of seclusion.
Remains on close observation.
BP – 130/90 mmlg, pulse 84.6 bpm

29/10/94 No evidence of any injury or bruising. Dr Murgha

Nursing 12.11.94 20.45 CP (4). Simon returned from time out. His mother said he'd spent the time worrying about returning and that he was expressing paranoid

Reflection

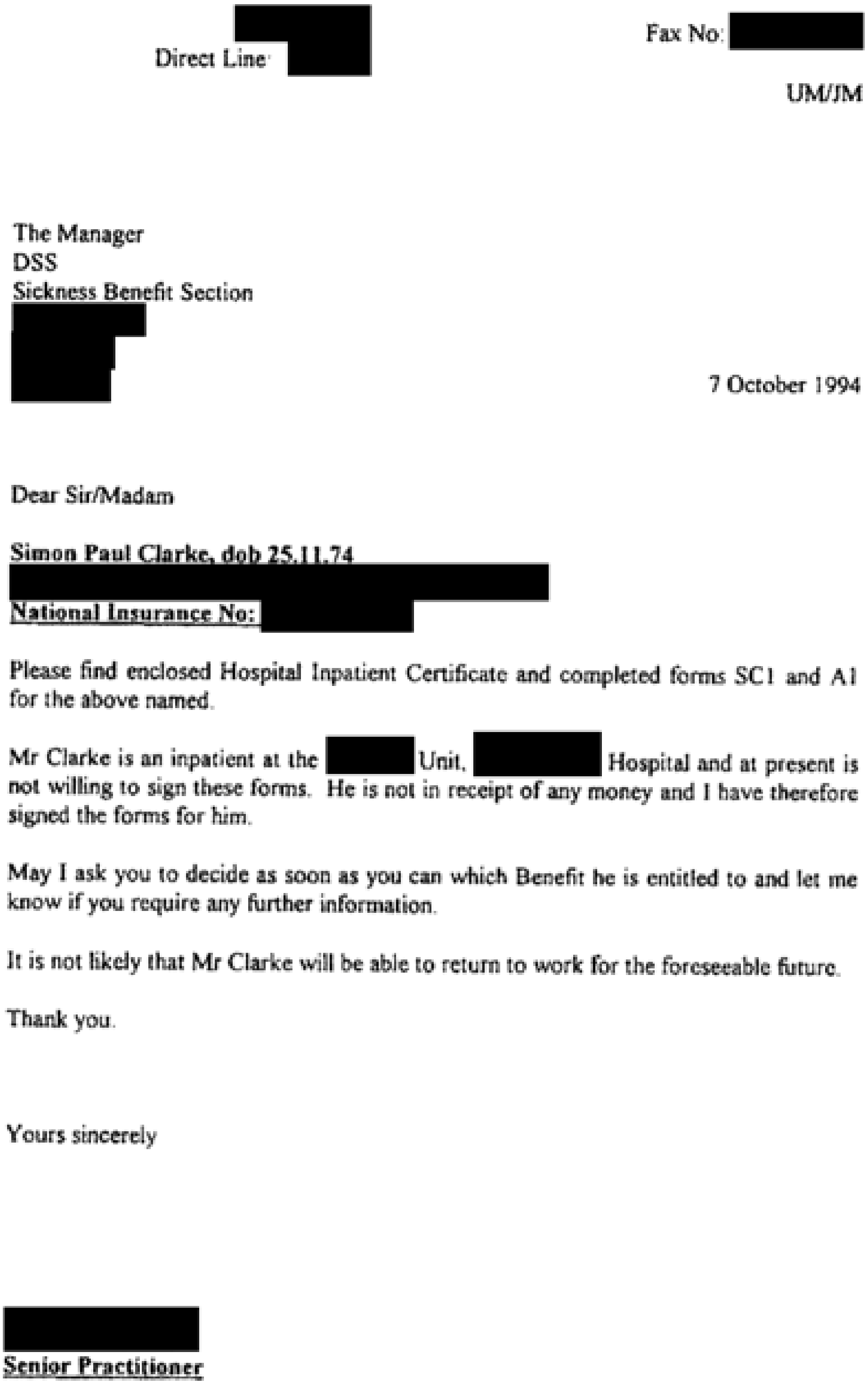
Despite this, I cannot see how their behaviour here would have helped. Going home was supposed to be a return to normality and familiarity, a chance to return to life outside the ward, and yet there are constant reminders of its reality and presence. It is almost as if the world of the ward had now finally instituted itself in the everyday world of my home-life. The consequences of this, psychologically, would be the internalisation of the culture of fear and the sense of always being watched. It is hard to see how any effect other than increased paranoia and fear would be possible.

The part concludes with seclusion. It is harrowing for me to read now. I wonder how harrowing it must have been for the staff. I cannot imagine they would have enjoyed

Part 7

Simon	Mother	Clinical Team	Reflection
haze swimming in your eyes. The nurses slip away quickly and the door slams abruptly. You rise quickly but sluggishly through the mist. Their faces are laughing at you through the narrow slit of a window. I just want my cigarettes; just give me my fucking cigarettes, you shout. Then the medication hits you with a head rush. You crumple slowly into the mattress.	4 Simon Clarkes. Coming for me to-night. Patients think we are snobs. Staff “ “ “ “ Broken into bank account. Everyone knows of me and hates me. Patients/Staff read my mind – incriminate me.	ideas. Simon has followed me around since his return asking for overnight leave. He will not accept my answer. He believes that that tonight the patients are going to kill him he wanted me to let him home so he had a quiet death rather than be “torn apart”. No words reassure him, he’s convinced it is going to happen. He is tense, pre-occupied. Given chlorpromazine 100 mg at 19.40 with no effect. Continues on close observation.	doing this. The nursing notes also indicate sound clinical practice: the relevant documentation is in place; the doctor’s examination is requested for, and completed, immediately; the family are informed; and all of these actions are recorded in the progress notes. However, the bureaucratic documentation does not record the incidental factors such as the nurses laughing. The patient’s experience is silent in the medical notes. Whilst some details of practice could be disputed, such as whether the whole buttock was exposed and whether the staff actually mocked me, and a more benign interpretation favoured (e.g., laughing as stress-release) it probably says something about the traumatic nature of such an experience that this is how it was remembered.
	Came home Saturday . 12 – 5.30. Unable to settle walking about, voicing usual fears . Did not sleep	13/Nov/94 Nursing 0615 Simon still harbours the thought that the nurses and patients are about to harm him. Appears very much like a “frightened” man. Took his medication with some persuasion. Slept well throughout the night. Close observation maintained.	

Document 7.1. Letter from social worker to Department of Social Security regarding sickness benefits.



Direct Line [redacted]

Fax No: [redacted]

UM/JM

The Manager
DSS
Sickness Benefit Section
[redacted]

7 October 1994

Dear Sir/Madam

Simon Paul Clarke, dob 25.11.74
[redacted]
National Insurance No: [redacted]

Please find enclosed Hospital Inpatient Certificate and completed forms SC1 and A1 for the above named.

Mr Clarke is an inpatient at the [redacted] Unit, [redacted] Hospital and at present is not willing to sign these forms. He is not in receipt of any money and I have therefore signed the forms for him.

May I ask you to decide as soon as you can which Benefit he is entitled to and let me know if you require any further information.

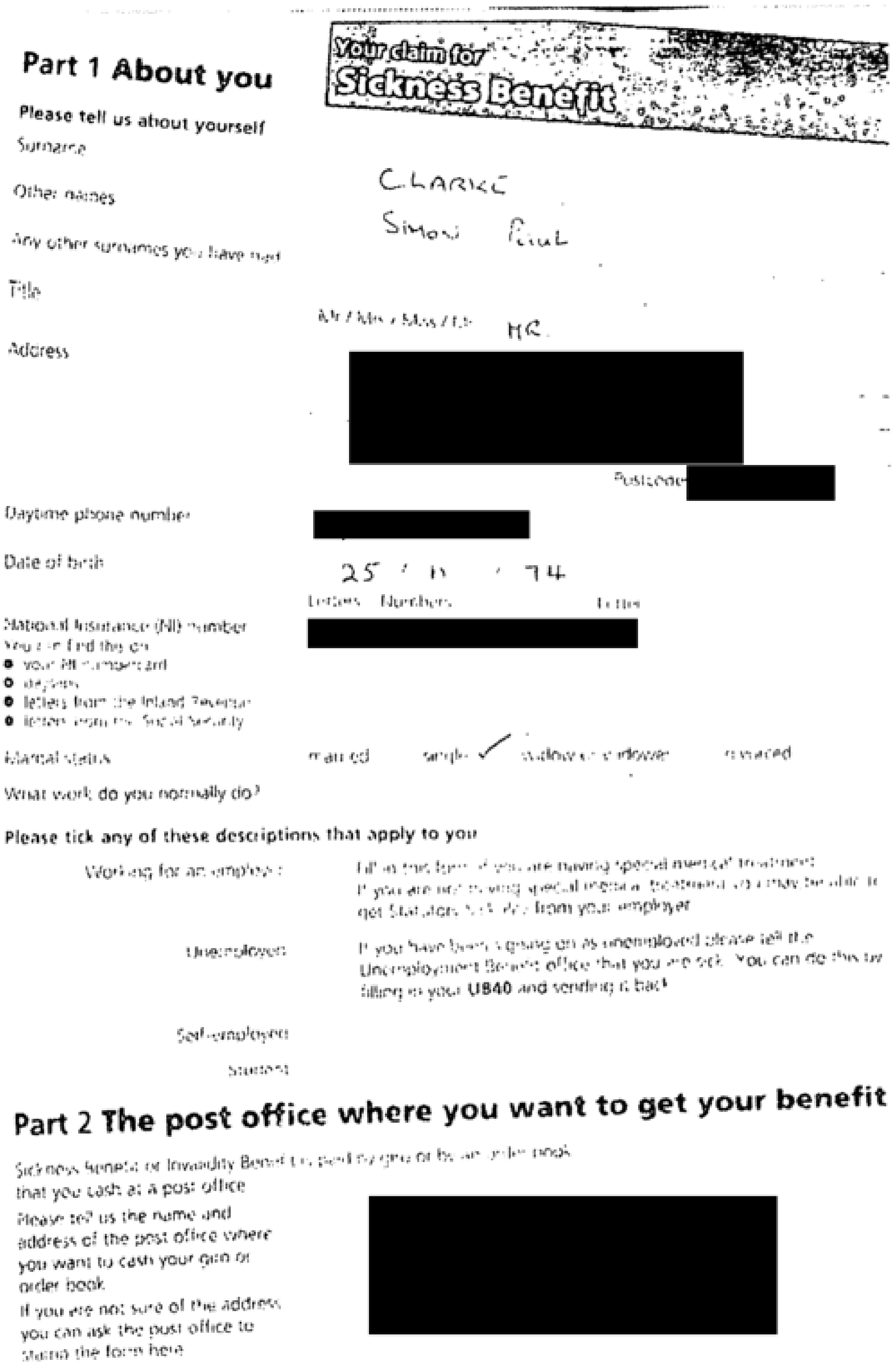
It is not likely that Mr Clarke will be able to return to work for the foreseeable future.

Thank you.

Yours sincerely

[redacted]
Senior Practitioner

Document 7.2. First page of sickness benefit forms.



Your claim for Sickness Benefit

Part 1 About you

Please tell us about yourself

Surname: CLARKE

Other names: SIMON PAUL

Any other surnames you have had

Title: Mr / Mrs / Miss / Ms MR.

Address: [redacted]

Postcode [redacted]

Daytime phone number [redacted]

Date of birth 25 / 11 / 74

National Insurance (NI) number
You can find this on
- your NI number card
- payslips
- letters from the Inland Revenue
- letters from the Social Security

Letters Numbers Letter
[redacted]

Marital status: married [single ✓] widow or widower divorced

What work do you normally do?

Please tick any of these descriptions that apply to you

Working for an employer	Fill in this form if you are having special medical treatment. If you are not having special medical treatment you may be able to get Statutory Sick Pay from your employer
Unemployed	If you have been signing on as unemployed please tell the Unemployment Benefit office that you are sick. You can do this by filling in your **UB40** and sending it back
Self-employed	
Student	

Part 2 The post office where you want to get your benefit

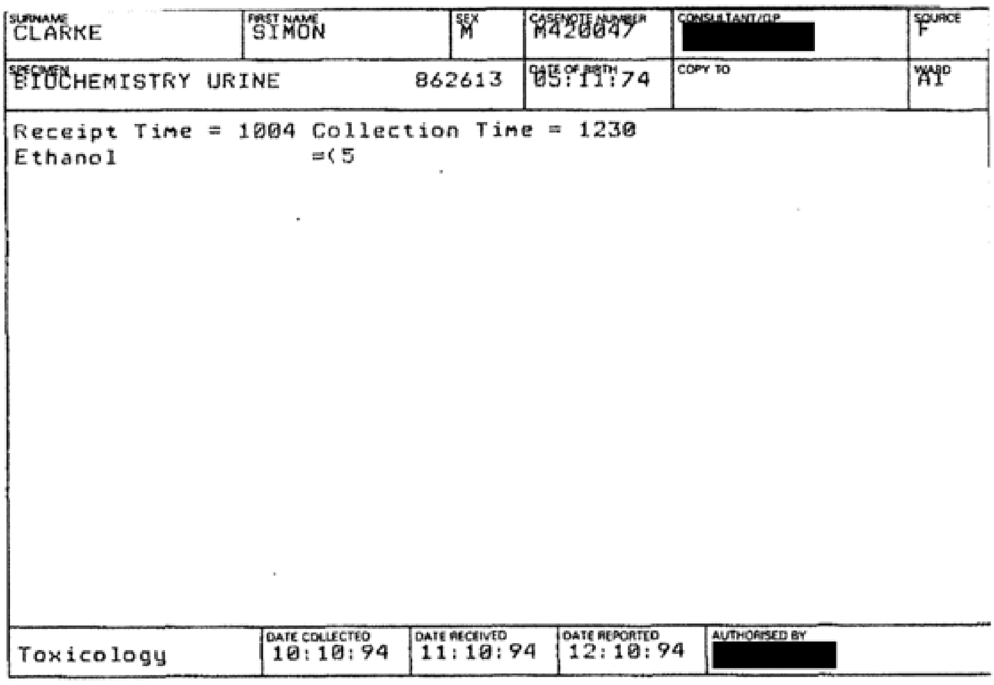
Sickness Benefit or Invalidity Benefit is paid by giro or by an order book that you cash at a post office

Please tell us the name and address of the post office where you want to cash your giro or order book.

If you are not sure of the address you can ask the post office to stamp the form here

[redacted]

Document 7.3. Results of urine test for toxicology report, page 1.

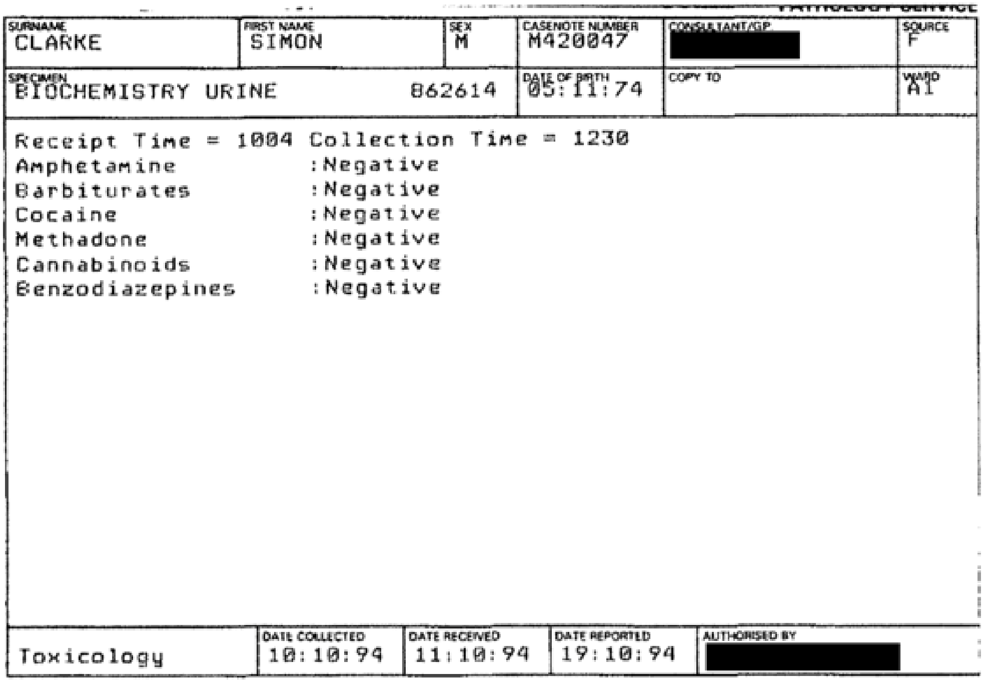


SURNAME CLARKE	FIRST NAME SIMON	SEX M	CASENOTE NUMBER M420047	CONSULTANT/GP [redacted]	SOURCE F
SPECIMEN BIOCHEMISTRY URINE 862613			DATE OF BIRTH 05:11:74	COPY TO	WARD A1

```
Receipt Time = 1004 Collection Time = 1230
Ethanol              =<5
```

Toxicology	DATE COLLECTED 10:10:94	DATE RECEIVED 11:10:94	DATE REPORTED 12:10:94	AUTHORISED BY [redacted]

Document 7.4. Results of urine test for toxicology report, page 2.

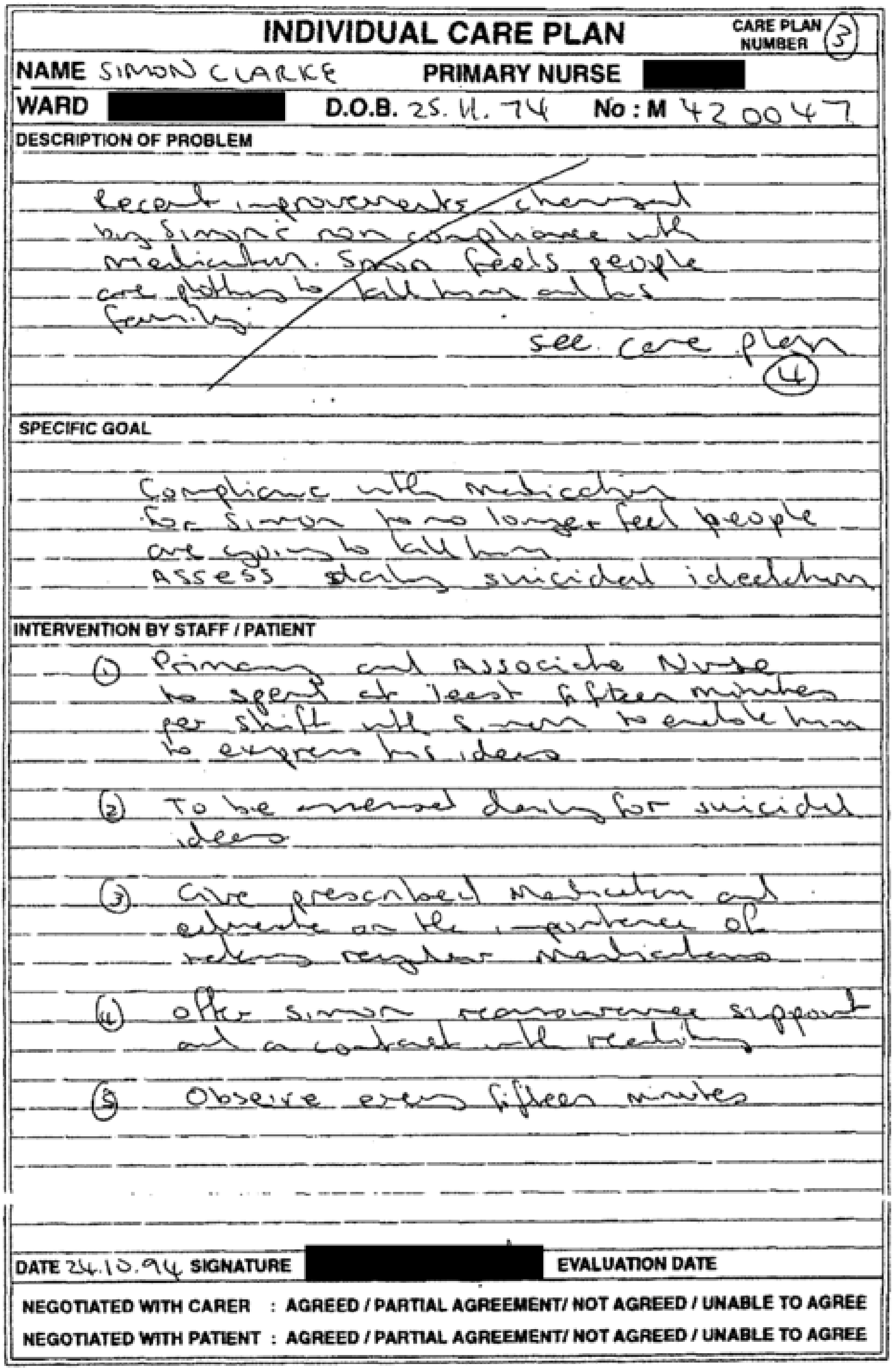


SURNAME CLARKE	FIRST NAME SIMON	SEX M	CASENOTE NUMBER M420047	CONSULTANT/GP [redacted]	SOURCE F
SPECIMEN BIOCHEMISTRY URINE 862614			DATE OF BIRTH 05:11:74	COPY TO	WARD A1

```
Receipt Time = 1004 Collection Time = 1230
Amphetamine          :Negative
Barbiturates         :Negative
Cocaine              :Negative
Methadone            :Negative
Cannabinoids         :Negative
Benzodiazepines      :Negative
```

Toxicology	DATE COLLECTED 10:10:94	DATE RECEIVED 11:10:94	DATE REPORTED 19:10:94	AUTHORISED BY [redacted]

Document 7.5. Patient individual care plan.



INDIVIDUAL CARE PLAN **CARE PLAN NUMBER** ③

NAME SIMON CLARKE **PRIMARY NURSE** [redacted]

WARD [redacted] **D.O.B.** 25. 11. 74 **No : M** 420047

DESCRIPTION OF PROBLEM

~~Recent improvements thwarted by Simon's non compliance with medication. Simon feels people are plotting to kill him and his family.~~

see care plan ④

SPECIFIC GOAL

Compliance with medication
for Simon to no longer feel people are going to kill him
ASSESS daily suicidal ideation

INTERVENTION BY STAFF / PATIENT

① Primary and Associate Nurse to spend at least fifteen minutes per shift with Simon to enable him to express his ideas

② To be assessed daily for suicidal ideas

③ Give prescribed medication and educate on the importance of taking regular medications

④ offer Simon reassurance support and a contact with reality

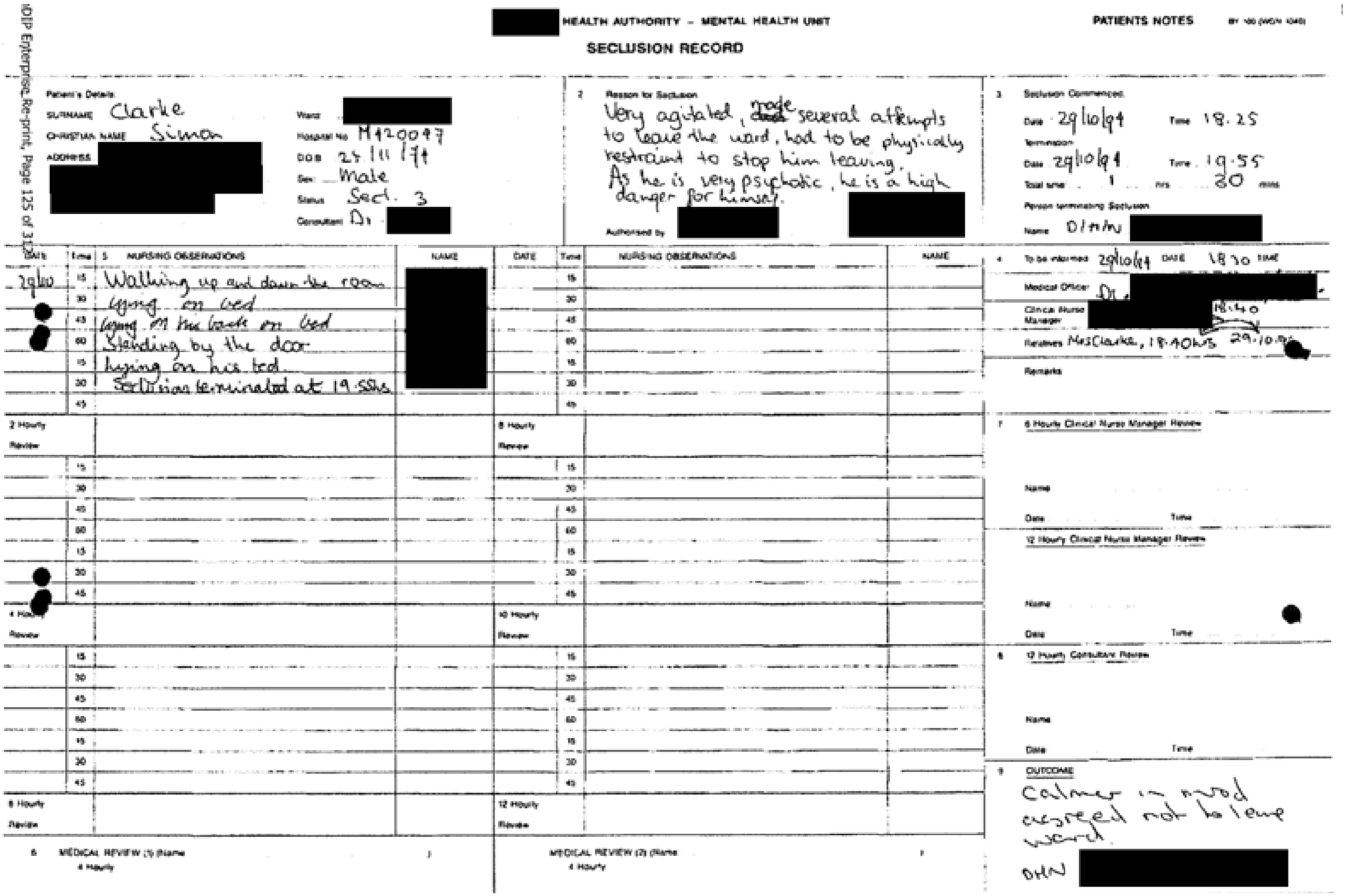
⑤ Observe every fifteen minutes

DATE 24.10.94 **SIGNATURE** [redacted] **EVALUATION DATE**

NEGOTIATED WITH CARER : AGREED / PARTIAL AGREEMENT/ NOT AGREED / UNABLE TO AGREE

NEGOTIATED WITH PATIENT : AGREED / PARTIAL AGREEMENT/ NOT AGREED / UNABLE TO AGREE

Document 7.6. Seclusion record form.



IDIP Enterprise Re-print, Page 125 of 312

[redacted] HEALTH AUTHORITY – MENTAL HEALTH UNIT

PATIENTS NOTES

SECLUSION RECORD

Patient's Details
SURNAME Clarke
CHRISTIAN NAME Simon
ADDRESS [redacted]
Ward: [redacted]
Hospital No M420047
DOB 24/11/74
Sex: Male
Status Sect. 3
Consultant Dr [redacted]

2 Reason for Seclusion
Very agitated, made several attempts to leave the ward, had to be physically restraint to stop him leaving.
As he is very psychotic, he is a high danger for himself.
Authorised by [redacted] [redacted]

3 Seclusion Commenced
Date 29/10/94 Time 18.25
Termination
Date 29/10/94 Time 19.55
Total time 1 hrs 30 mins
Person terminating Seclusion
Name D/n/n [redacted]

4 To be informed 29/10/94 DATE 18.30 TIME
Medical Officer Dr [redacted]
Clinical Nurse Manager [redacted] 18.40
Relatives Mrs Clarke, 18.40hrs 29.10.94
Remarks

DATE	Time	5 NURSING OBSERVATIONS	NAME	DATE	Time	NURSING OBSERVATIONS	NAME
29/10	15	Walking up and down the room	[redacted]		15		
	30	Lying on bed			30		
	45	Lying on his back on bed			45		
	60	Standing by the door			60		
	15	Lying on his bed.			15		
	30	Seclusion terminated at 19.55hrs			30		
	45				45		
2 Hourly Review				8 Hourly Review			
	15				15		
	30				30		
	45				45		
	60				60		
	15				15		
	30				30		
	45				45		
4 Hourly Review				10 Hourly Review			
	15				15		
	30				30		
	45				45		
	60				60		
	15				15		
	30				30		
	45				45		
6 Hourly Review				12 Hourly Review			

6 MEDICAL REVIEW (1) (Name)
4 Hourly

MEDICAL REVIEW (2) (Name)
4 Hourly

7 6 Hourly Clinical Nurse Manager Review
Name
Date Time

12 Hourly Clinical Nurse Manager Review
Name
Date Time

8 12 Hourly Consultant Review
Name
Date Time

9 OUTCOME
Calmer in mood
agreed not to leave
ward.
DHN [redacted]

Part 8. Electroconvulsive Therapy (ECT)

ECT is suggested by the doctors as there appeared to be little signs of improvement. Despite giving consent to the treatment, I interpreted the process according to a very different framework of understanding than the psychiatric team. I appeared to find the process of ECT traumatic, but show some signs of improvement following its delivery. However, it is ambiguous to what degree I was ‘playing the game’ to get discharged. My mother was pleased with my apparent progress, although she also observed that I seemed to be quite depressed. The clinical team also commented on this low mood, although it is interpreted as signs of ‘insight’. I was given more overnight leave from the ward, although some paranoia remained. Towards the end of this part of the narrative, discharge was raised by the psychiatric team for the first time.

Part 8: ECT

Simon

Another piece of paper; something else to sign. ECT they tell you. We need your consent. Do you have a choice? I mean, really have a choice?

This is part of the plan. The final act. They will cement your brain so you will never be able to access the spiritual world (their world) again.

What if you don't sign? Two seconds and a sigh. You sign. Crushing shame, despair. Terror. What if you didn't sign? Why did you sign?

How does it work? Well, no one really knows for sure, says the nurse. But it's like the wires in your brain have got crossed, and what ECT does is uncross them for you. While explaining this she crosses and uncrosses the index fingers of her right and left hand,

Mother

15th Nov – Simon yesterday was asked by Dr Furbois if would have ECT treatment. Drugs change.
Trimipramine 150ml
Depixol 40 mg weeks.
Chlorpromazine prn.

Simon said he would not have it as he was not ill. He seemed very tense and I would not take him out for a walk due to his intensity and I was on my own.

Paranoia seems to obsess him and he was unable to think of anything else.

17th Nov. Simon didn't have ECT as staff wanted Dr Furbois signature on form and he was not available. Although Simon had signed the form last night he was, they said, still undecided this morning.

Clinical Team

14/11/94 15.45 Dr Fubois WR
Patient is seen :- not too good, still worried about his safety, people want to harm him, made poor eye contact, restrict in his answers, with a flat mood, believes he will be sent to prison. Denies hallucinations. His brain is dead. Cannot read, delusions of reference from radio. Still suicidal risk wishes he could die, life is useless. Simon is apparently deteriorated.

To be seen next W/R
To stop clopixol and give risperidone
Dopixol 400 mg weekly.
offered a ECT treatment, subject to negotiation?

16/11/94 Discussed with father and patient about ECT treatment. Patient agrees to have ECT.
Consent √
ECT prescription √

Reflection

This was by the far hardest section to write about, for many reasons. To begin with, there is the sheer emotional impact that reading these sections has on me, even now. ECT is an emotive issue in mental health, but here a variety of emotions suddenly come to the forefront, especially in my account and my mother's diary. For me, ECT was probably one of the most traumatic elements of my experience on the ward and occurred the day before my 20th birthday. As I hope my account shows, it was a very frightening experience to be subjected to. I felt like I was being forced, or at least coerced, into having this treatment. I did not, at the time, believe it made much difference.

As my mother's account suggests, my parents did not have the same view as me. I am now wearing my

Part 8: ECT

Simon

to helpfully illustrate. It's like naked finger-puppets doing a little jig.

One small act of rebellion. You drink water the night before. Brief respite. Relief, however fleeing.

First time, early morning upon waking. No chance to drink water the night before. No escape. The anxiety is ever-present. No breakfast or morning tea; not this time.

You are escorted, politely but firmly, by the nurse you know to the corridor at the back of the ward, which has always been closed. Now, it is open. You walk into the room. Three nurses you don't know. One of them is very friendly. Your escort chats with the other nurses and leaves with a quick nod to you. Good luck, she says with a smile.

Mother

James & I took him for a long walk. We went out at 3pm so that he could get some sunshine.

Paranoia intense.

1) Patients had taken his back door key and got into information on our bank and we were ruined. This had happened on Woodbrook 2.
2) Whole world knows about him, through television.
3) People/patients read his thoughts.
4) Staff want to get rid of him because he's too much trouble.
5) "We're finished"?
6) His life is over.
7) Every time someone walks by he thinks they know him, says everyone in the hospital knows him.

25.11.94 Simon had ECT Thursday (24th). When elle & I

Clinical Team

21.11.94 Nurses 13.20. CP Ψ Simon has not been talking of his persecuted ideas all he talks about is going home or going out for an hour or going out on his own. He doesn't listen when told it is not possible. He was for ECT but he told me he drunk some water discussed with anaesthetist ECT considered now asking seen by Dr Sheik see clinical note continues on close observation

0900 BP 140/90. Temp 37. Pulse 76

24.11.94 Had 1st ECT
good Bilateral contraction
lasted 24 secs

Nursing 24.11.94 13.00. Simon up early and restless and anxious before going for E.C.T. treatment Went ahead with no problems Tearful & anxious immediately after treatment on return to ward

Reflection

glasses and seem to be getting better. Reading this now, it disturbs me: it seems paradoxical that something that has always been associated with disability and shame is described as a positive indicator of 'being himself'. My parents' attribution of ECT being the harbinger of change is also supported by the nursing notes. Aside from some very strange language, where I am described as having a 'good fit' and 'specialled' (sic), there are several accounts of me stating that I found ECT helpful and was happy with it. This is, of course, contradicted by my account and what I recall, but perhaps does illuminate the divergence of reporting on the use of this treatment, as well as the unreliability and potentially changeable nature of memory and subjectivity. Reading this section now, I am just simply

Part 8: ECT

Simon

The table, with the machine at the head that looks like a large, CB transistor radio.
The same two student nurses from your first ward room are sitting on the bed at the back of the room, the hospital curtain partly drawn.
It’s showtime.
One of them shakes her head.
Sad, she says.

You are gently laid down on the bed, head just below the CB.
You put up no resistance.
You try to focus on the white ceiling as the disembodied faces of the nurses hover over you.
They explain what will happen, but you don't take it in.
You are anxious and struggling to breathe.
Are you ready?
You nod slightly, your head now held by the light restraints.
You will feel a scratch on your

Mother

saw him later he was wearing his glasses!! He was alert and seemed hyperactive.

We met Dr Sheik Simon asked him if he could go home & stay to night but was told he had to take things slowly. ellie and I went for a walk with him, we were waiting for Lush & Sean. He spoke to quite a few people when out including the chaplain. He still had paranoia though but not so bad & persistent We had to go back for some panadol for his headache.

We left at 1pm as it didn't look as if they were coming. He went in quite happily. Lush phoned later (they were late) they had a good visit with Simon showing no signs of paranoia.

When I picked him up at 11:45am on his birthday he had just woken up. We came home

Clinical Team

has appeared quite settled. Says “I feel better, when can I go home”. Simon “specialled’ whilst awake before going for e.c.T looks forward to parents visiting this P.M. N/B [illegible]

24.11.94 I spoke with Simon this afternoon. Objective and subjectively he is a lot better not depressed. He denied of having paranoid delusions and hallucinating. He is happy with ECT.

28/11/94 Night report 0615. Has been slightly restless. Still appears suspicious. Kept asking whether he “was in trouble”. Needed much reassurance. Referred to bed up to midnight. Has slept well. NBM from midnight. For ECT morning.

Nursing. 28.11.94. 12.00. CP4 Simon was given ECT treatment

Reflection

overwhelmed with the volume of information and the degree of disagreement between the main accounts. There is so much I want to pull out and ask questions of from the text. For example, when was ECT cited as necessary? Why was ECT used here and had the medical team really tried everything else? To what degree could the change be attributed to ECT, or my willingness to start playing at being sane again? To what degree do the pressures of needing to find a bed and get me out of hospital influence over-optimistic staff reports of my progress? My paranoia is still clearly present and is reported on by both my mother and the staff consistently. So, what has changed now to warrant consideration of my discharge? Why is discharge discussed now, when any progress surely would have been tentative, provisional?

Simon

hand, says the nice nurse.
You do. It hurts.

That’s it they say. You can go now.
But nothing happened, you say.
They laugh. It’s over, finished.
That’s all it is.
You leave the room, bemused, rubbing your neck for some reason.
Was this a charade?
Some elaborate game?
All part of the plan?
Are they taking the piss again?

You remember the film you saw recently, David Bowie in *The Man Who Fell to Earth*. Bowie is playing an alien and is on a table surrounded by medical staff, conducting tests on him. They notice he has contact lenses in his eyes, which he wears as part of his human disguise. He tries to take the contacts out himself, but

Mother

he had a shower, dressed up, and we had a meal at the Warren with Mum & James.

No signs of paranoia when he came back home, watched omnibus edition of Pink Floyd. Although he had some paranoia, it was slight & not lasting. Needed constant reassuring that he would get home soon. Took back with him a book, poster for his wall & table lamp. Hopefully this is the start of recovery.

29.11.94 Simon had his 2nd ECT Monday. He’s so much improved. The depression seems to have left him. Dr Furbois told him he can go home this weekend and start going out on his own. He went over the common today, there’s still some paranoid, he said something funny is still going on. Some boys on the common pointed to him and laughed.

Clinical Team

this morning his fit lasted 22 secs. he made a good recovery. Simon remains pleasant and cooperative he has no suicidal thoughts at the moment At times he thought that people were after him, but after his treatment the thoughts started to subside at bit. Simon feels about having ECT and his main concern is about being discharged home and how much longer he has to be in here, he is hoping once he is discharged to go back to his old job [illegible]. At times he looked preoccupied and he complained of being bored. Most of his time he wandered the corridors smoking. Has taken a good [illegible] and in complaint with medication.

28-11-94 Objectively and subjectively Simon is not depressed. He still has paranoid delusion > but no hallucinations, “something might happen to me”

Reflection

Taking all of these considerations together, the problem is not necessarily that ECT does not ‘work’ (whatever that means). It is hard for me to deny that ECT must have played some role in me getting out of hospital. Even if I was performing sanity in order to get out of hospital, something must have changed for me to see this strategy as a viable one. I do not any longer seem consumed with the paranoia and, possibly for the first time, I interact with patients in something resembling normality. There are even examples from staff and my mother where I report feeling happy. Of course, I say ‘recovery’ here, but of course this is a loaded term, for what does ‘recovery’ really mean in this context? The crux of my thoughts on ECT are, therefore, if there is a cure then it comes at a dreadful cost, and this cost was not obviously apparent

Simon

the medical staff lose patience. I want to go home. Yes, yes, of course, says the doctor, bored and irritated. I want to go home. Very soon now, intones the doctor as they manoeuvre him to the X-ray machine. Please, please, don’t do it – you don't understand. They strap him to the machine anyway. There is a sharp, metallic click. Blue shock. Scream. The X-ray causes the contact lenses to permanently affix themselves to his eyes. Grinning, vacant smiles of the medical team. They’re stuck, says the Bowie-alien, incredulous. They’re stuck. I’ll never get them off. More smiles from the medical team; their vacancy is non-negotiable. His head falls onto chest, crestfallen. He cries.

You come back to the ward. Your head is fuzzy. Dazed, and confused. Other patients swim in

Mother

I also told him that the week before he last he thought the house was bugged and he replied ‘I think it is’.

He told me he thought at one time that Wendy was taken to the hospital, killed and served up for dinner. ‘They’ made James become a rent boy and sent me off to Holland to sit the ‘window’.

He keeps asking ‘how long will it be before I’m discharged’ but he’s definitely more settled and happier.

He was disturbed to find that Dr Sheik had written on his v. Ray form “paranoid schizophrenia’. Penfold said he will look into it for him.

2.12.94 - Took Simon out after his 3rd ECT. He was very happy. Said he felt good about himself.

Clinical Team

He is socializing with the patients also liked to watch T.V, although his concentration is still partially impaired. He complained of backache from a previous accident, 4 months ago and wants an x-ray to be done.

NURSING. 29.11.94. Continues to improve, absent of delusional ideas even though probed and confronted. Now realises that he has been mentally ill and accepts that he may fall ill again if he does not continue with the medication and uses cannabis and excessive cannabis. Allowed out unescorted. No problems encountered.

30.11.94 OCC. THERAPY. Seen, OT programme discussed, Simon will start next week. Says feels agitated/restless and has difficulty concentrating. Feels much better in himself since starting ECT but did ask if he would ever get

Reflection

at the time. However, it left its mark. For many years afterwards, I would have nightmares about being forced onto a table and subjected to various forms of electrical torture. Sometimes I would even wake up screaming.

Elsewhere, my account suggests that being subjected to ECT has emotional, psychological and even spiritual consequences of somehow being closed down or separated from something vital. I think it is very hard to put into words the experience of having something like ECT and afterwards feeling like something has been taken. It is interesting that the staff report me crying after one of the sessions. Why would I cry? What sort of treatment makes people cry afterwards for no apparent reason? Is the short-term benefit of a reduction in some symptoms worth the trauma

Simon

and out of focus on the bright, white-washed ward. Something has gone. Was it valuable? Barry, the elderly patient, hunched and grunting, beard and dreads now shaved, has put drawings up on the wall. This one catches your attention: a picture of a blue amorphous blob with the barely legible scrawl underneath, “you are that drop of rain that falls on good earth and is gone forever”. That’s you, that is. You cry.

The next time is not so quick. Same scenario, different people. Same shit, different toilet, comments another patient waiting in line.
Only this time it is not over with a click.

After the scratch, you feel yourself descend in and out of consciousness, like a camera lens trying to focus. The hysterical

Mother

Richard took him out later but the visit was not so good, he wanted to get back to the ward quickly to feel safe. He had been up to Woodbrook 2 to see Bobby and he saw Nathan who bothered him. We told Jenny later. She said it was because he was not happy on Woodbrook 2 & it brought back bad memories.

Picked him up to come home for the night. He was disappointed it was not 2. We had an argument in the car. He does not want us to crowd him, and will [illegible] be strict with him when he’s home. He was angry that we had phoned and told staff how he was yesterday.

Said that the medication was useless, made him worse, and that he didn't need it. Other patients had come off it and were better. Said he wasn't going to spend rest of his life on

Clinical Team

completely’ better.
J. Mon Student

Nursing. 1.12.94 13.00. Simon had 3rd E.C.T. treatment this am. good fit and recovery. continued to ask “am I in trouble”, able to rationalise this and says “it’s the tail end of my paranoia”. Simon says he does not want any more E.C.T treatment N/R [illegible]

2\12\94 nursing. 1300. Simon hoping to go for two nights over-night leave it was felt by nursing staff that it was too soon + one night would be more useful to assess Simons mental state. He has now gone on overnight leave, to return Saturday evening. TTO’s supplied.

5/12/94. Simon seemed happy & relaxed. He complained of having paranoid ideation, “someone might take his money from bank

Reflection

experienced for many years after?

This latter issue also, I think, brings up the role of consent and how meaningful it was to discuss consent to somehow like myself, in this state. I am impressed with how the notes frequently report attempts to engage me in decision-making and there is even one account of not proceeding with treatment because the consultant psychiatrist has not signed off on it. From a procedural perspective at least, the approach of the nurses appears to be sound. However, I was clearly ambivalent about receiving ECT and my mother reports me becoming very angry after one session. I think these examples highlight something very real that was missed in the bureaucratic entries of the clinical notes. That is, I did not feel like I had any choice and that any choice was

Simon

beeping of the machine changing pitch and tempo with the camera lens. When does this stop?

Things seem different. You are more aware and yet more foggy. Clarity has been gained at the price of something else, which you can't quite identify.

For the first time, you join in the conversation with other people, this time the cleaner and another patient. You are shocked to find they don't hate you. You ask them, but don't you hate me? O no, they say, you’re far too nice. But what about the money? They laugh, that’s your paranoia. Really? You get an inkling that you may have actually been wrong, or what it means to start playing at being sane.

You’ve become friends with the patient, a young mother in her

Mother

medication.

Simon came about 11am. He went to the Green Man at Forest Grove. He said he had 2 ½ pints. Asked how he got on, he said that the pub got very crowded and he got paranoid.

He couldn't sit still when he was at home.

Worried about our money. Ranspal, and still thought something funny was going on.

Found out later that he had two ‘puffs’ How disappointing that he has such a lack of control and insight into his condition. Especially after being told specifically by Penfold. Still perhaps he will only learn by his mistakes He was still a bit paranoid Sat morning but it gradually seemed to get better. He did ask to go back earlier, then kept changing his mind

‘Get me out of there’

Clinical Team

etc.” He said he can reject his paranoid ideas most of the time but sometimes they got on board and make him restless and agitated. He denied of being depressed and having any suicidal ideas. He said he feels “calm & happy inside”. There are no hallucinations and his insight is patently presented. I spoke with his father and he said that Simon is 1000 times better than he was before ECT, but he is indecisive and paranoid most of the time. He has warm relationship with family.

Dr. Kaveen

5/12/94 nursing 1300. Simon had 4th ECT. 23 sec. fit, good recovery, returned to ward. Continues to feel he is “in big trouble” – worried about people getting his money.

His mood appears brighter, mixing with fellow patients, went for short walk returned without any

Reflection

likely to have ramifications that were outside of the framework of the ordinary consensual discourse of non-madness. For me, having ECT was the culmination of the ‘real’ process going on behind my detainment on the ward: I was to be finally ‘neutered’ spiritually by the demonic entities that had driven me mad in the first place, so that it would be impossible for me to enter the spiritual world again. Like the alien in the Bowie film, the medical team unknowingly and unwittingly perform a medical task that had devastating consequences for me. Unlike the medics in the film, I do not believe the medical team in my situation were in any way callous. Indeed, were actually very gentle and, I think, wanted to help. Yet, there is a real sense that the psychologically implications of ECT, and their unintended effects, may have been secondary to the

Simon

20s. She feels safe. She looks out for you. Every time you see something new happen (policeman enter the ward, alarm going off, seeing another patient you don’t recognise etc.) you go to her. You tell her what you think is going on. Her two responses: no, you didn't see that; or, that’s just your paranoia. You know you did see that, and you don't think it was your paranoia, but you choose to agree with her anyway. You start to get more leave. You can go home again. You realise how this works.

This time there is a que for the ECT. You sit there in line with the old ladies, most of them quiet and immobile and wearing fixed expressions of horror, despair or confusion. After their course of ECT, they take the old ladies to the ward hairdresser to get their blue rinse done, as a treat. You

Mother

Stick up for me once in your life.

Don’t be passive.

Someone in there tried to kill himself & he was out in a week.

I’m not paranoid anymore (was yesterday/still is

4.12.94 Picked Simon up about 11am, still has a little paranoia.

Above is what he was saying, quite vehemently asking will I be out by Christmas as I can’t stand it much longer.

Couldn't relax whilst at home.

Asked to go back at 3pm – could of gone back at 7pm.

8.12.94 Simon came home Tuesday & stayed the night. I took him into Portown to get a CD. We went into McDonalds but he was not comfortable in there.

Clinical Team

problems.

Patient seen. Feels not bad generally, spent an overnight at home, a little bit depressed, a bit optimistic about the future. Still has some ↓ conspiracy thoughts, at times believe that people are talking about him. Clearer in mind. better to concentrate, reads newspaper. Keen to work out a discharge plan more appropriate, realistic.
Dr Furbois would suggest 2-3 weeks from now to think about discharge plan. To be allowed spent one night during the week and have W/E leave home after having discussed it with parents.

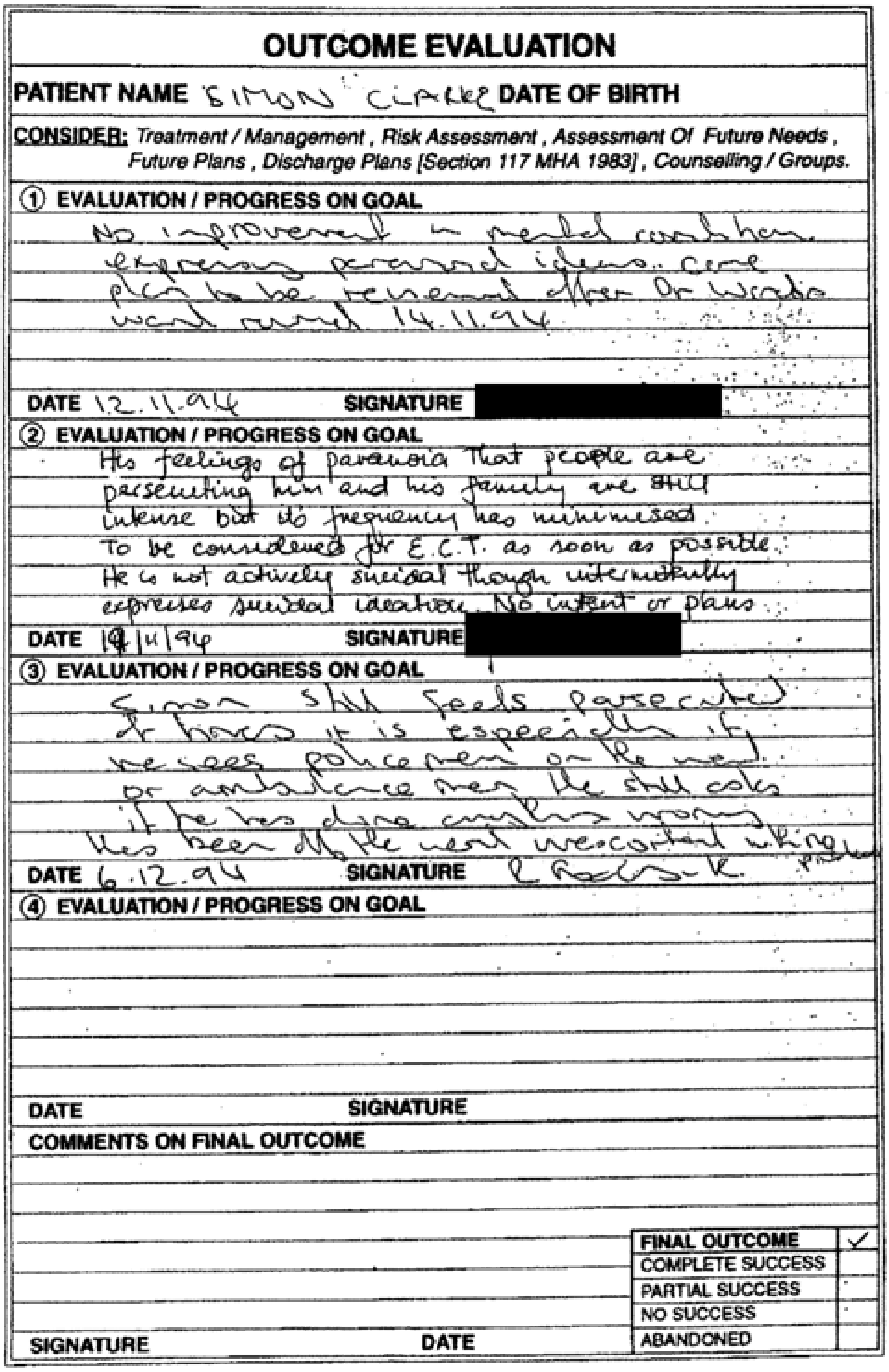
Depixol inj. 40 mg every 2 weeks instead of once weekly, much more better, continue with E.C.T sessions

Reflection

immediate need of reducing symptoms. For example, the nurses may seem interested to hear about my experiences and what I believed, but there is no sign that they were interested in working with the content of these experiences. Once the symptoms were reported, they contribute to the process of formulating a framework and treatment approach that is unrelated to the experiences I reported. An objection might be made here that I was mad and my beliefs about the situation were delusional. Therefore, should it matter what I believed, as long as the treatment helped? My response is that meaning is everything in the treatment process. If I believed that ECT represented punishment and some process of spiritual exile, however justified or legitimate, then it was likely that the treatment would be

Simon	Mother	Clinical Team	Reflection
wonder why they haven't combined the ECT and the rinse together, to save money. Mum and Dad are happy. Mum tells you she knew you were getting better when she saw you wearing your glasses. Dad says to you, son, that place sorted you out. This disturbs you, but you can't exactly say why.	He saw with his friends later that night , but they were going to a gig , he decided that he is better not to go. He seemed to enjoy himself , he was still worried about Ranypial & money. He said Wednesday morning that he felt like a senile old man. He asked to go back to Woodbrook 1 . He phone an hour later and asked if Rich ~~and~~ would for a drink with him.	8/12/94 nursing 10.10. Simon had ECT this morning and a good fit. Was very confused when he woke up.	experienced as punishment and spiritual exile. These effects would likely be compounded and more significant in the long-term than the remittance of some short-term symptoms. In fact, I experienced them as more harmful.

Document 8.1. Outcome evaluation nurses' sheet.



OUTCOME EVALUATION

PATIENT NAME SIMON CLARKE **DATE OF BIRTH**

CONSIDER: *Treatment / Management , Risk Assessment , Assessment Of Future Needs , Future Plans , Discharge Plans [Section 117 MHA 1983] , Counselling / Groups.*

① EVALUATION / PROGRESS ON GOAL

No improvement in mental condition. expressing paranoid ideas. Care plan to be reviewed after Dr Wardo ward round 14.11.94

DATE 12.11.94 **SIGNATURE** [redacted]

② EVALUATION / PROGRESS ON GOAL

His feelings of paranoia That people are persecuting him and his family are still intense but its frequency has minimised. To be considered for E.C.T. as soon as possible. He is not actively suicidal though intermittently expresses suicidal ideation. No intent or plans.

DATE 19|11|94 **SIGNATURE** [redacted]

③ EVALUATION / PROGRESS ON GOAL

Simon still feels persecuted at times it is especially if he sees policemen on the ward or ambulance men. He still asks if he has done anything wrong. Has been off the ward unescorted walking

DATE 6.12.94 **SIGNATURE**

④ EVALUATION / PROGRESS ON GOAL

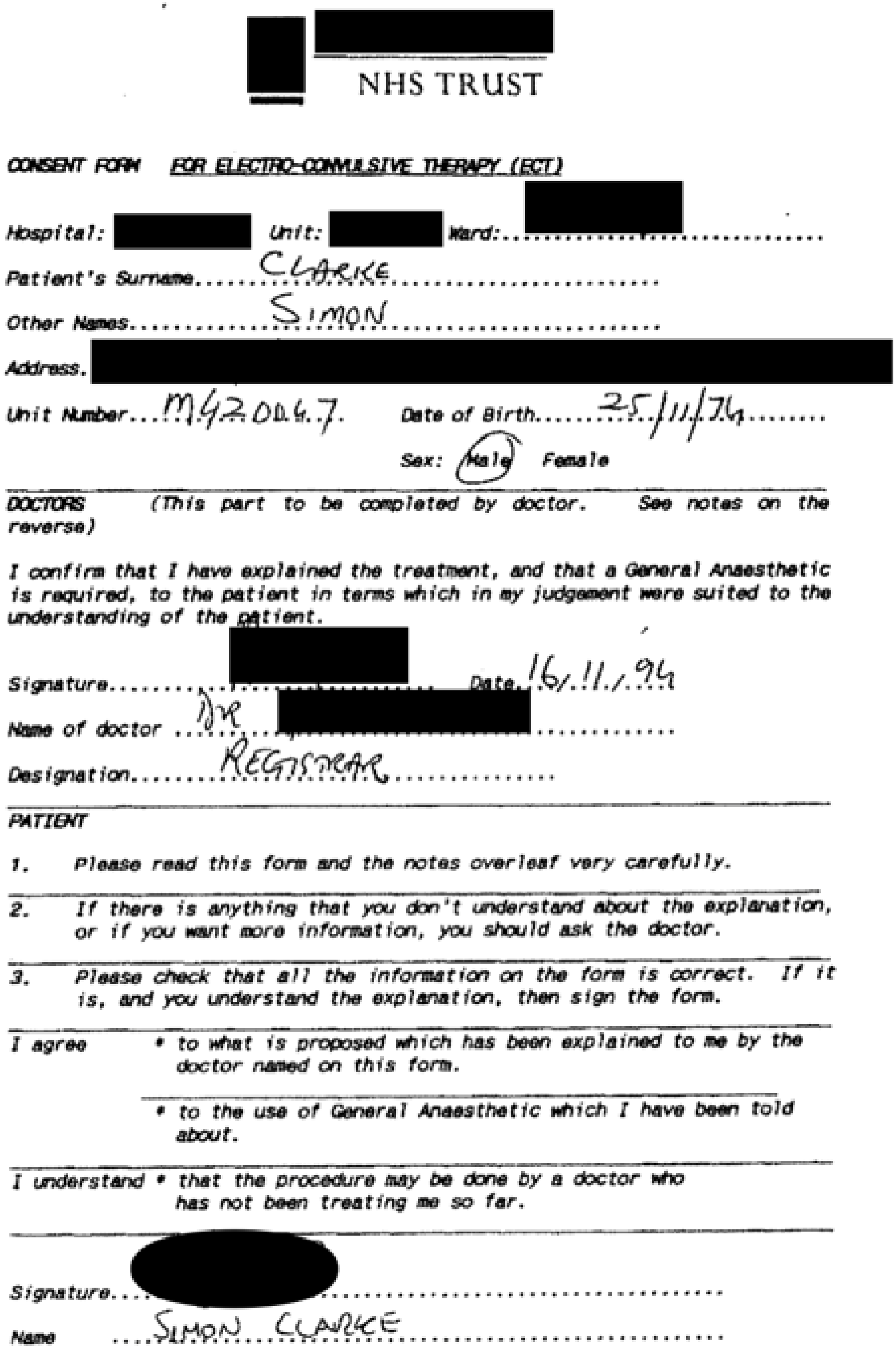
DATE **SIGNATURE**

COMMENTS ON FINAL OUTCOME

FINAL OUTCOME	✓
COMPLETE SUCCESS	
PARTIAL SUCCESS	
NO SUCCESS	
ABANDONED	

SIGNATURE **DATE**

Document 8.2. Consent form for Electro-Convulsive Therapy.



[redacted] NHS TRUST

CONSENT FORM **FOR ELECTRO-CONVULSIVE THERAPY (ECT)**

Hospital: [redacted] Unit: [redacted] Ward: [redacted]

Patient's Surname ....CLARKE....

Other Names ....SIMON....

Address. [redacted]

Unit Number ...M420047.   Date of Birth ....25/11/74....

Sex: [✓ Male] Female

DOCTORS (This part to be completed by doctor. See notes on the reverse)

I confirm that I have explained the treatment, and that a General Anaesthetic is required, to the patient in terms which in my judgement were suited to the understanding of the patient.

Signature....[redacted].... Date 16/11/94

Name of doctor ...DR [redacted]....

Designation....REGISTRAR....

PATIENT

1. Please read this form and the notes overleaf very carefully.

2. If there is anything that you don't understand about the explanation, or if you want more information, you should ask the doctor.

3. Please check that all the information on the form is correct. If it is, and you understand the explanation, then sign the form.

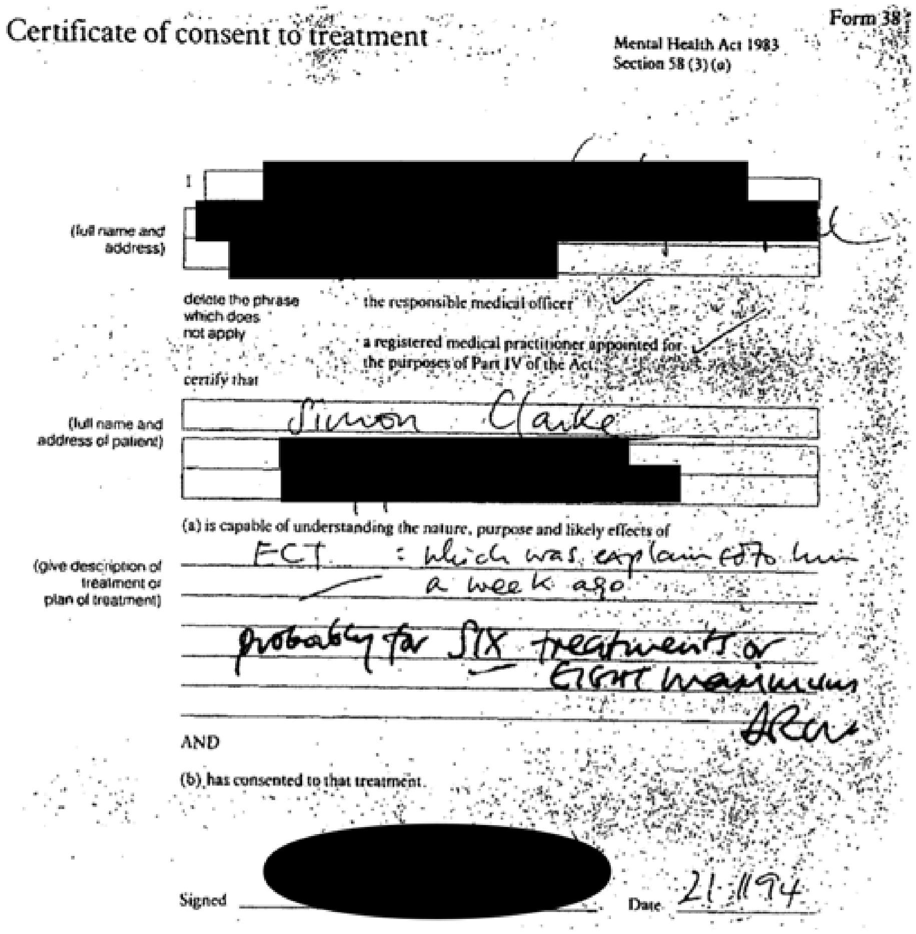
I agree
- to what is proposed which has been explained to me by the doctor named on this form.
- to the use of General Anaesthetic which I have been told about.

I understand
- that the procedure may be done by a doctor who has not been treating me so far.

Signature...[redacted]....

Name ....SIMON CLARKE....

Document 8.3. Certificate of consent to treatment.



Certificate of consent to treatment

Form 38
Mental Health Act 1983
Section 58 (3) (a)

I [redacted] (full name and address)

delete the phrase which does not apply
the responsible medical officer
a registered medical practitioner appointed for the purposes of Part IV of the Act

certify that

Simon Clarke [redacted] (full name and address of patient)

(a) is capable of understanding the nature, purpose and likely effects of

ECT : which was explained to him a week ago

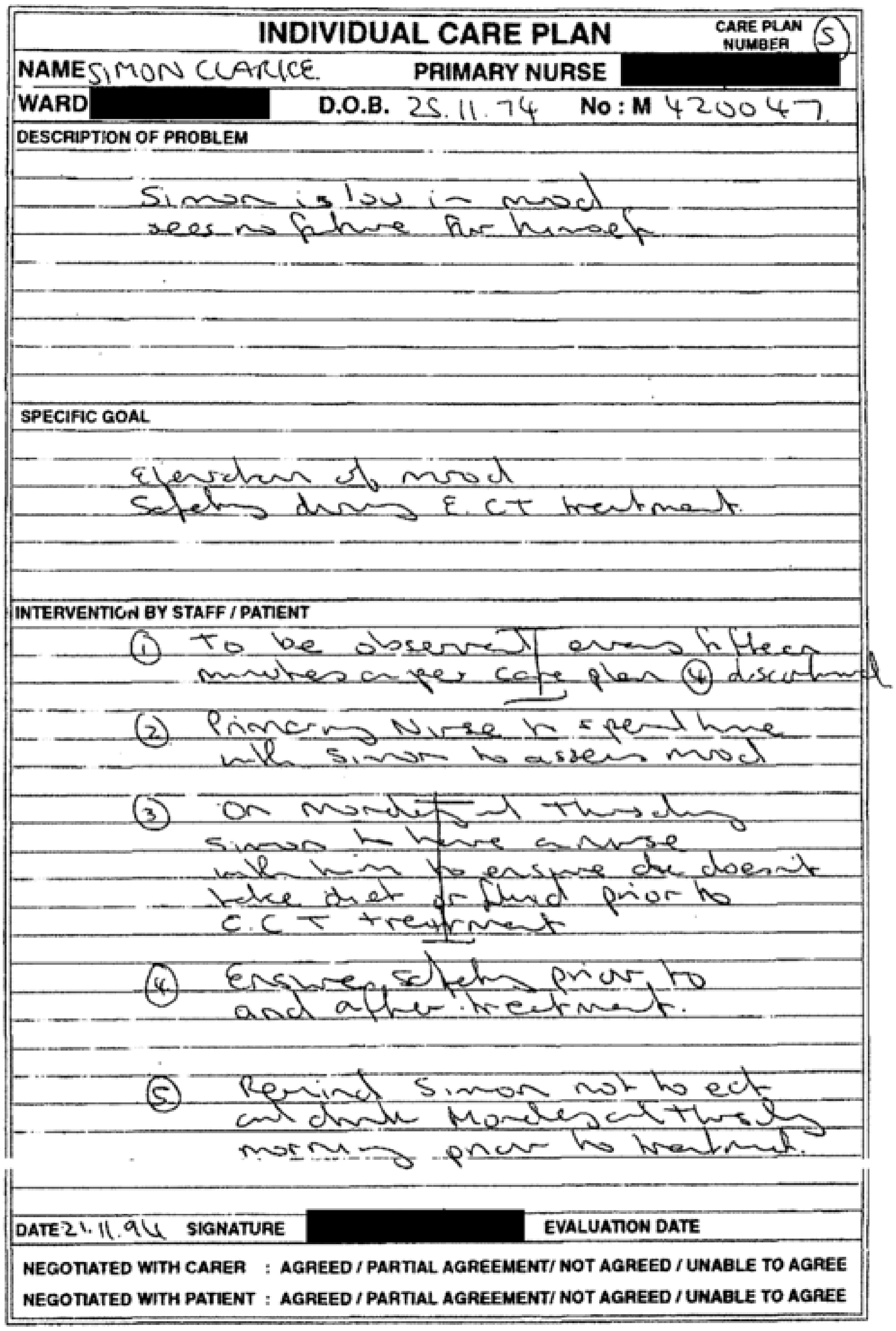
probably for SIX treatments or EIGHT maximum (give description of treatment or plan of treatment)

AND

(b) has consented to that treatment.

Signed [redacted] Date 21·11·94

Document 8.4. Individual care plan.



INDIVIDUAL CARE PLAN

CARE PLAN NUMBER ⑤

NAME SIMON CLARKE. **PRIMARY NURSE** [redacted]

WARD [redacted] **D.O.B.** 25.11.74 **No : M** 420047.

DESCRIPTION OF PROBLEM

Simon is low in mood
sees no future for himself

SPECIFIC GOAL

Elevation of mood
Safety during E.CT treatment.

INTERVENTION BY STAFF / PATIENT

① To be observed every fifteen
minutes as per care plan ④ discontinued

② Primary Nurse to spend time
with Simon to assess mood

③ On Monday and Thursday
Simon to have a nurse
with him to ensure he doesn't
take diet or fluid prior to
E.C.T treatment

④ Ensure safety prior to
and after treatment.

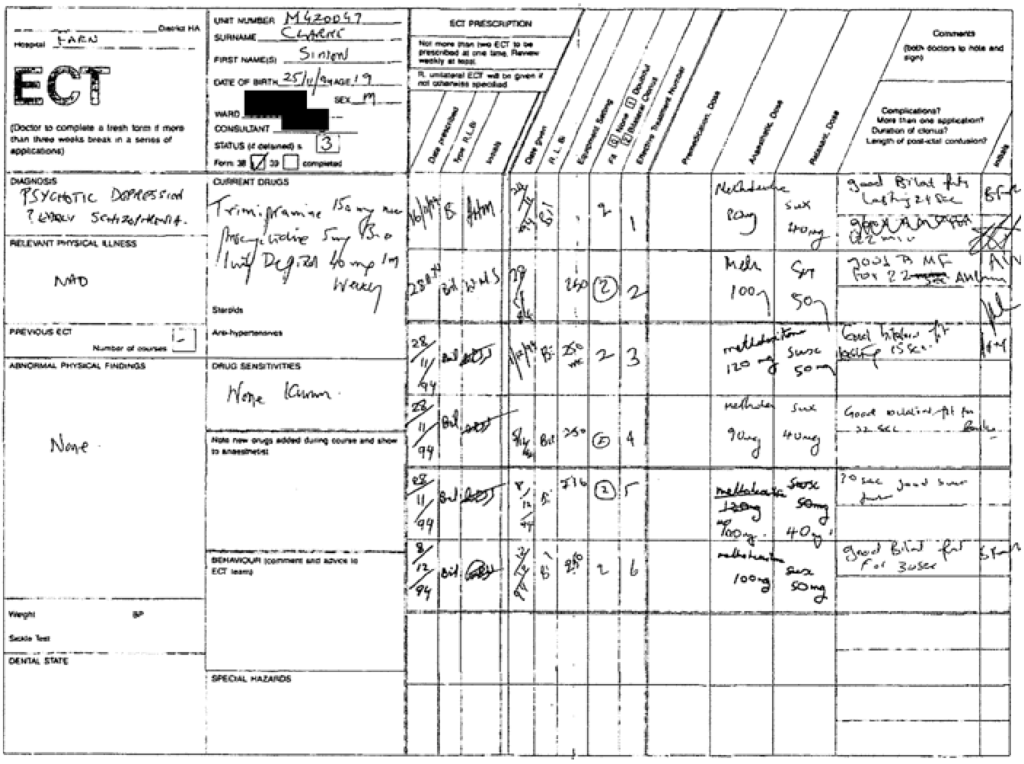
⑤ Remind Simon not to eat
and drink Monday and Thursday
morning prior to treatment.

DATE 21.11.94 **SIGNATURE** [redacted] **EVALUATION DATE**

NEGOTIATED WITH CARER : AGREED / PARTIAL AGREEMENT/ NOT AGREED / UNABLE TO AGREE

NEGOTIATED WITH PATIENT : AGREED / PARTIAL AGREEMENT/ NOT AGREED / UNABLE TO AGREE

Document 8.5. Electroconvulsive Therapy record forms.



District HA
Hospital FARN

ECT

(Doctor to complete a fresh form if more than three weeks break in a series of applications)

UNIT NUMBER M420047
SURNAME CLARKE
FIRST NAME(S) SIMON
DATE OF BIRTH 25/11/94 AGE 19
SEX M
WARD [redacted]
CONSULTANT
STATUS (if detained) s. 3
Form: 38 ☑ 39 ☐ completed

DIAGNOSIS
PSYCHOTIC DEPRESSION
? EARLY SCHIZOPHRENIA.

CURRENT DRUGS
Trimipramine 150mg nocte
Procyclidine 5mg b.d.
Inj Depixol 40mg im Weekly
Steroids
Anti-hypertensives

RELEVANT PHYSICAL ILLNESS
NAD

PREVIOUS ECT
Number of courses -

ABNORMAL PHYSICAL FINDINGS
None.

DRUG SENSITIVITIES
None known.

Note new drugs added during course and show to anaesthetist

BEHAVIOUR (comment and advice to ECT team)

Weight BP
Sickle Test

DENTAL STATE

SPECIAL HAZARDS

ECT PRESCRIPTION

Not more than two ECT to be prescribed at one time. Review weekly at least.

R. unilateral ECT will be given if not otherwise specified

Date prescribed	Type R.L.B.	Initials	Date Given	R.L.B.	Equipment Setting	Fit 0 None 1 Doubtful 2 Marked Clonus	Effective Treatment Number	Premedication, Dose	Anaesthetic, Dose	Relaxant, Dose	Comments (both doctors to note and sign) Complications? More than one application? Duration of clonus? Length of post-ictal confusion?	Initials
16/11/94	B	Ahm	24/11/94	Bil	,	2	1		Methohexitone 80mg	Sux 40mg	Good Bilat fits lasting 24 Sec ~~[illegible]~~ 22 sec	
28/11/94	Bil	WMS	29/11/94		250	②	2		Meth 100mg	Sux 50mg	Good Bi MF for 22 ~~sec~~ sec	
28/11/94	Bil		1/12/94	Bi	250 mc	2	3		methohexitone 120 mg	Sux 50mg	Good bilateral fit lasting 15 sec.	
28/11/94	Bil		5/12/94	Bil	250	②	4		methohex 90mg	Sux 40mg	Good bilateral fit for 22 sec	
28/11/94	Bil		8/12/94	Bi	276	②	5		methohexitone ~~120mg~~ 100mg.	Sux 50mg 40mg	70 sec good bilat fit	
8/12/94	Bil		12/12/94	Bi	250	2	6		methohexitone 100mg	Sux 50mg	Good Bilat fit for 30sec	

Part 9. Discharge

The discharge process was now underway. Several incidents caused me to question the accuracy of my interpretations of previous events, and an encounter with another patient suggested that there was a commonality to this experience amongst patients. Although I appeared to be improving, there was still a significant residue of paranoia remaining. There was also some ambiguity as to how much I was masking my real symptoms in order to get out of hospital. I was eventually discharged with a diagnosis of ‘paranoid schizophrenia’, and my care shifted to the community. My final entry described me ‘going around in circles’, and coming back to where it all started, the home.

Part 9: Discharge

Simon

Every day you pass the hard-looking man on the corridor, with just a nod of recognition both ways. This has been going on for two months. This time as you pass you ask him whether he was brought in from the local prison. No, he says baffled, I had a breakdown. I saw God he adds with conviction. Come in here, he says, inviting you into his room. You follow him. Do you think something is going on? He asks. Yes, you say. He bursts out laughing. I thought they were all witches, you say. He laughs even louder. Me too! He says. This is a strange place. Very strange. Do you think something is going on? You ask. He can’t stop laughing. O yes definitely, he says laughing. A few days later he is discharged. The way you think of it now is as an exchange: they don't want you here because they need the bed;

Mother

15.12.94 Simon came home Tuesday and stayed until Wednesday Thursday night. He was much better. He stayed in Wednesday Tuesday

Wednesday he went to Annes.

Still has paranoia – Money, Woodbrook II.

16.12.94 Fri – Picked Simon up. Doesn't feel too good – depressed & more paranoia . Usual – Woodbrook II patients stole his key – made a copy & can get inside into our home –

Says – can’t believe I let people walk all over me – refers to Michael whom he believes stole his track suit bottoms

Says he is passive and lets people walk over him. – he doesn't like himself.

SAT – Says – Still feeling depressed – Feels he talks down

Clinical Team

16/12/94 Nursing 12:50 hrs. Simon appear well, said that he enjoyed his leave and that “The paranoia seems to have lifted” and I comming to terms with things.” Generally Simon was up for breakfast and has kept himself occupied during morning; ate lunch.

19/12/94 Dr Furbois W/R 15:45

Patient seen c/o being a little paranoid. with no any triggers for that Still have restless in his legs. Slept well at home. Also started a bit depressed but without having any suicidal ideas. Parents are helpful. Request counselling services for his difficulties of realization.

CPN contact to continue with as regular basis for some support. 2 weeks trial leave to be given. To come back after that to be seen by me.

Reflection

The final section concludes with my discharge from the ward and with me being taken off section. As my mother’s and the clinical notes indicate, I was far from being symptom free. Whereas the paranoia was constant, it is now fluctuating. I also show some evidence of questioning my original beliefs. However, the paranoia is now interspersed with reports of intense feelings of self-loathing, particularly in terms of feelings of a lack of self-assertion and self-respect.

That these symptoms appeared for the first time at this point in the narrative, raises the question of what function the paranoia may have served for me in the first place. Was it masking some very difficult feelings about myself that I was unable to fully realise or acknowledge at the time? If so, the removal of the paranoid

Part 9: Discharge

Simon

you don't want to be here at all. But they need valid reasons to let you go, and those reasons are connected with your symptoms.

So, you just tell them what you think they want to hear. Not too much, so that it sounds like you're bullshitting; enough so that they think you're getting better. No matter that you still believe the paranoia. No matter you think you will never be well again.

The nurse who is always a wearing a shirt and tie, looks like management but isn't, but perhaps would like to be. You don't really like him - he is too 'business' compared with many of the other nurses (including the managers).

The woman who I like and looks out for me, the mother of two young children, gets into an argument with her husband. He

Mother

Feels Worse in the mornings – hallucinates – but voices don't speak – it's like he hears things & thinks its about him.

Says – hes now believes that he has a serious mental problem that may be permanent.

Doesn't think he will get any better.

He went out with his friends.

Feels very lonely – doesn't seem to have much in common any more with his friends.

21.12.94 – Remains paranoid – usual – Woodbrook 2 – money.

Says he's either depressed or paranoid.

Told him he can talk to us about it but we must be able to say when he's had enough.

Clinical Team

<u>19/12/94</u> 1600 According to the mother's information Simon not too bad, he is quite and comfortable. She reported that Simon is still have lots paranoia e.g. That patients at Woodbrook I keep his keys with them. that everybody knows about his delusions because they talked about him in the TV She also stated that Simon became a bit depressed possible due to his realization that he is mentally ill. Eg. ' I think I got a long term mental illness. At the same time he sleeps well, eats good and at times expressing suicidal ideas with no any immediate plans. "I feel like killing myself"
Mrs Clarke thinks that Simon needs someone to talk to about his feeling preferably on a weekly basis, and to focus on something, he doesn't need to come back into hospital now but to be given more freedom with some rehab

Reflection

symptoms without substituting anything in its place would appear almost cruel. Even worse, there is in both mine and my mother's account a certain degree of pessimism expressed about my capacity to return to 'normal' life again. The experience seems to have now separated me out from my peers as different and left me with the sense of loneliness and isolation. A consequence of taking up 'normality' perhaps, but one that has no solution.

It is also interesting to notice that counselling has been mentioned again, recorded in the clinical notes as a request from my mother. A request for psychotherapy was, of course, the place where the referral started, a fact which seems to have got lost in the process. Unfortunately, this request was not acted on. Perhaps it suggests the lack of

Part 9: Discharge

Simon

leaves with the kids. She shouts at him after they go through the door. She kicks at the door. Mr Business comes over and asks her gently to calm down. She bursts into tears and he consoles her as she weeps on his shoulder. When Mr Business passes you start arguing with him again about your leave. For the first time, he loses his official manner. Look, he says to you angrily. Do you think I like this? Some things I just don't like doing, but they have to be done. Like telling a mum she has to stay in the ward when she wants to see her kids. Do you understand? Sorry, you say, ashamed. She was kind to you, and you were being selfish.

You are going home a lot now. You keep your thoughts to yourself. It seems to work. You feel like going to bed and not getting out again.

Mother

Went out with friends later that evening.

30.12.94. Has been much better – goes out with friends although he says it is a bore. Has not been talking about paranoid thoughts although he still has them and says he can cope.

Today however he went to Portown but was warned about busy it was – looks & acts agitated. Says everyone will know him. He went anyway with Richard and the boys.

Came back just the same – convinced that something is going to happen. Things that nurses had said to him, Jeremy, and leaving his cards about Woodbrook 2.

He's so convinced it's true and seems worried & unhappy.

Clinical Team

programme.

4/1/94 Patient seen.
Feeling well.
Not suicidal
Slightly suspicious
Will come back to face Dr Furbois team on Monday
C/T Same TP.

9.01.95 <u>Dr. Jose W/R</u>
16.15 Simon feels generally alright, although still underneath some paranoid ideas but not to the extent of interfering with his usual routine.
Really ready to be discharged next week.
117 meeting to arrange next week.
To invite GP, S/W, the pt's mother, CPN

9/01/95 Parents were seen by Dr Furbois and invited for the 117 meeting.

Reflection

importance that talking therapies had to the medical team, or the lack of funding, or priorities. Again, this is not a criticism of staff but a reflection on why this request was not offered at any point in my patient journey, despite being my original request.

To conclude, I would like to have been able to say that the experience ended on a positive note. Indeed, some people reading this account might even conclude that the ward saved my life and prevented something much worse than the experiences recorded here – perhaps suicide or some form of extreme self-harm. At least, this seems to be the conclusion that my parents have come to in the account. However, I still find it difficult to to see it that way. Coming out of hospital, I was emotionally and socially crippled. I had lost

Part 9: Discharge

Simon

An old, bald man, with the shakes, who speaks with a voice registering perpetual dissatisfaction in his thin, nasal, heavily accented, tone. He doesn't usually speak to you, but he comes over to you this time. He points at you. It’s your hell: you live in it! You ask him about it much later and he says he has no recollection of saying this.

There is one nurse who you thought said to you would be beat up by the new inpatients. When you see him again, you ask him what he meant by that. He looks at you bemused. He shakes his head and looks at you again. You realise he doesn't even remember who you are.

It’s hard to get the balance right. You never really know what is enough’. You think you can tell by

Mother

Went out with his friends later

31.12.94 Not talking about worries so much today.

Unable to decide whether to go out with friends or us. In the end Richard made the decision as he was still undecided in the car. Seemed to have a good time. Dropped him off at 1.30am – friends.

1.1.95 Said he walked past a couple this evening and they said, ‘that's the one that was done for child abuse’ and they gave his looked back at him ?

14.1.95 These past few weeks Simon has been so happy. There has been no paranoia . When asked he says he still has it but that it is fading.

Clinical Team

Dr. Furbois, , Dr Sheik (Dr Furbois Registrar), Louise M S/W, CPN.
Dr. Jose.
Dr. Kaveen – (Training Doct’)
Simon & his mother.
ward staff & pharmacist.
Patient seen – Still gets anxious now and then. Generally well. Paranoia now & then. Good eye contact, good rapport, appropriate in his behavioural & emotional response. To start a part time job. Mother feels Simon can handle that job, he sleeps ‘OK’, generally. The parents confirmed his improvement and quite happy with that.
Simon by Dr Furbois’s opinion is much more better, healthier. Will continue to take his medications. Not to take/abuse drugs in the future.
Will be seen as an outpatient at Woodbrook Unit.

Reflection

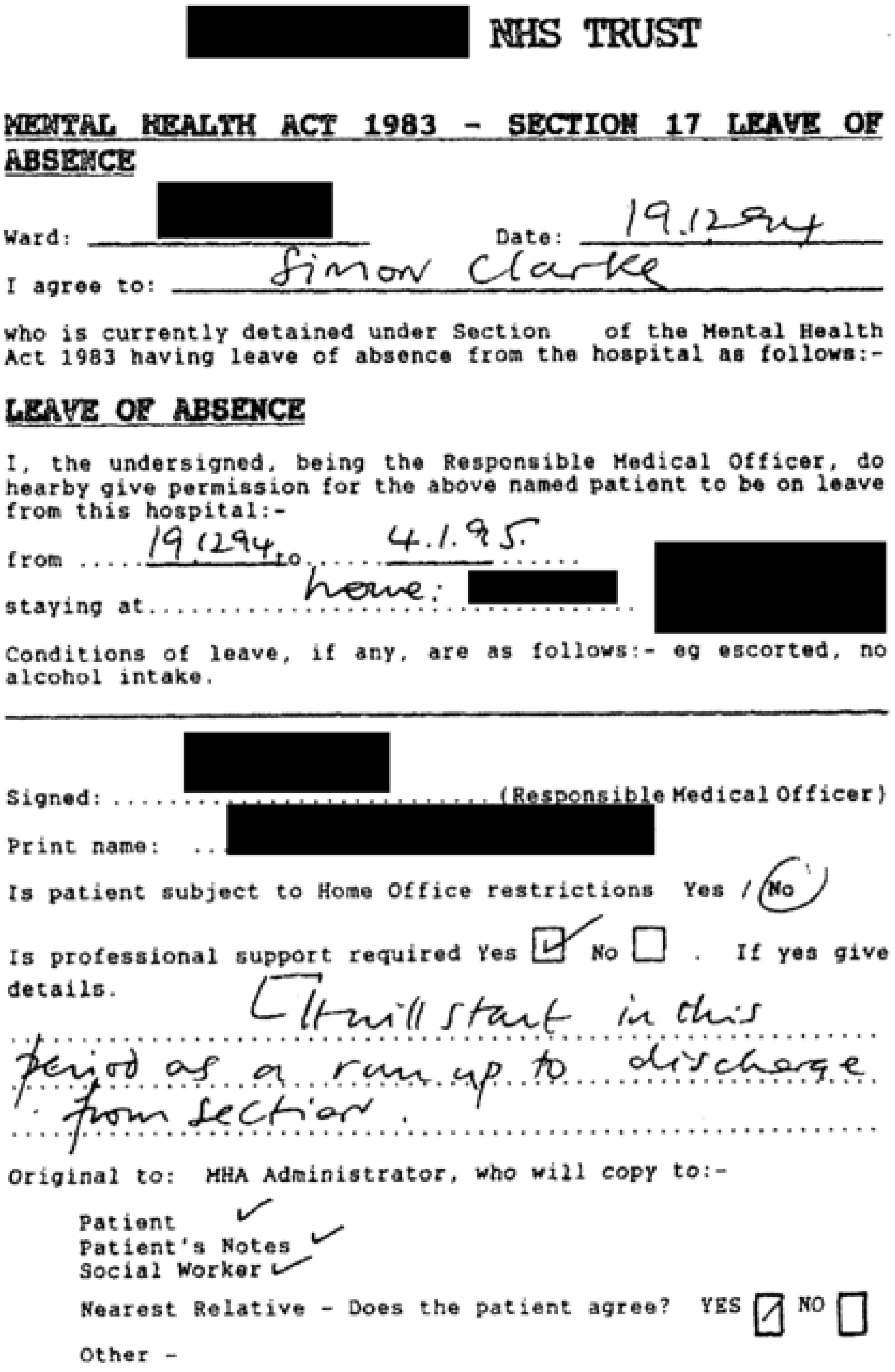
something vital and was now a broken person (or ‘a senile old man’ as I describe myself in my mother’s diary).

I would go back to smoking marijuana again, in much larger quantities than before. Whereas I used to take drugs to experiment, I now took them to escape. I was so depressed at times that it was only when I was stoned that I felt any genuine sense of enjoyment. However, a year or so after the events described here, my cousin committed suicide in a psychiatric ward under circumstances that were remarkably similar to mine. This precipitated another breakdown that was, in part, triggered by traumatic memories of when I was on the ward. Although I narrowly avoided being sectioned this time, the event precipitated a recovery of sorts

Part 9: Discharge

Simon	Mother	Clinical Team	Reflection
'the nurses' reaction, but you are never really sure. What if this is part of the previous game? Or were they just voices in your head? Or did you just misinterpret what you heard? What if there is no game? You now walk the streets at night like a zombie. It is quiet now, and not many people around to make you feel paranoid. Round and round the quaint suburban streets, in a circuit. Past your old primary school. Past the small shopping precinct, with the video shop and the newsagents where you did your first paper round. Past the woods with the trim trail where you used to walk to school and where you and your friends smoked cigarettes, got drunk and took drugs. Back home.	He should be discharged from section & Woodbrook I to-morrow. Has arnold the CPN. He advised him to play classical, soothing music on his Walkman when he feels threatened. 19.1.95 Simon was discharged from the ward & section Monday – 16th January. He is much better,. He told Dr that he still gets the odd paranoia – and depression – but only lasts short while. His main problem at the moment is getting up in the morning. Because he gets up so late he is unable to go to bed early – visious circle.	Next Depo inj. due to next week. (23/1/95) Seen taken off. Sec. 3 The CPN will give him his Depo-inj regularly and had discussed with Simon during the 117 meeting. Given Procyclidine 5mg BD. Flupenthixol 40 mg 5M (215v) Trimipramine 100 mg. on 16/01/95 Seen W/R 177 meeting was held, see above notes Simon was taken off the Section 3 of the MHA 1983 . 117 form was filled in.	- a religious conversion as a 'born-again' Christian and a move to London to train as a teacher. Although this would lead to another breakdown, it would be my last major mental health episode and be the final contact with mental health services. The recovery was largely because of a long stay in an open therapeutic faith community in Deal, Kent. Finally, 6 years after the events recorded here, I would get psychotherapy, with radical and long-reaching effects, but which was not, sadly, provided by the NHS. Here, however, there is no turning point. My mother's final note comments on the vicious cycle I appear to be trapped in – going to bed late, not getting up in time. My final entry also describes the feeling of going around in circles, symbolised by the nocturnal circular walk.

Document 9.1. Mental Health Act leave of absence form.



[redacted] **NHS TRUST**

MENTAL HEALTH ACT 1983 - SECTION 17 LEAVE OF ABSENCE

Ward: [redacted] Date: 19.12.94

I agree to: Simon Clarke

who is currently detained under Section of the Mental Health Act 1983 having leave of absence from the hospital as follows:-

LEAVE OF ABSENCE

I, the undersigned, being the Responsible Medical Officer, do hearby give permission for the above named patient to be on leave from this hospital:-

from 19.12.94 to 4.1.95.

staying at home: [redacted] [redacted]

Conditions of leave, if any, are as follows:- eg escorted, no alcohol intake.

Signed: [redacted] (Responsible Medical Officer)

Print name: [redacted]

Is patient subject to Home Office restrictions Yes / [✓ No]

Is professional support required Yes ☑ No ☐ . If yes give details.

CT will start in this period as a run up to discharge from section.

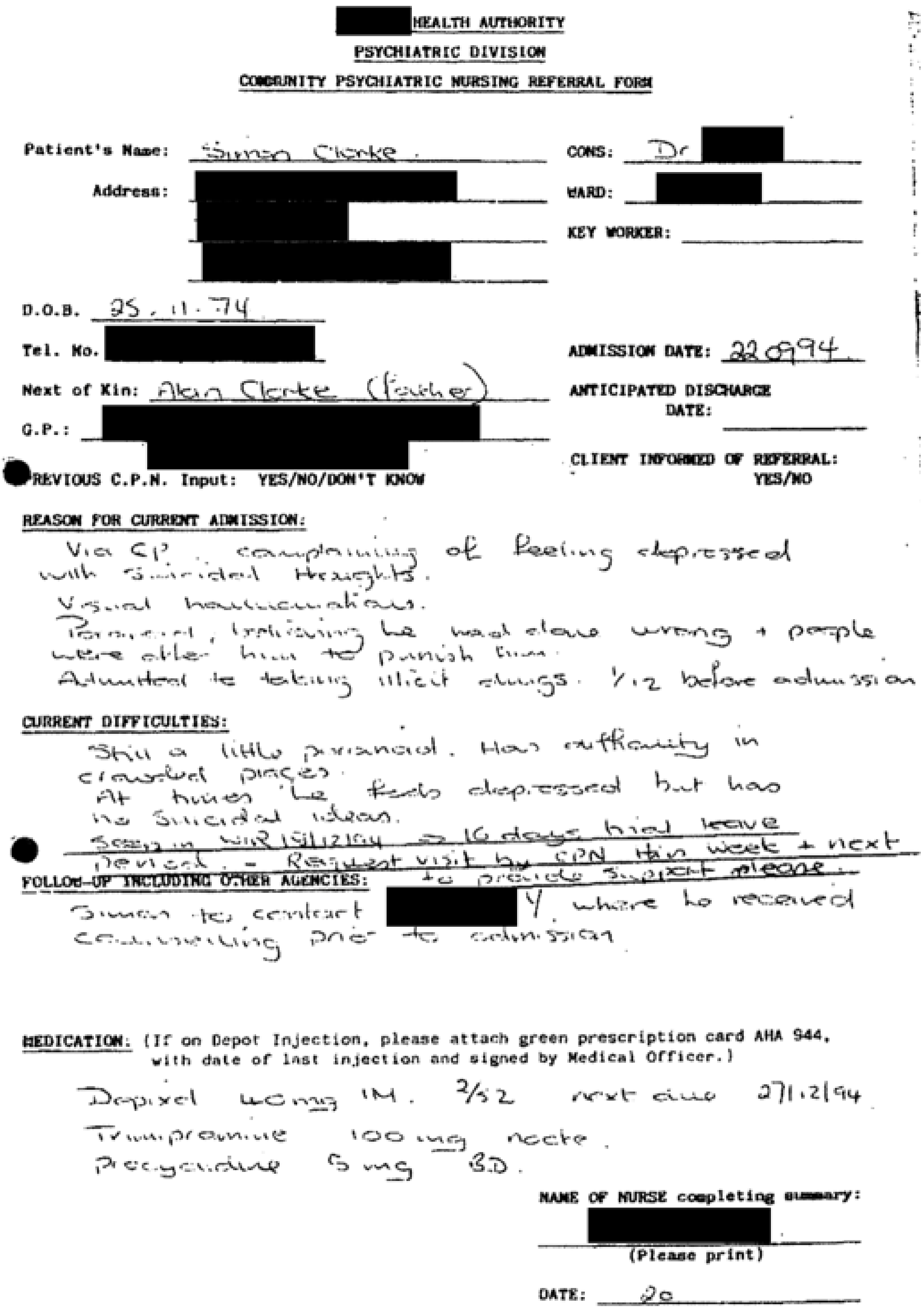
Original to: MHA Administrator, who will copy to:-

Patient ✓
Patient's Notes ✓
Social Worker ✓

Nearest Relative - Does the patient agree? YES ☑ NO ☐

Other -

Document 9.2. Community psychiatric nursing referral form.



[redacted] **HEALTH AUTHORITY**

PSYCHIATRIC DIVISION

COMMUNITY PSYCHIATRIC NURSING REFERRAL FORM

Patient's Name: Simon Clarke.
CONS: Dr [redacted]
Address: [redacted]
WARD: [redacted]
KEY WORKER:
D.O.B. 25.11.74
Tel. No. [redacted]
ADMISSION DATE: 22.09.94.
Next of Kin: Alan Clarke (father)
ANTICIPATED DISCHARGE DATE:
G.P.: [redacted]
CLIENT INFORMED OF REFERRAL: YES/NO
●**PREVIOUS C.P.N. Input:** YES/NO/DON'T KNOW

REASON FOR CURRENT ADMISSION:

Via GP, complaining of feeling depressed with suicidal thoughts.
Visual hallucinations.
Paranoid, believing he had done wrong + people were after him to punish him.
Admitted to taking illicit drugs 1/12 before admission

CURRENT DIFFICULTIES:

Still a little paranoid. Has difficulty in crowded places.
At times he feels depressed but has no suicidal ideas.
● Seen in WR 15/12/94 → 16 days trial leave period. - Request visit by CPN this week + next to provide support please.

FOLLOW-UP INCLUDING OTHER AGENCIES:

Simon to contact [redacted] Y, where he received counselling prior to admission

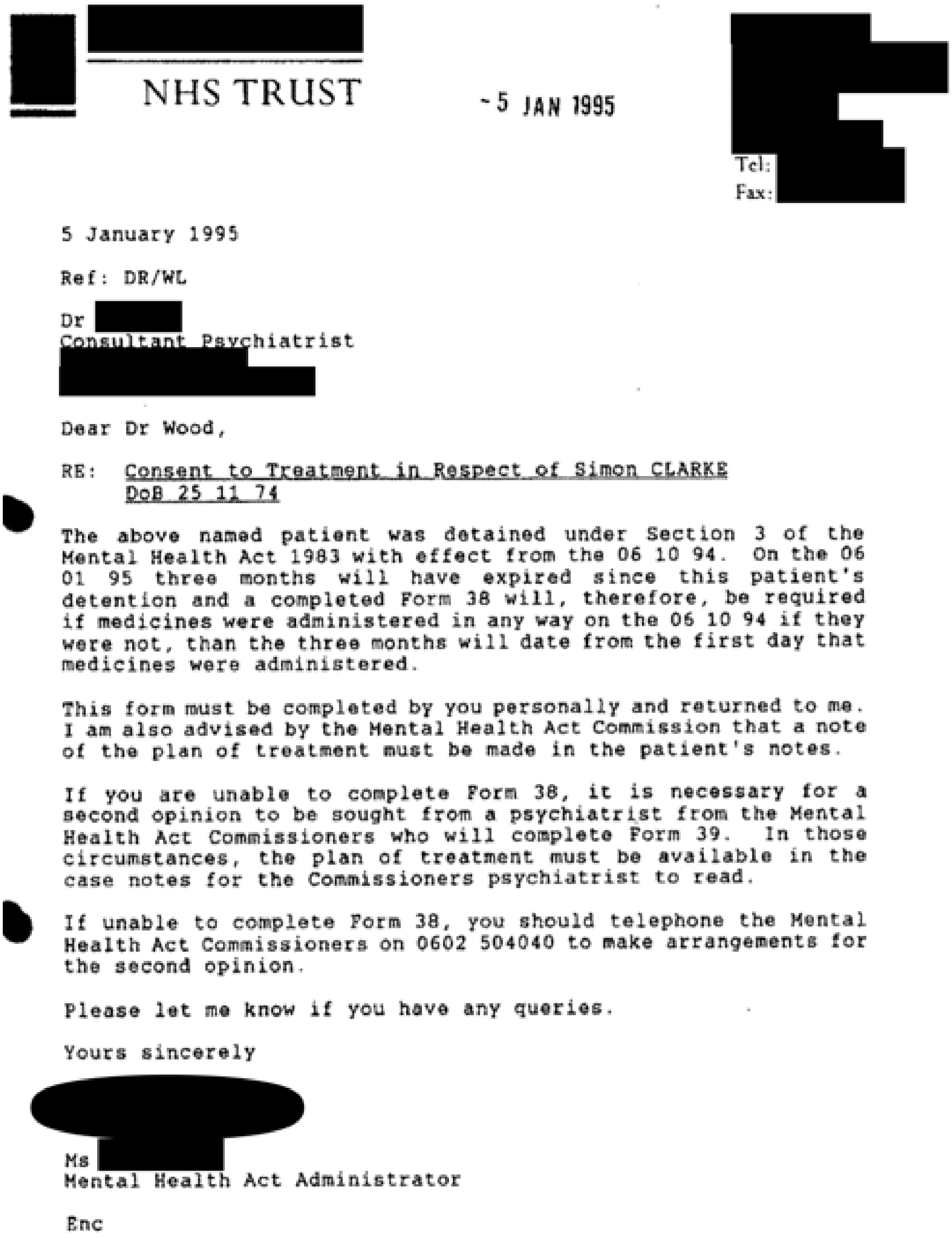
MEDICATION: (If on Depot Injection, please attach green prescription card AHA 944, with date of last injection and signed by Medical Officer.)

Depixol 40mg IM. 2/52 next due 27.12.94
Trimipramine 100mg nocte.
Procyclidine 5mg B.D.

NAME OF NURSE completing summary: [redacted]
(Please print)

DATE: 20

Document 9.3. Consent to Treatment review form.



[redacted]
[redacted]
NHS TRUST

[redacted]
Tel: [redacted]
Fax:

-5 JAN 1995

5 January 1995

Ref: DR/WL

Dr [redacted]
Consultant Psychiatrist
[redacted]

Dear Dr Wood,

RE: Consent to Treatment in Respect of Simon CLARKE
DoB 25 11 74

The above named patient was detained under Section 3 of the Mental Health Act 1983 with effect from the 06 10 94. On the 06 01 95 three months will have expired since this patient's detention and a completed Form 38 will, therefore, be required if medicines were administered in any way on the 06 10 94 if they were not, than the three months will date from the first day that medicines were administered.

This form must be completed by you personally and returned to me. I am also advised by the Mental Health Act Commission that a note of the plan of treatment must be made in the patient's notes.

If you are unable to complete Form 38, it is necessary for a second opinion to be sought from a psychiatrist from the Mental Health Act Commissioners who will complete Form 39. In those circumstances, the plan of treatment must be available in the case notes for the Commissioners psychiatrist to read.

If unable to complete Form 38, you should telephone the Mental Health Act Commissioners on 0602 504040 to make arrangements for the second opinion.

Please let me know if you have any queries.

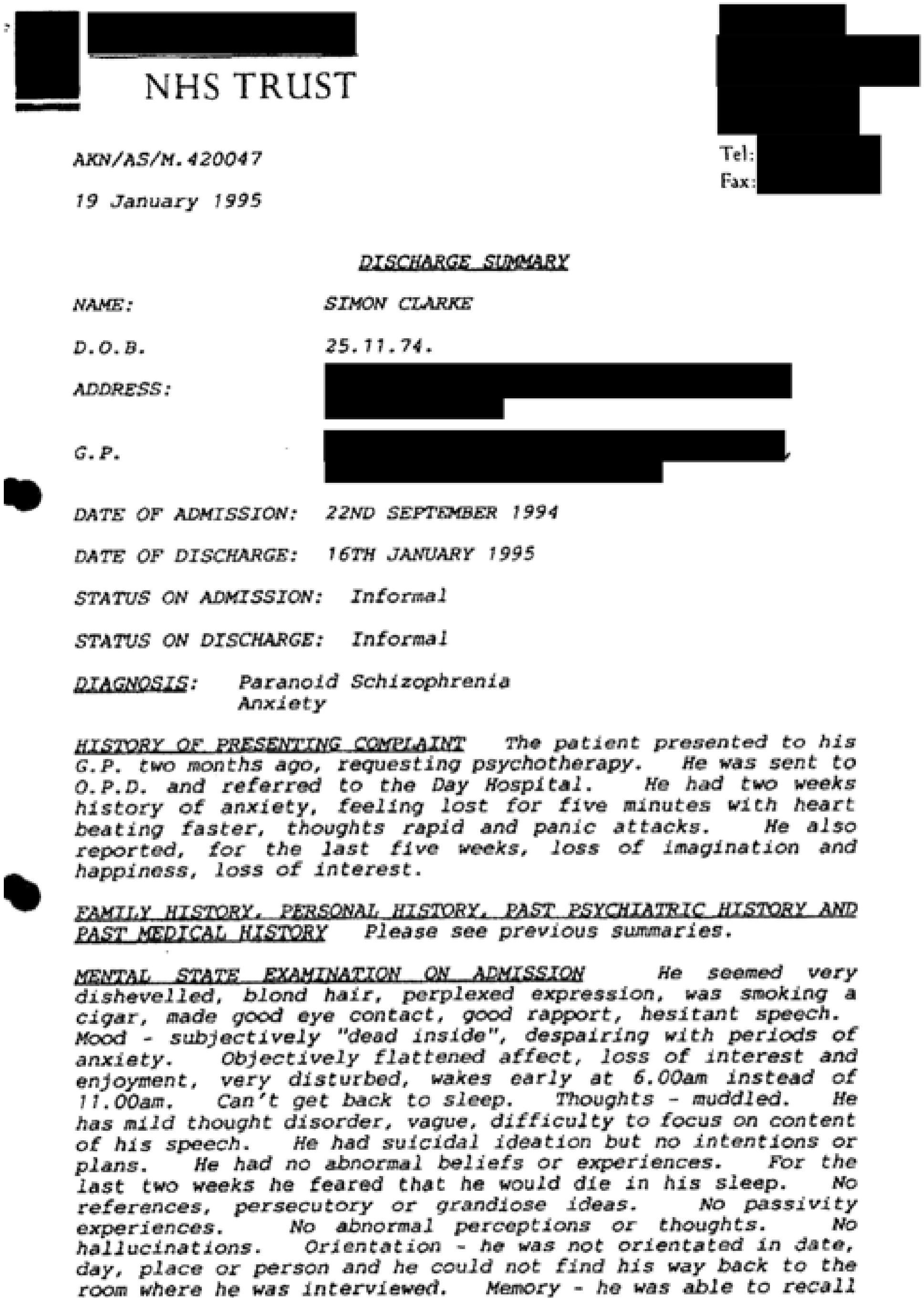
Yours sincerely

[redacted]

Ms [redacted]
Mental Health Act Administrator

Enc

Document 9.4.1. Discharge summary, page one.



[redacted] [redacted]
NHS TRUST

[redacted]

Tel: [redacted]
Fax:

AKN/AS/M.420047

19 January 1995

DISCHARGE SUMMARY

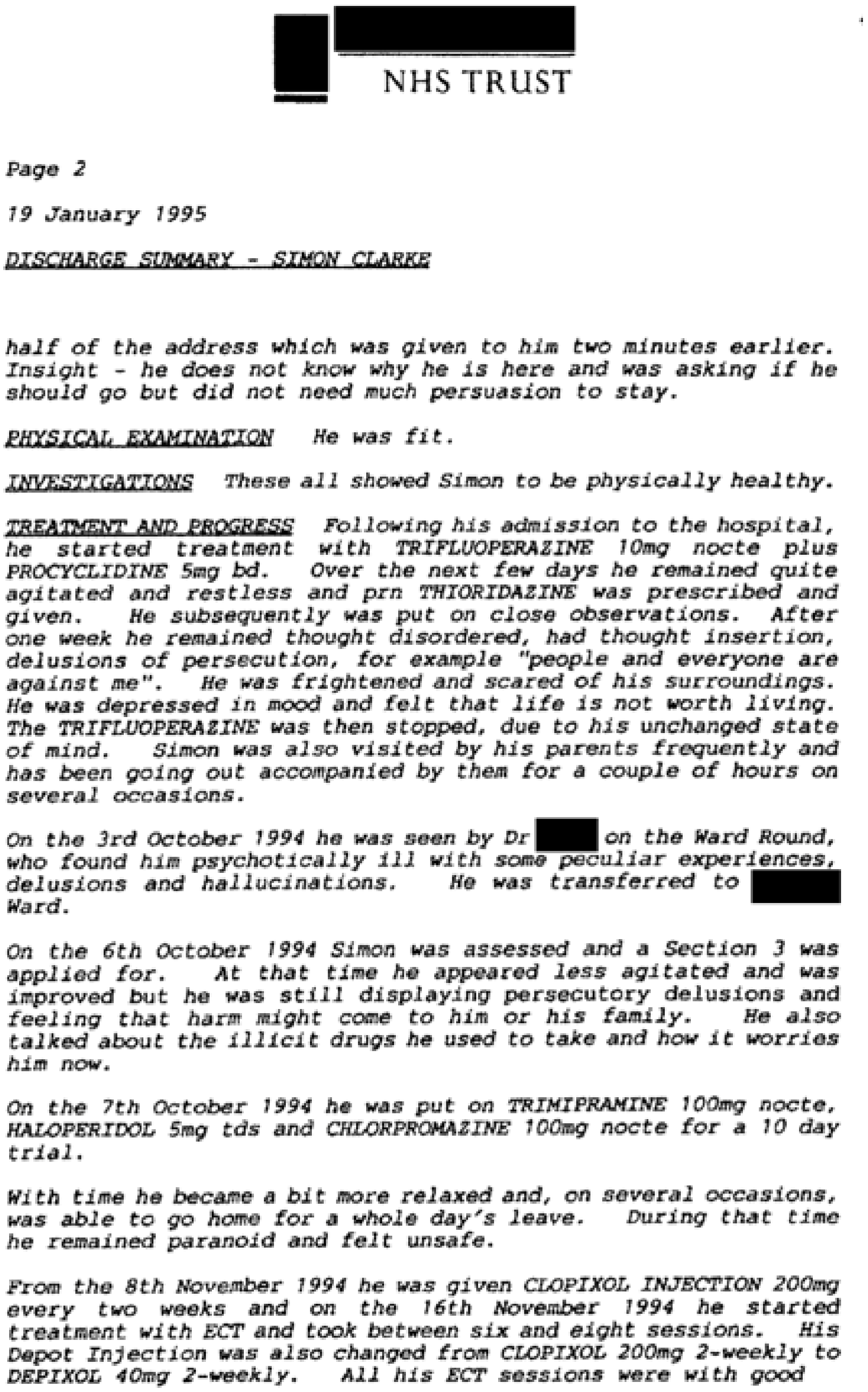
NAME:	SIMON CLARKE
D.O.B.	25.11.74.
ADDRESS:	[redacted]
G.P.	[redacted]
DATE OF ADMISSION:	22ND SEPTEMBER 1994
DATE OF DISCHARGE:	16TH JANUARY 1995
STATUS ON ADMISSION:	Informal
STATUS ON DISCHARGE:	Informal
DIAGNOSIS:	Paranoid Schizophrenia Anxiety

HISTORY OF PRESENTING COMPLAINT The patient presented to his G.P. two months ago, requesting psychotherapy. He was sent to O.P.D. and referred to the Day Hospital. He had two weeks history of anxiety, feeling lost for five minutes with heart beating faster, thoughts rapid and panic attacks. He also reported, for the last five weeks, loss of imagination and happiness, loss of interest.

FAMILY HISTORY, PERSONAL HISTORY, PAST PSYCHIATRIC HISTORY AND PAST MEDICAL HISTORY Please see previous summaries.

MENTAL STATE EXAMINATION ON ADMISSION He seemed very dishevelled, blond hair, perplexed expression, was smoking a cigar, made good eye contact, good rapport, hesitant speech. Mood - subjectively "dead inside", despairing with periods of anxiety. Objectively flattened affect, loss of interest and enjoyment, very disturbed, wakes early at 6.00am instead of 11.00am. Can't get back to sleep. Thoughts - muddled. He has mild thought disorder, vague, difficulty to focus on content of his speech. He had suicidal ideation but no intentions or plans. He had no abnormal beliefs or experiences. For the last two weeks he feared that he would die in his sleep. No references, persecutory or grandiose ideas. No passivity experiences. No abnormal perceptions or thoughts. No hallucinations. Orientation - he was not orientated in date, day, place or person and he could not find his way back to the room where he was interviewed. Memory - he was able to recall

Document 9.4.2. Discharge summary, page two.



[redacted] NHS TRUST

Page 2

19 January 1995

DISCHARGE SUMMARY - SIMON CLARKE

half of the address which was given to him two minutes earlier. Insight - he does not know why he is here and was asking if he should go but did not need much persuasion to stay.

PHYSICAL EXAMINATION *He was fit.*

INVESTIGATIONS *These all showed Simon to be physically healthy.*

TREATMENT AND PROGRESS *Following his admission to the hospital, he started treatment with TRIFLUOPERAZINE 10mg nocte plus PROCYCLIDINE 5mg bd. Over the next few days he remained quite agitated and restless and prn THIORIDAZINE was prescribed and given. He subsequently was put on close observations. After one week he remained thought disordered, had thought insertion, delusions of persecution, for example "people and everyone are against me". He was frightened and scared of his surroundings. He was depressed in mood and felt that life is not worth living. The TRIFLUOPERAZINE was then stopped, due to his unchanged state of mind. Simon was also visited by his parents frequently and has been going out accompanied by them for a couple of hours on several occasions.*

On the 3rd October 1994 he was seen by Dr [redacted] on the Ward Round, who found him psychotically ill with some peculiar experiences, delusions and hallucinations. He was transferred to [redacted] Ward.

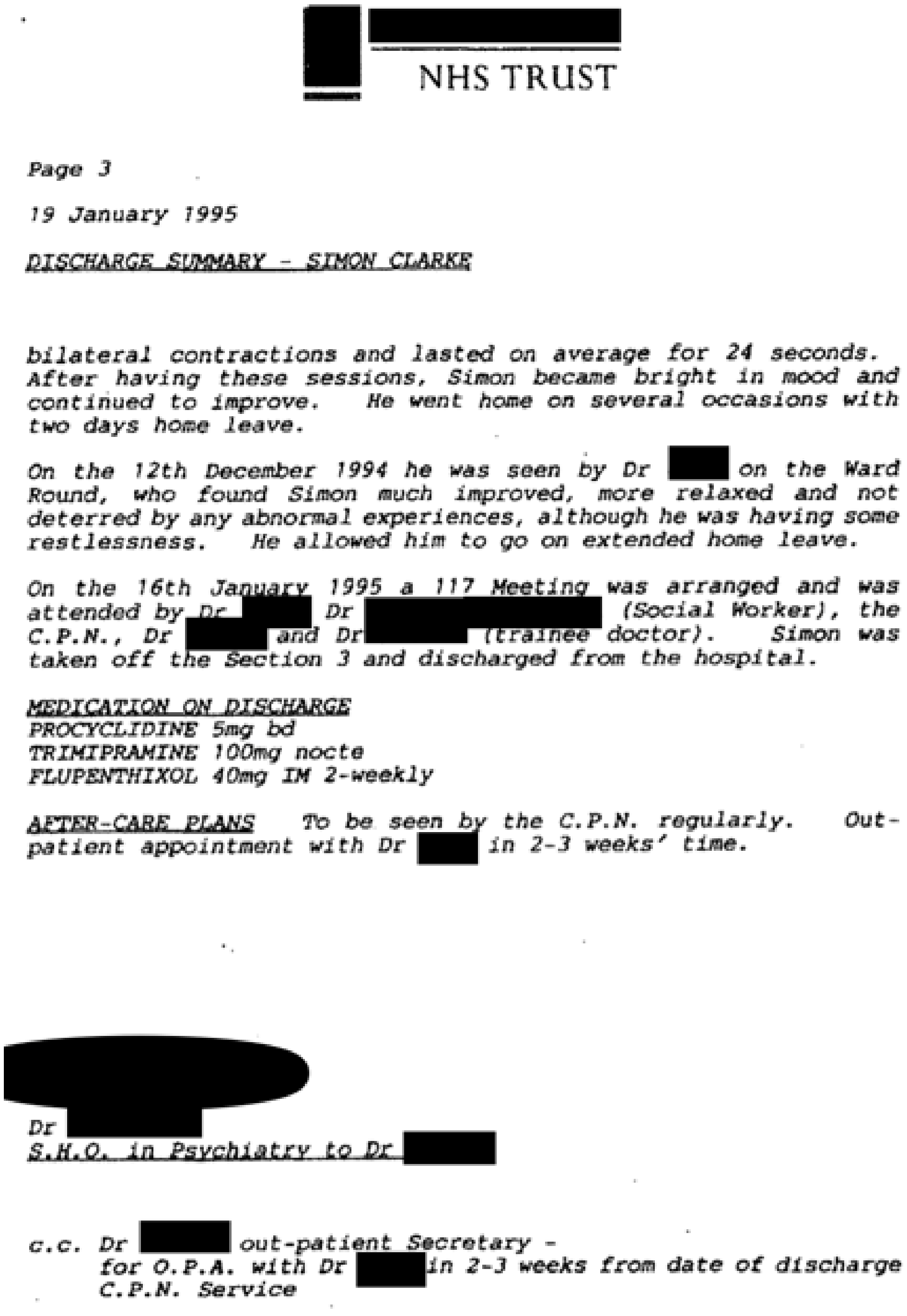
On the 6th October 1994 Simon was assessed and a Section 3 was applied for. At that time he appeared less agitated and was improved but he was still displaying persecutory delusions and feeling that harm might come to him or his family. He also talked about the illicit drugs he used to take and how it worries him now.

On the 7th October 1994 he was put on TRIMIPRAMINE 100mg nocte, HALOPERIDOL 5mg tds and CHLORPROMAZINE 100mg nocte for a 10 day trial.

With time he became a bit more relaxed and, on several occasions, was able to go home for a whole day's leave. During that time he remained paranoid and felt unsafe.

From the 8th November 1994 he was given CLOPIXOL INJECTION 200mg every two weeks and on the 16th November 1994 he started treatment with ECT and took between six and eight sessions. His Depot Injection was also changed from CLOPIXOL 200mg 2-weekly to DEPIXOL 40mg 2-weekly. All his ECT sessions were with good

Document 9.4.3. Discharge summary, page three.



[redacted] NHS TRUST

Page 3

19 January 1995

DISCHARGE SUMMARY - SIMON CLARKE

bilateral contractions and lasted on average for 24 seconds. After having these sessions, Simon became bright in mood and continued to improve. He went home on several occasions with two days home leave.

On the 12th December 1994 he was seen by Dr [redacted] on the Ward Round, who found Simon much improved, more relaxed and not deterred by any abnormal experiences, although he was having some restlessness. He allowed him to go on extended home leave.

On the 16th January 1995 a 117 Meeting was arranged and was attended by Dr [redacted] Dr [redacted] (Social Worker), the C.P.N., Dr [redacted] and Dr [redacted] (trainee doctor). Simon was taken off the Section 3 and discharged from the hospital.

MEDICATION ON DISCHARGE
PROCYCLIDINE 5mg bd
TRIMIPRAMINE 100mg nocte
FLUPENTHIXOL 40mg IM 2-weekly

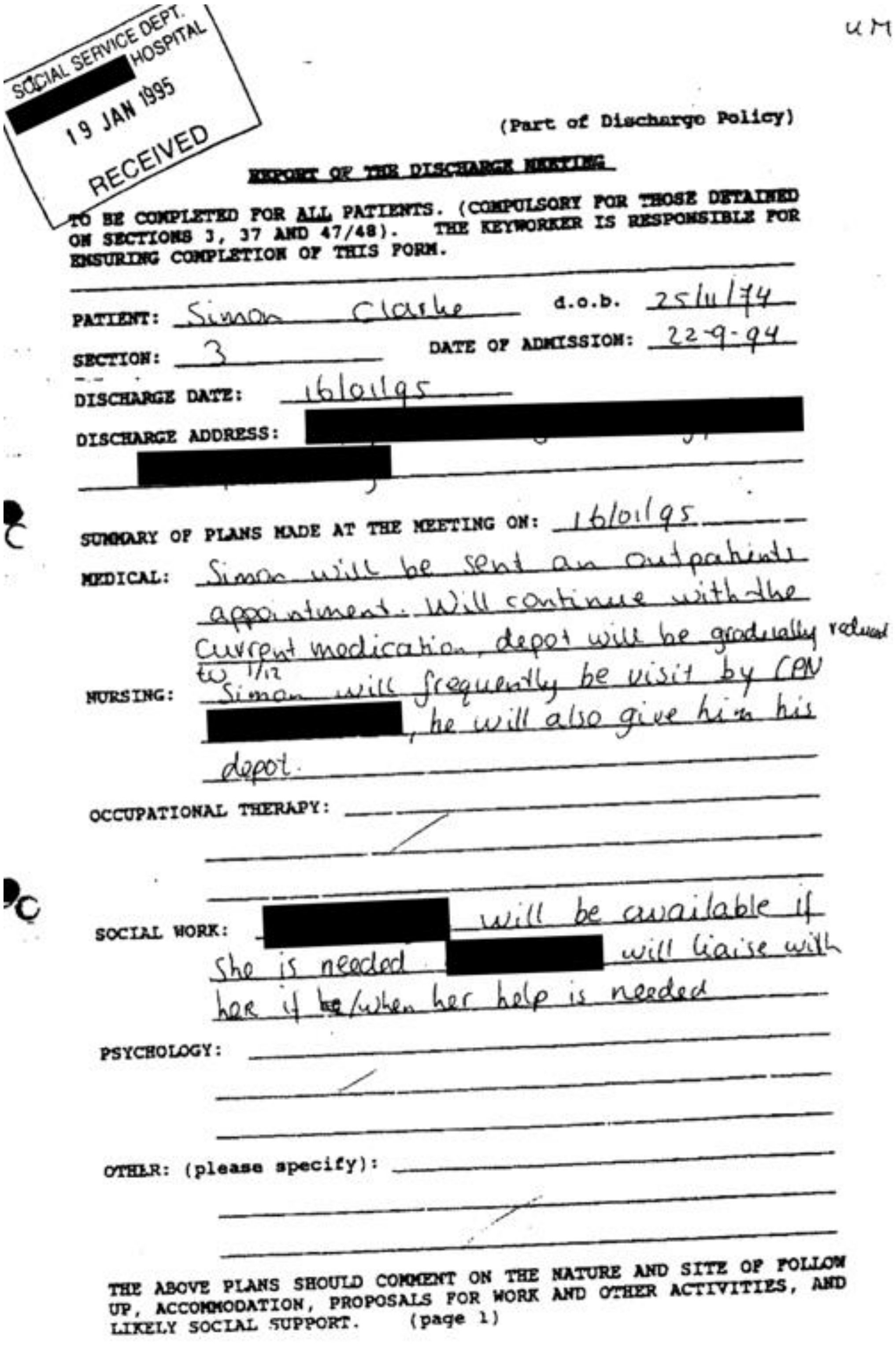
AFTER-CARE PLANS *To be seen by the C.P.N. regularly. Out-patient appointment with Dr [redacted] in 2-3 weeks' time.*

[redacted]

Dr [redacted]
S.H.O. in Psychiatry to Dr [redacted]

c.c. Dr [redacted] out-patient Secretary -
for O.P.A. with Dr [redacted] in 2-3 weeks from date of discharge
C.P.N. Service

Document 9.5.1. Discharge plan, page one.



SOCIAL SERVICE DEPT.
[redacted] HOSPITAL
[redacted]
19 JAN 1995
RECEIVED

UM

(Part of Discharge Policy)

REPORT OF THE DISCHARGE MEETING

TO BE COMPLETED FOR ALL PATIENTS. (COMPULSORY FOR THOSE DETAINED ON SECTIONS 3, 37 AND 47/48). THE KEYWORKER IS RESPONSIBLE FOR ENSURING COMPLETION OF THIS FORM.

PATIENT: Simon Clarke d.o.b. 25/11/74

SECTION: 3 DATE OF ADMISSION: 22-9-94

DISCHARGE DATE: 16/01/95

DISCHARGE ADDRESS: [redacted]

[redacted]

SUMMARY OF PLANS MADE AT THE MEETING ON: 16/01/95

MEDICAL: Simon will be sent an outpatients appointment. Will continue with the current medication, depot will be gradually reduced to 1/12

NURSING: Simon will frequently be visit by CPN [redacted], he will also give him his depot.

OCCUPATIONAL THERAPY:

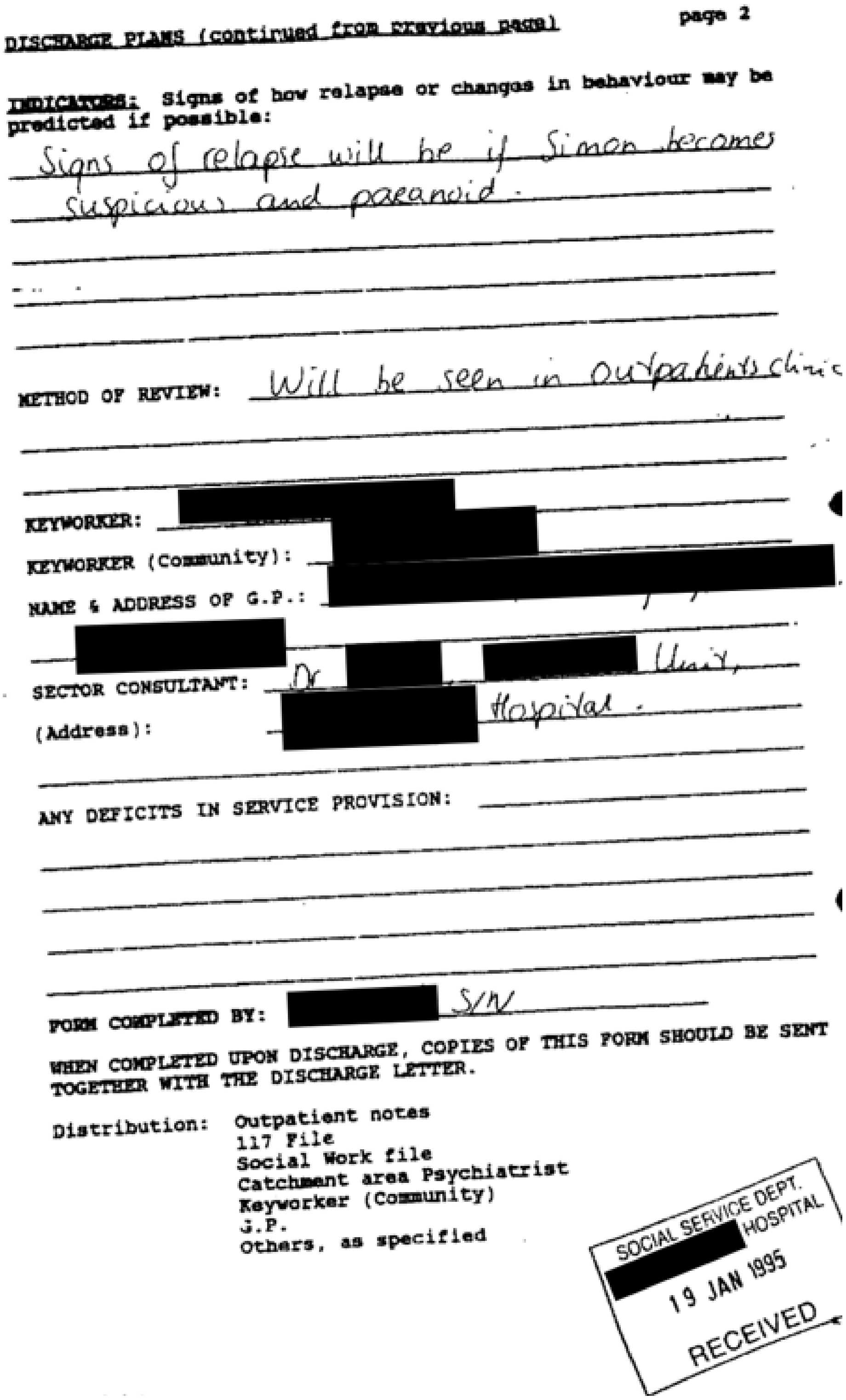
SOCIAL WORK: [redacted] will be available if she is needed [redacted] will liaise with her if ~~be~~/when her help is needed

PSYCHOLOGY:

OTHER: (please specify):

THE ABOVE PLANS SHOULD COMMENT ON THE NATURE AND SITE OF FOLLOW UP, ACCOMMODATION, PROPOSALS FOR WORK AND OTHER ACTIVITIES, AND LIKELY SOCIAL SUPPORT. (page 1)

Document 9.5.2. Discharge plan, page two.



DISCHARGE PLANS (continued from previous page) page 2

INDICATORS: Signs of how relapse or changes in behaviour may be predicted if possible:

Signs of relapse will be if Simon becomes suspicious and paranoid.

METHOD OF REVIEW: Will be seen in outpatients clinic

KEYWORKER: [redacted]

KEYWORKER (Community): [redacted]

NAME & ADDRESS OF G.P.: [redacted]

[redacted]

SECTOR CONSULTANT: Dr [redacted] [redacted] Univ,

(Address): [redacted] Hospital.

ANY DEFICITS IN SERVICE PROVISION:

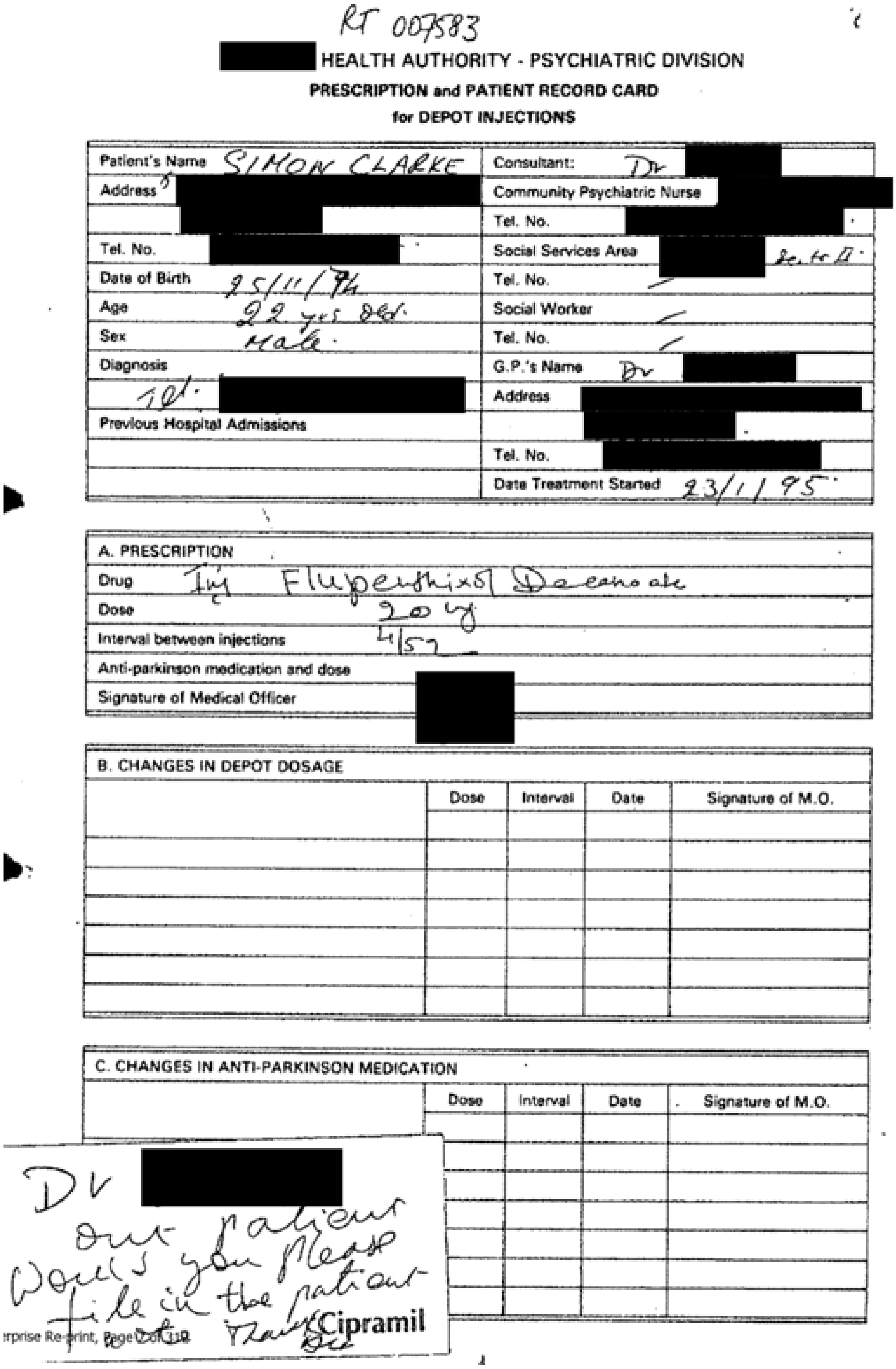
FORM COMPLETED BY: [redacted] S/N

WHEN COMPLETED UPON DISCHARGE, COPIES OF THIS FORM SHOULD BE SENT TOGETHER WITH THE DISCHARGE LETTER.

Distribution:
- Outpatient notes
- 117 File
- Social Work file
- Catchment area Psychiatrist
- Keyworker (Community)
- G.P.
- Others, as specified

SOCIAL SERVICE DEPT.
[redacted] HOSPITAL
19 JAN 1995
RECEIVED

Document 9.6. Prescription card for depot injections.



RT 007583

[redacted] HEALTH AUTHORITY - PSYCHIATRIC DIVISION

PRESCRIPTION and PATIENT RECORD CARD
for DEPOT INJECTIONS

Patient's Name	SIMON CLARKE	Consultant:	Dr [redacted]
Address	[redacted]	Community Psychiatric Nurse	[redacted]
	[redacted]	Tel. No.	[redacted]
Tel. No.	[redacted]	Social Services Area	[redacted] Sector II.
Date of Birth	25/11/74	Tel. No.	—
Age	22 yrs old.	Social Worker	—
Sex	Male.	Tel. No.	—
Diagnosis		G.P.'s Name	Dr [redacted]
	[illegible] [redacted]	Address	[redacted]
Previous Hospital Admissions			[redacted]
		Tel. No.	[redacted]
		Date Treatment Started	23/1/95

A. PRESCRIPTION	
Drug	Inj Flupenthixol Decanoate
Dose	20 mg
Interval between injections	4/52
Anti-parkinson medication and dose	
Signature of Medical Officer	[redacted]

B. CHANGES IN DEPOT DOSAGE

	Dose	Interval	Date	Signature of M.O.

C. CHANGES IN ANTI-PARKINSON MEDICATION

	Dose	Interval	Date	Signature of M.O.

Dr [redacted]
our patient
Would you please
file in the patient
notes
Thanks
Dr

Cipramil

rprise Re-print, Page [illegible] of 110

CHAPTER 5. ANALYSIS

INTRODUCTION

The previous chapter presented the data of the thesis in the form of a multi-layered narrative, called a ‘quadrilogue’, that depicted a pathway through an inpatient psychiatric unit, from admission to discharge. There were nine parts of the narrative in total and each part covered a different aspect of the inpatient process. This narrative was based on my experience of being a psychiatric inpatient in 1994 and presented four main perspectives on the experience: mine, compiled from memories, poems and notes written at the time and then reconstructed in the form of a second-person narrative; my mother’s, told through her diary that she wrote during the time just before I was admitted; that of the clinical team, reported through my NHS clinical notes; and that of the reflective voice, compiled from research diaries and through conversations with supervisors, colleagues and family members during the research process.

The quadrilogue was generated in response to the thesis research questions. The primary thesis question was: what is an authentic representation of madness? A secondary question, related to the first and overlapping with it to some extent, was: what does an authentic representation tell us about the social context in which madness is treated? This chapter outlines the method I used to answer these questions. I begin by discussing different analytic methods and the rationale for my choice of reflexive Thematic Analysis (TA). I then describe how this method was applied to the narrative through the coding process. Finally, I explore how three main themes (double binds, mis/recognition, despair) were generated from the coding process.

5.1 Analysis Framework and Method

5.1.1 Choice of Thematic Analysis

The data will be analysed using an abductive TA approach. TA is a method frequently employed in health and social science research in order to systematically identify important patterns across the data that might be interesting or important to the research focus or question (Braun and Clarke, 2006). One danger in the analysis is that the dialogical approach taken by the thesis needed to avoid becoming over-prescriptive and 'monological'. As Frank (2005) elaborates, 'Monological research imagines the words of research participants as raw material for its analyses. Qualitative researchers are unfortunately prone to adopt the quantitative researchers' usage of referring to "raw data," suggesting that the true value of the final report lies in the process of refining, finishing, and, one could even say, civilizing this raw material' (p. 90). Thus, there was a balance that needed to be maintained in the analysis: between allowing the narrative sufficient space to 'breathe' (Frank, 2010), whilst also enabling a systematic relation of 'data' to theory, and vice versa, in order to say something meaningful about madness and its treatment in social context. As there is no set way of doing TA (Clarke and Braun, 2018), this allowed for some degree of flexibility in how the analysis was applied, avoiding an over-prescriptive monologicalism described by Frank (2010).

Several other approaches were also considered, including Discourse Analysis (DA), Narrative Analysis (NA), Grounded Theory (GT) and Interpretative Phenomenological Analysis (IPA). GT was discounted on the grounds that the coding procedure is rigorously prescriptive and thus potentially too monological for the dialogical approach taken in the thesis. Although IPA has been used in conjunction with autoethnography and narrative approaches (see Allen-Collinson, 2011), the theoretical position underlying IPA makes assumptions regarding the authenticity of self and society that are not consistent with the non-essentialist, ‘tactical’ perspective on self and authenticity taken by this thesis and discussed in Chapter 2. DA was appealing on the basis that it analyses both the processes of how ‘talk’ is transformed into discourse and the discursive functions underlying talk (Parker, 1990). Some variants of DA linked with Foucauldian theory also allow for an analysis of discursive power (Hook, 2001), particularly in terms of institutions such as psychiatry and how psychiatric subjects are constructed in discursive formations (Iliopoulos, 2012). However, DA was rejected on the basis that the focus on discourse alone was too limited for the scope of the thesis; whilst I was interested in showing how psychiatric practices might transform the patient subjectivity into particular discursive formations, I also wanted to show how pivotal roles and actions also contributed to the construction of a psychiatric subject beyond a focus on discourse alone. Ultimately, because action and personal subjectivity in DA is often reduced to a too narrow conception of discourse (Parker, 2013), I thought DA would be too limited for the purposes of this thesis.

Autoethnography is considered a form of narrative inquiry (Bochner, 2001). Narrative Analysis (NA), on the other hand, is a more explicit method of analysing and discussing the products of narrative, particularly in terms of the main narrative's (and narrator's) content and structure (Riessman, 1993). Like TA, there is no set way of doing NA and the form and function of the analysis will depend on the epistemological assumptions underlying the research and the research question itself (Etherington, 2004). For example, a structural NA approach might look at how a story is structured and what is disclosed or omitted in the central narrative, whilst a constructionist version of NA might look at how different narrators in the story are positioned (and how they position themselves) within the narrative itself (Riessman, 1993). As a methodology of narrative analysis, autoethnography can be applied on the basis of different epistemological assumptions (Chang, 2008).

However, a narrative methodology need not be analysed using a strict form of NA (Frank, 2005). One of the drawbacks of using NA for mental health research is that the central focus of NA is on the story itself, largely to the detriment of other factors such as discourse, power and role (Russo, 2016a). Whilst these elements of discourse and role might be considered important in NA as a by-product of narration, they are considered secondary to the analysis of the function and form of the narrative itself (Riessman, 1993). This thesis is looking at how a particular subject is constructed in particular discourses alongside personal experience and as it occurred in a context dominated by the powerful discursive form of psychiatry. It is not just looking at the narrative expression of these discursive formations.

Another weakness of NA is that it is assumed to be supported by narrative theory. Whilst there are many variations of how narrative is understood and the form the analysis takes may differ according to the context in which the research takes place (Ethrington, 2004), one of the key assumptions is the story's linearity in terms of beginning, middle and end, along with an analysis of the development of a person's story across the lifespan (Riessman, 1993). As discussed, it is very difficult to assume linearity or tight narrative structure in madness and any attempt to do so risks imposing too much upon the data (Stone, 2004). Also, rather than providing a life-history approach to the events described in the data section, this thesis is looking at the events within a very concentrated time period. I am thus not considering broader narrative constituents of the main participants in the data and so an NA method would not allow for a detailed analysis of the data itself. Finally, the implicit assumption of narrative theory on the authenticity of self (Bochner, 2001) is inconsistent with this thesis' approach, which troubles the relation between authenticity and narration.

For this thesis therefore, TA has a number of advantages over NA. It is both interpretative and descriptive and so enables an analysis of both semantic themes (i.e. the explicit and surface meanings of what is said without interpretation) and latent themes, 'the underlying ideas, assumptions, and conceptualisation – and ideologies - that are theorised as shaping or informing the semantic content of the data' (Braun and Clarke, 2006, p. 84). As this thesis is both seeking to describe the experiences of madness and consider some of its underlying social determinants, TA is well-suited to the core aims and focus. Finally, unlike NA, TA is atheoretical, although theory can, and should, support the analysis in an informed way (Clarke and Braun, 2019). Thus, TA gives my approach more flexibility in terms of using theory outside of a narrow narrative lens. As the theoretical approach outlined in Chapter 2 is sceptical about the possibilities of exclusively narratological understandings of human phenomena, particularly in madness, it would be inconsistent to adopt wholesale a narrative analytic approach in this section.

5.1.2 Thematic analysis and abduction

TA can be applied deductively (i.e. ‘top-down’, applying pre-existing theory to the data), or inductively (i.e. ‘bottom-up’, data-driven) in terms of analysing data (Clarke, Braun and Hayfield, 2015). A third possibility is offered by the abductive tradition (Tavory and Timmermans, 2014). An abductive approach entails relating emergent data back to concepts and theory with the intention of extending, clarifying or challenging pre-existing concepts, whilst also relating theories back to the data in order to inform subsequent data analysis and theming (Clarke and Waring, 2018). A key purpose of this thesis is to relate some of the main themes of the narrative to existing critical theory, whilst also looking at how the data may inform the development of new understandings on psychiatric practice. The abductive tradition, compatible with TA, thus allows for a dialogic approach between theory and data (Tavory and Timmermans, 2014) that is consistent with the focus of the thesis.

In addition, the decision to use TA was based on the need to identify and extract key themes that speak across perspectives and provide meaningful patterns across the four main sources. An abductive thematic analysis was thus used to search the data for repeated patterns of meaning that could then be grouped according to themes and related to existing theory. Consistent with an abductive approach (Clarke & Waring, 2018), these themes, once identified from the data, were then related to existing theory, including the theory discussed in Chapter Two in relation to the difficulties of establishing the concept of authenticity and the limits of mad narratives to speak about madness. As the question of authenticity and first-person voice is a highly contested issue that needs to employ authenticity in a ‘tactical’ way with madness narratives, it also necessitates a significant engagement with theory prior to analysis. An abductive approach thus allows for a more flexible, ‘tactical’, engagement with theory in a way that more the rigid inductive, or the looser deductive, methods would not allow.

5.1.3 Latent thematic analysis and reflexivity

A latent thematic analysis was also used (Clarke and Braun, 2018), whereby the analysis goes ‘beyond the semantic content of the data, and starts to identify or examine the underlying ideas, assumptions, and conceptualizations - and ideologies - that are theorised as shaping or informing the semantic content of the data’ (Braun and Clarke, 2006, p. 84). This form of TA has been called ‘reflexive TA’ by Braun and Clarke (2019). In other words, themes are not ‘discovered’ as they ‘emerge’ from the data but are actively created through the process of organising and analysing the sources of data as a whole. This process includes the use of theory and reflexivity as analytic tools in the development of the main themes, as the analysis proceeds (Clarke and Braun, 2013).

This approach was necessary because the nature of the research question itself and the type of data some of the thesis was using (i.e. data derived from personal experience). More importantly perhaps, the research question is looking at different representations of madness and what these representations tell us about how society deals with madness. A latent, reflexive approach is useful as an analytic method because it allows for an analysis of the discursive patterns that were constitutive of the ‘me’ that had these experiences, and the overlaps between the different discursive constructions of ‘me’.

A key analytic tool in this process of developing latent themes was the use of reflexivity. Reflexivity is defined as the way a researcher attends to the process of knowledge construction, particularly in terms of how the data impacts upon them (Clarke and Braun, 2013). Reflexivity is a concept that is allied to interpretative notions of reality and thus assumes an engagement with data at a latent, rather than at a semantic, level (Clarke et al., 2015). It is also a vital and indispensable component of autoethnography because of the method’s use of personal experience and it is then utilised as ‘data’ in the consideration and analysis of social context (Ellis, 2004).

However, in terms of my thesis, the use of reflexivity was also a way of managing myself in the process of looking at very difficult emotional material. The memories were considerably painful and sometimes traumatic, and it was often a challenge to consistently return to them. Analysing these very painful experiences also required a degree of personal strength alongside the reflexivity that gave me some capacity to consider the experiences according to a wider lens, for example, in terms of different perspectives and discourses on the experiences. It also necessitated a closer working with my supervisors to ensure that this process did not become overwhelming, and that I was able to maintain an appropriate level of academic distance to the material.

5.2 Analysis of the Narrative

5.2.1 Coding the data

Given the issues discussed above, it was therefore appropriate for me to identify latent themes across the four perspectives according to the steps outlined by Braun and Clarke (2006). These steps provide a broad guideline and flexibility is required in terms of how these steps are applied to the specific data, research methodology or research question (Braun and Clarke, 2019). The steps outline by Braun and Clarke (2006) can be outlined in the following way:

1. Familiarising yourself with your data: transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes: coding interesting features of the data in a systematic fashion across the entire data set and collating data relevant to each code.

3. Searching for themes: collating codes into potential themes and gathering all data relevant to each potential theme.
4. Reviewing themes: checking if the themes work in relation to the coded extracts and the entire data set.
5. Defining and naming themes: ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report: selection of extracts for final analysis, relating back of the analysis to the research question and literature, and producing a scholarly report of the analysis.

Although these steps were followed in a fairly consistent way, I needed some flexibility in how I approached the analysis of the data in line with both the methodology and the theory underlying the choice of methodology. This is especially relevant in terms of my thesis: the quadrilogue is an autoethnographic methodology that requires a significant degree of adaptation with regards to traditional methods of data collection because of the use of personal experience as primary data alongside other sources. However, the data in the quadrilogue presents more unusual challenges in that it combines both ‘evocative’ depictions of personal experiences alongside traditional social science data sources such as diaries and medical notes. These sources were constructed according to different purposes (e.g., my mother’s perspective via her diary, which she told me was for the purpose of containing overwhelming emotions; whilst the clinical notes are legal documents and statutory requirement for NHS staff to record clinical information) and so needed a flexible method to respond to these differences (Chang, 2016). Likewise, the development of the methodology was closely tied to theoretical positions including narrative (e.g. Frank, 2005, 2010) and critical theory (e.g. De Certeau, 1984; Spivak, 1988, 1990). These theories emerged from discussions around the insufficiency of narrative and concepts such as ‘authenticity’ in Chapter Two, emphasising the fluid, non-essentialist nature of the self (Spivak, 1990; Wright, 2002), especially for experiences such as madness (Stone, 2004). Given these challenges, a more interpretivist stance was taken (Clarke and Braun, 2019).

This flexibility related to both the stages of initial coding and in terms of developing the wider themes. For example, Step 1 (‘Familiarising yourself with your data’) is complicated by the fact that the data is based on my personal experience. My closeness to the data, in terms of it being drawn from my experience (either directly through my account, or indirectly through mother’s diary and NHS notes), necessitated a process of *de-familiarisation* in terms of separating myself from the events of which I had prior knowledge. However, alongside this, it also required a process of *familiarisation.* For example, I had to read other people’s experience of me, including my mother’s diary and the clinical notes. As I had not read either of these sources in any particular depth, it was like coming to them for the first time. However, they were not quite *unfamiliar* either, as I could remember some of the events depicted, even if, at times, they differed to my recollection in minor or major ways.

Thus, my experience of aspects of the data, most notably the depictions of me as represented in the notes and in my mother’s diary, were not straightforwardly familiar or unfamiliar. As Chang (2008) has observed, such challenges can arise in autoethnography when other sources are used alongside personal experience as data. However, ambiguity with regards to personal experience data was further complicated for me in terms of my own experience of the events. These experiences had taken place many years ago but, due to their extreme nature, were also *unfamiliar* to me. As many of the experiences took place when I was ‘not in my right mind’, they were therefore strange and unfamiliar to me at the time of experiencing them. They were thus never really ‘familiar’ to me in first place.

This dual relationship of familiarity and de-familiarity to the data thus made this step very complicated and could perhaps be better described as (*de)familiarisation,* i.e., a familiarity that was, at the same time, deliberately made unfamiliar. In order to support this process of (de)familiarisation, I kept a research diary with my reflections and observations on the data as it occurred to me during this process. These personal reflections were supplemented mainly through discussions with my supervisors and other colleagues.

However, it was also supported through feedback when I presented the material at conferences and at seminars, as well as conversations with colleagues and peers, friends and family members. As an example of this process, at one conference I presented the ward round episode in Part 3 and one psychiatrist, in particular, took umbrage. He was particularly concerned with my interpretation of the ward round, especially with my description of the doctor ‘running away’ and the implication that this psychiatrist’s behaviour was ‘intimidating’ rather than ‘concerned’. Although I felt the psychiatrist’s response was overly defensive, perhaps on the basis of professional camaraderie, it led to an engaging discussion about such things as the role of interpretation, differences of perception, how medical interventions may exacerbate tensions etc. From this, I was able to see that the data and method was interesting to peers and colleagues; it was challenging and likely to provoke discussion and debate; and could provide useful in terms of an educative tool. It also encouraged to be more reflexive with the data, particularly with regards to seeing other people’s perspective on the data.

These ongoing reflections crystallised into a separate ‘voice’. Whilst the material of the other three ‘voices’ in the quadrilogue (Simon, mother, clinical team) had already been synthesised, the fourth ‘voice’ summary of these reflections was eventually synthesised to become the fourth voice of the researcher in the quadrilogue. This fourth voice was situated alongside the other three voices in the quadrilogue, providing a form of early analysis and reflection. When I began the formal process of analysing the data, I returned again to this fourth voice in order to begin identifying initial themes and patterns that had already been constructed from this voice.

Important themes were thus already being identified from this early stage. Having collated the quadrilogue along with the researcher’s reflective voice, I began to analyse the data relating to the three perspectives of patient, mother and clinical team in more detail in order to start to identify portions of the text that could fit more discrete units of code. This stage corresponded with Step 2 (Generating initial codes) outlined by Braun and

Clarke (2006). I did not code the researcher voice because, to some extent at least, this voice was already part of the analysis in terms of providing an extended reflection and commentary on the data itself. Therefore, having gained some idea of what the important themes may be, I went through each of the three perspectives in the nine sections of the data systematically, coding sections which were relevant or salient according to initial impressions that were named with a short piece of text. Whilst the fourth voice in the quadrilogue initially provided a lens to focus the process of coding so that the most salient aspects of the data could be gleaned according to these reflections, during this stage of coding the data from the researcher voice was set aside in order to allow a fresh perspective on the data.

During this process I used what Jackson, Backett-Milburn and Newall (2013) call ‘emotional reflexivity’, which they describe as the researcher’s focus on the impact of the work on them *at an emotional level* during the process of conducting the research and analysing the data. At this stage, the work became exceedingly difficult: I found myself becoming emotional in response to reading the material, often weeping at my computer screen. I sometimes felt a keen sadness towards my younger self and overwhelming grief at the cost this series of events had had for me. I felt anger towards my parents, that they abandoned me to the inpatient, so quickly in my opinion, and were then so gushing in their praises of the ward. I also felt considerable anger towards the mental health service in general, and towards some staff members in the hospital in particular.

The process reminded me of a play by Winship, Hall and MacDonald-Winship (2014) based on Bion’s (1997) war memoirs, that I was fortunate to see at the time of analysing the data. In this dramatic reconstruction, old Bion, now in his 80s, encounters his younger self, on demob from his experiences of the horrors of the First World War. Older Bion berates his younger self, calling him ‘flatulent’ and ‘priggish’. His younger self seems nonplussed by this, and almost amused. However, both older self and younger self share the trauma of what happened. When watching the play, and subsequently reading the passage from Bion’s (1997) memoirs, I was struck by how this ‘trauma’ of losing my mind and being sectioned, and the impact it had had on me, seemed to provide a bridge between my old and younger self. It enabled me, perhaps, to be more reflective and even compassionate. I found myself feeling pity and guilt towards my mother, through what she had gone through watching me suffer, with her sense of desperation and powerlessness and her feelings of grief at the ‘loss’ of her son. I could also see that staff were often placed in impossible positions, which I could not appreciate at the time. I remembered the patient at the end, who helped me and made me feel safe, even when I was unable to reciprocate. Towards the end of the process, I felt something of an echo of Bion’s older self: ‘in the end you will live a life filled with knowledge and you shall accept your burdens as a source of strength’ (Winship et al., 2014, p. 11).

All of these reflections added to the process of coding. The coding frame itself is provided in Appendix 3. These codes were initially used as markers to anchor the relevant piece of text with signifiers that captured some important aspect of the data. Once the complete data set had been coded in this way, I went back over from the start of the data again, recoding sections according to how they corresponded to data that occurred later in the narrative. These codes became broad ‘central organising concepts’ (Braun and Clarke, 2013) underpinning and uniting the apparent disparate observations and capturing the implicit meaning the data alluded to, but which was consistently present throughout the narrative as a whole. This part of the process corresponded broadly with Step 3 (Searching for themes: collating codes into potential themes and gathering all data relevant to each potential theme) of Braun and Clarke’s (2013) guidelines, with the important caveat that extracts from the data were not gathered into their respective themes, but the themes mapped across the data as a whole. This was to maintain the narrative integrity of the data and to avoid a ‘monological’ (Frank, 2005) approach to data analysis that separated different elements without maintaining the integrity of the data as a whole.

5.2.2 Generating themes

Following the coding of all nine sections, the codes were then reviewed in light of the full data set and the codes organised into preliminary themes. This corresponded to Steps 4-6 of Braun and Clarke’s (2006) guidelines. Themes were first identified as appropriate ways of describing patterns of codes that were similar in nature. For example, there were frequent occurrences of codes called ‘double binds’ and these codes described circumstances when people in the narrative seemed to find themselves placed in ‘no win’ situations. However, there were also codes (e.g. ‘internal contradictions’) whereby a form communication could be characterised as containing contradictory or conflicting messages. Whilst reading critical theory alongside the coding I came across Gregory Bateson’s (1972) theory of the double bind which appeared to capture perfectly these instances of no-win situations revealed through contradictory communication. In discussion with supervisors, we agreed that this theoretical framework was a good fit for the coding of these particular instances in the data. Thus, the first theme was created: double binds.

Having identified ‘double binds’ as a preliminary theme, I then returned to the data set to search for other patterns that could be constructed into other themes. Another frequent occurrence in the coding was instances when people in the narrative interpreted the meaning of situations, or other people’s communications, in ways that appeared to be at odds with other people’s interpretations of the same situation. For example, in my narrative I often imbued events with a particular signification that reflected a certain view of the world that did not appear to be shared by others (e.g. interpreting the events of the ward round in Part 3 as a fatalistic intervention by evil spirits; interpreting neighbours’ conversation as evidence there was a conspiracy against me and my family.) These events were coded in various ways such as ‘projections’, ‘paranoia’ or ‘mistrust’ and reflected instances of a framework of meaning imposed onto events to give them a certain interpretation.

However, I noticed that this was also present in the clinical team's account, albeit in the form of psychiatric language and terminology imposed on my and my mother's experience. For example: in Part 2, the psychiatrist used the signifier 'despair' but treated the symptom in terms of a psychiatric category without checking my meaning; in Parts 2, 3 and 4 the psychiatric assessments frequently focussed on my behaviour in other institutional contexts such as school, often without a clear relevance to my presenting problem. These particular events in the narrative were coded in various ways, such as 'diagnostic transformations', 'coercion' and 'institutional cross-checking'. Finally, I also observed that my mother employed similar tactics whereby past events in my life were reinterpreted by her in certain ways, such as signs of medical illness. These were coded in the analysis with codes such as 'interferences about causality' and 'search for meaning'.

As I progressed in the coding through the narrative, these events were labelled 'misrecognition' as this seemed to be an appropriate signifier for a theme that described the numerous discrepancies in meaning that occurred between the different accounts, and thus became the working title of the second theme. However, in discussing the theme with my supervisors, I quickly realised that the term 'misrecognition' was not quite exact enough: it implied that what had occurred in the narrative was the misconstrual of an 'essential' meaning that these other interpretations had somehow 'missed'. However, as I argued in Chapter 2, it is not desirable (or even possible) to fix an essential meaning in this way. After reading more theory, in particular Lyotard's (1983) concept of the differend, I realised what was occurring appeared to be much more fundamental and that particular ways of understanding the world (e.g. psychiatric) were being imposed on others (mine and my mother). Even worse, it was impossible for me and my mother to express our complaints in the terms dictated by the discursive framework of medico-legal psychiatry. Thus, any attempt at ‘recognition’ was bound to lead to increased suppression and domination, or ‘mis/recognition’. Indeed, this realisation that there is a violence inherent within psychiatric discourse that creates a schism within the act of recognition led me to re-label the second theme with the oblique between ‘mis’ and ‘recognition’.

For the third theme, I noticed that there was a significant focus in the narrative on affect, revealed through the coding, mostly of a negative nature. In the clinical notes, this was either described as an absence of affect (e.g. ‘negative symptoms of schizophrenia’; ‘emotional flatness’) or the presence of ‘anxiety’ or ‘depression’. In my account, my main affect state was characterised by me early on as ‘despair’, although I also mentioned ‘fear’, ‘terror’ and ‘dread’. My mother’s account made frequent reference to affect as well, and this was either her descriptions of my affect state that employed medicalised signifiers (‘paranoia’) or the use of her own words (‘disturbed’).

That negative affect was important in the narrative, and a frequently occurring code, was thus undeniable. The question for me was deciding which aspect was the most significant for the thesis and how best to group these codes into a theme that best captured the experience. During discussions with my supervisors, I identified that all of these instances could be captured by the word I initially used at the beginning of the narrative to describe my experiences: *despair*. Further reading into this concept revealed that there was a paucity of theory using this signifier in the mainstream psychiatric literature, but that it had been covered to some degree by existentialist and psychoanalytic writers. Significantly, these writers not only talked about the despair *in* psychosis, but the despair generated *by* psychosis. It therefore fitted as a descriptor across all the three accounts in the narrative. I had thus identified the third and final theme of the thesis.

5.3 Discussing the Themes

In the following three Chapters, I will be discussing the three themes generated from the analysis of the narrative: double binds, mis/recognition and despair. In order to relate the data to the research literature and back again, I will be referencing particular sections in the narrative: Parts (1-9), accounts (Simon, Mother, Clinical Notes), along with the line numbers of specific text. All references to the narrative will thus be accompanied by these three pieces of identifying information. For example, a reference to text in my account in Part 3 at lines 2-3 would be represented in the following way: S3:2-3. Along with this, I will also be referring directly to the documents that append each Part.

SUMMARY

This section outlined the method I used to analyse the data in the narrative, namely reflexive thematic analysis. I outlined the rationale for choosing this approach against other alternatives. I then described the steps involved in the analysis, from coding the narrative to producing the main themes. Three themes were eventually constructed from the data: double binds, mis/recognition and despair. The next three chapters will discuss these themes in more detail.

CHAPTER 6. DOUBLE BINDS

INTRODUCTION

In the last chapter, I discussed my analysis strategy. I began by identifying several different possible approaches to analysing the data, before arguing for the use of reflexive Thematic Analysis (TA) as the best fit for the thesis methodology. I also argued for an abductive use of TA which involves relating the data to existing theory and vice versa, as opposed to using an exclusively, ‘bottom-up’ inductive approach or a ‘top-down’ deductive form of TA. I then described my application of TA to the data in the narrative, including the coding procedure and my use of reflexivity and theory. Finally, I discussed how the main themes were generated from the coding and through the use of theory. The analysis resulted in three main themes in total: double binds, mis/recognition and despair.

In the next three chapters I will be discussing each of these three themes in detail, with a different theme per chapter. In this chapter, I will be discussing the first theme generated from the data: ‘double binds’. I begin with a clarification of the term ‘double binds’, before moving onto providing an outline of the most significant theoretical treatment of the concept, Gregory Bateson’s (1972) double bind theory, considering the ways the theory has been applied in organisational health research. I will then move onto the narrative itself, isolating several incidents where double binding communication was consistently evident. The chapter is organised according to these incidents and include admission, transfer to the ICU, ECT and discharge. It should be noted that these examples are neither exhaustive nor comprehensive, as a full outline would be well beyond the scope of this chapter. However, these examples represent the clearest moments of when double binds were most prominent in the narrative.

6.1 Double Binds

The term ‘double bind’ is often used colloquially to refer to situations where people feel pulled in different and irreconcilable directions, particularly with regards to decisions that can be characterised as “catch-22” or “damned if you do, damned if you don’t”. An example would be the fate of Field Marshal Rommel at the hands of the Nazi regime: Rommel was given a choice between committing suicide privately in return for assurances that his reputation would be preserved and his family avoiding persecution, or a trial where he faced public disgrace and execution. This situation is a double bind in the sense that whatever Rommel chose, the end result would be the same (death). Another example would be the position of voters in a first-past-the-post electoral system where the party they support has very little chance of winning in their constituency: they could either vote for a party that does not represent their needs (but may contribute to the loss of their main adversary through a ‘tactical’ vote), or vote for their own party but effectively ‘waste’ their vote.

Turning to the data, there are many situations where people in the narrative find themselves in these “catch-22” situations. For example, I needed help but the care offered by the mental health system was restrictive; my mother often seemed to be torn between caring for me and keeping the mental health team informed of what was going on; the mental team clearly wanted to help me but it is unlikely that their preferred method of treatment would have been forced restraint or involuntary detention. Taken together therefore, going mad in the narrative appeared to force “no-win” situations on all main communicants.

However, in social theory the concept of ‘the double bind’ refers more specifically to communication patterns characterised by incongruences and not just to “no win” situations. Developed originally by Bateson, Jackson, Weakland and Healey (1952) following their research into family communication in schizophrenia, the double bind theory describes the effects of ‘two contradictory injunctions at different levels of communication, involving two parties or entities, where it is not possible either to name the contradiction or to escape it’ (Bateson, 2005, p.16). In other words, double binds are not just ‘catch-22’ situations whereby people are caught between conflicting decisions but are the result of injunctions placed upon communicants that are inherently contradictory at multiple levels of communication. As I will show throughout this chapter, there are frequent examples of such communication patterns in the narrative.

In Bateson’s (1972) classic formulation of the double-bind, six interrelated characteristics of a double bind situation are highlighted, each of which need to be present for it to constitute a double bind. These are outlined below and represented schematically in Figure 1:

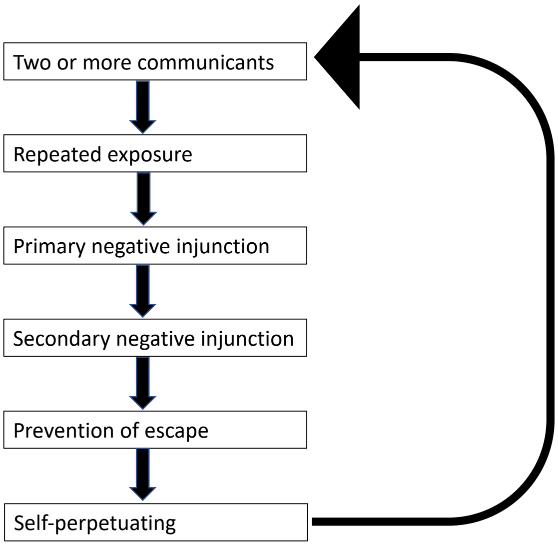
1. *Two or more communicants*. It assumed that the relationship between communicants is significant and intense. Although this has commonly been interpreted as two people, it can apply to any entity

involved in an interaction (Bateson, 2005). In Bateson's (1972) original theory, one of the communicants was identified as the 'victim' or 'recipient' of the other communicant's messages.

2. *Repeated exposure*. The double bind describes a pattern of behaviour enacted over long period of time in the experience of the recipient, not merely one-off interactions.
3. *Primary negative injunction, enforced by threats of punishment or signals that threaten survival*. The negative injunction involves a requirement to act in a certain way (e.g. 'do not do this/do this, or I will punish you') and punishment may involve either the expression of hostility or the withdrawal of love or affection.
4. *A secondary negative injunction that conflicts with the first, also enforced by threats of punishment or signals that threaten survival*. The secondary injunction is often communicated implicitly (e.g. nonverbally) and forbids the recipient from identifying the original injunction (e.g. 'I am not the punishing agent').
5. *A tertiary negative injunction that prevents the victim from withdrawing from the situation*. It is assumed that escape is impossible because of the repeated exposure to the interactions, or because the recipient is unaware of the double bind situation and so cannot comment on its existence.
6. *Double binding becomes self-perpetuating and no longer requires the full set of ingredients in order to function*. The effects of the double bind may therefore be enacted in different contexts to the

original relationship or may become internalised in the recipient's experience.

Figure 1 Bateson's (1972) double bind theory



The final step ('double binding becomes self-perpetuating') is crucial here, because it implies that the perception of double binds becomes habitual in the experience of the 'victim' and this way of perceiving gets carried through into subsequent interactions (Bateson, 2005). Indeed, Bateson (1972) suggested that what psychiatrists called the symptoms of psychosis were internalised, experiential representations of double binding communication so that 'the pattern of conflicting injunctions may be even be taken over by hallucinatory voices' (p. 208). In other words, viewing the content of symptoms such as auditory and visual hallucinations, paranoia and unusual beliefs could provide evidence of double binds.

For this theme, I argue that double binds, formulated in the terms outlined by Bateson (1972) are present throughout the narrative in terms of the communication between different communicants. I will be showing discrete examples from the data of when these types of communication occurred. By ‘communicants’ I am referring here to the three main voices in the data of the quadrilogue: myself, my mother and the clinical team. I also recognise, along with Laing (1969), that ‘double-binds can be two-way’ (p. 147). However, it is also worth noting that Bateson (1972) did not characterise communicants as ‘individuals’ but as ‘entities’ in an interacting system. Rather than target specific individuals therefore, I will be showing how the ‘entity’ of the mental health system produces and replicates double binding forms of communication. In other words, it is not just that double binding communication occurs in the mental health system between communicants (and thus can be considered one or two way); doubling binding frames the interactions that occur and is thus a central feature of the mental health system in the narrative itself.

6.1.1 Double bind theory in health research

Since its original inception as a theory for the development of schizophrenia, the double bind theory has been extended from psychosis to general psychopathology and, beyond this, as a way of understanding skills acquisition and learning (Visser, 2003; Bateson, 2005). More recently, the double bind theory has been used as a way of understanding how organisations place a series of contradictory injunctions upon workers (Visser & van der Heijden, 2015). A number of studies have applied the double bind theory to organisation health contexts (Visser, 2010) using a variety of different approaches, including quantitative surveys (Hornung, Lampert & Jürgen Glaser, 2016), focus groups (Weimand, Sällström, Hall-Lord & Hedelin, 2016) and participant observation (Kerosuo, 2011). Taken together, these studies constitute a growing body of empirical research into what has been called the ‘organisational double bind’ (Wagner, 1978).

However, there are several issues with this body of research. For example, whether using quantitative or qualitative methods, the tendency in some of the empirical research into double binds is to isolate the data within its context and then try and extrapolate the findings to its assumed more universal processes or mechanisms (Cullen, 2006). However, a key issue with this approach is that, by isolating the phenomena to discrete units of behaviour, the confluence between the data and the wider social and cultural context is often missed (Parker, 2007). As Bateson (1978) observed, ‘quantification will always be a device for avoiding the perception of a pattern’ (p. 42), particularly in situations where the context is defined by complexity or multiplicity such as health systems (Engeström & Sannino, 2011).

In examining this issue in relation to the narrative, it is helpful to revisit a key aspect of the double bind theory: Bateson’s (1972) development of the double bind theory went beyond the dyad of the interaction between two people to consider how the broader social ecology, as part of wider group or social processes, might create pathological double binds within its members (Visser, 2003). It may therefore be more accurate to see the double-bind as a theory of how ecologies or ‘minds’ function together, than just interactions between two people. Double binds are therefore ‘not only something that happens to a mind but something that happens in a mind’ (Bateson, 2005, p.

17) and, for that reason, is more than just a theory of the aetiology of schizophrenia (Cullen, 2006). Double binding processes do not reside ‘within’ or even between ‘individuals’: it is a function of the pressures and tensions that exist within a much wider socio-political system (Bateson, 2005). In this section therefore, I will be looking at how double binding communications occur across the system.

Such binds are often a feature of nursing practice: error reporting in routine practice might be a management requirement, but might also conflict with organisational injunctions to avoid risk-taking (Leroy et al., 2012); change management strategies might threaten safety protocols which nurses then have to implement (Kerosuo, 2011); and the application of policy injunctions, such as target-setting, might conflict with how nurses understand their roles, their understanding of organisation priorities and the availability of resources (Tomm-Bonde et al., 2013). When faced with such incongruences between policy and practice, unbearable intensity between communicants (usually front-line clinical staff, patients and carers) may be inevitable (Visser, 2010). Given this research, I will thus also be considering what policy drivers and political pressures in the wider ‘ecology’ of the mental health system may have influenced some of the communication patterns in my data.

Another issue with organisational health research using the double bind theory is that there is often a lack of clarity or precision in terms of how the theory is conceptualised and applied. For example, a range of situations are often classified as ‘double binds’, including institutional contradictions, forced choice paradigms where workers find themselves in ‘catch-22’ situations, paradoxes of communication and communicative incoherence (see Visser & van der Heijden, 2015, for a review). However, Bateson’s (1972) original theory conceptualised the double bind specifically as a communicative action composed of six elements, whereby two or more messages negate each other, creating a situation in which a successful response to one message results in a failed response to the other messages (Bateson, 2005).

In order to be consistent with the original theory therefore, I am analysing the double binds in the narrative according to the components of the original theory. As I will show in the next section when I examine double binds in the narrative, my ‘voices’ were communicating to me in double binding ways before I even made contact with the mental health system. Alongside this, I was already viewing the world in double binding terms through my paranoid world-view (‘self-perpetuating’). However, what I will also show is that the mental health system not only inadvertently reinforced these internalised doubling binding terms, but in some ways actually extended them. The following section is divided into three sections that map different stages of my journey through the mental health system: pre-patient, inpatient and post-patient.

6.2 Double Binds in the Narrative

6.2.1 Pre-patient

My account in Part 1 provided a detailed representation of my state of mind before I came into contact with the mental health system. One of the key elements of this representation is the description of my voices. It is not clear from the narrative whether these 'voices' were auditory hallucinations or 'thought-like' experiences (Woods et al., 2015) that, nevertheless, were experienced as something 'other' than my own voice. Either way, the voices were derived from literary sources that I had been reading at the time. These included the poems of T.S. Eliot and Jim Morrison, and the writings of Franz Kafka and Friedrich Nietzsche. In the narrative in Part 1, the voices are represented as fragments from the original works that are then connected together as a string of phrases that form a new web of associations. The voices in Part 1 can thus be represented in the following way as discrete voices or 'personas' (Woods et al., 2015):

1. *Meeting you at your parent's gate… We will tell you what to do… What you have to do…To survive. (*Morrison, 1990*)*
2. *Because I do not hope… Because I do not hope to turn… Because I do not hope. (*Eliot, 2004*)*
3. *The dogs are still playing in the yard… but the quarry will not escape them… never mind how fast it is running through the forest already.* (Kafka, 2004)
4. *Reflected from my golden eye… This dullard knows that he is mad… Tell me that I am not glad!* (Eliot, 2004)

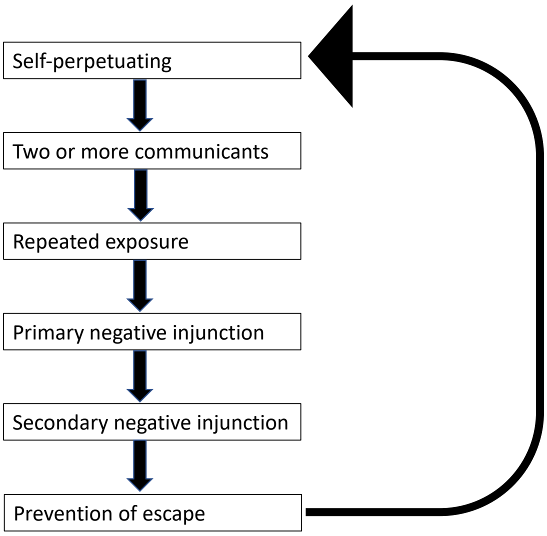
5. *Everyone is very kind to A… More or less as one tries to guard an excellent billiard table… Until the time when the great player comes… Who will carefully examine the table… Will not put up with any damage done to it previously… but then, when he himself begins to play, lets himself go… Wildly, in the most inconsiderate manner.* (Kafka, 2004)
6. *When you look long into the abyss… The abyss also looks into you*. (Nietzsche, 2003)

In the context of the narrative, all these voices or personas communicated in double binding ways. For example, the presence of threat was there in all six voices, either explicitly (voices 3, 4 and 5) or implicitly (1, 2 and 6). There was also conflict between primary and secondary injunctions between different voices. For example, Voice 1 offered some form of solace, which was contradicted by the other voices (2, 5 and 6) denying that escape or survival was possible (the tertiary injunction). A conflict between primary and secondary injunctions was also represented within individual voices themselves. For example, Voice 5 presented an appearance of kindness and protection that was then revealed to be the prelude to an advanced form of punishment.

Therefore, the content of the voices suggested that double binding process were already present in my experience at the time. In Bateson's (1972) terms, this indicated that the double bind had become self-perpetuating in my experience: I was already experiencing the world in double binding patterns and so therefore double binding was likely to be replicated in my subsequent interactions with the world. This point was further reinforced by my mother’s account in Part 1, which also provided evidence of double binding communication. For example, in her description of my attempts at help-seeking the primary injunction, which could be expressed as ‘we respect his autonomy’ (M1:15-18), was directly contradicted by the secondary injunction which could be expressed as ‘we will talk with his GP about him, without him knowing about it’ (M1:12-18). That she continued to pressure me to seek help, or even seek help on my behalf in my absence (M1:13-17), suggested a tertiary injunction that could be expressed as no escape from the pressure to seek help from statutory services and a withdrawal of care that would result from the intervention of services with them taking over some aspects of the caring role.

The narrative at this point therefore suggested a context whereby double binding injunctions had become self-perpetuating in my experience and had become a feature of the communication between me and my mother. Such was the representation of my experience prior to any interaction with mental health services. At the time of first contact with the mental health services therefore, Step 6 of Bateson’s (1972) original theory had become Step 1. This situation is represented schematically below in Figure 2.

Figure 2 Adapted version of Bateson's (1972) double bind theory.



What becomes quickly apparent however, is that double bind situations also became a feature of the communication between the mental health team and me. The first example of this was during the first meeting with the psychiatrist when I 'denied feeling depressed' (C2:27-28) but 'fairly insistently used the word "despair"' (Document 2.1.1.). Instead of the alternative word of 'depression' (which was used by the GP and initially by the psychiatrist), the psychiatrist subsequently used my word. This was represented both in my account (S2:40-44) and also in the psychiatrist's subsequent report (Documents 2.1.1. and 2.1.2.). However, his use of the word was not based upon my meaning (which I discuss in more detail in Chapter 8) but in terms of the frequency and duration of the psychiatric diagnostic symptom check-list ('But patient also says he becomes more despaired in the morning for about ½ hr, gets better during the day but again despaired just before going to bed until he sleeps', C2:15-20).

This is double binding in the sense that the primary injunction, which can be expressed in the form ‘we want to know what you are experiencing’ conflicts with the secondary injunction that can be expressed as ‘whatever you say, your experience will be re-interpreted in our terms’. The tertiary injunction at this point was not so much in terms of the threat of punishment (that can be seen in the section below), but in the possibility of the withdrawal of care. That the doctor used my language, even if his meaning was different, prevented me from commenting on the bind. For example, how could I possibly have complained about the doctor if he demonstrated use of my language?

Another example of doubling binding communication is the inconsistency in communication between different staff members at different times in my early contact with services, especially with the attitude and approach of staff in the Day Hospital (DH) and that of the ward round. For example, when I was a patient in the DH (between Parts 2 and 3), the nursing notes (Document 2.5) indicated that I was ‘keen’, ‘cooperative’, ‘joined in some groups with encouragement’ (entry dated 15/9/94) and was ‘glad’ to be attending (19/9/94). Indeed, the treatment approached seemed fairly light: I did not attend the DH frequently and non-attendance was only followed up with one phone call from DH staff on 13/9 (Document 2.5). If there were concerns about risk then it was not documented; indeed, there are only 7 entries on the notes in the two-week period from admission to the DH on 6/9 and the ward round on 21/9, and these were relatively brief and contained no mention of serious concerns. In addition, the psychiatrist’s letter to the GP (Document 2.1.2) reported the problem as ‘inadequate personality’ and suggested ‘social skills training’ as a treatment. Both diagnosis and treatment suggested the doctor viewed my difficulties as relatively mild.

However, at the ward round this picture changed dramatically, from the last entry from the DH on 19/9 recording no concerns (Document 2.5), to ‘risk of serious self-harm’ (C3:55) following the ward round. What was particularly curious here was that the judgment of serious risk appeared here in the absence of any new, or at least significant, clinical information. For example, in my conversations with the psychiatrists it was reported that I had ‘thoughts about killing himself; but not current’ (C3:46-47) and this information was consistent with the information provided by assessment with the psychiatrist in Part 2 (C2:61-62). From the notes therefore, there was no evidence of current suicidal intention or intent to self-harm. It could perhaps be argued that the staff were concerned about my ‘unpredictable’ (C3:51-53) behaviour and that the heightened perception of risk based on intuition and thus could not be captured in the notes. If this was the case, then it was not communicated clearly or consistently.

There is thus an incongruence between communication and intervention within different parts of the mental health service. This incongruence constituted a double bind, for the primary injunction at this stage, which could be expressed as ‘you can engage with our service on your terms, as we are not that concerned about you’, conflicted with a secondary injunction that was revealed at a later stage in the process and could be expressed as: ‘we will force you to engage with us, if we deem it necessary’. This latter message revealed another double bind, in that the psychiatrist’s diagnosis and prognosis in Part 2, which could be expressed by the primary injunction ‘we do not think there is much wrong with you’ was incongruent with the ward round doctors’ diagnosis of ‘paranoid schizophrenia’, communicating a very different message (‘we are very concerned about your safety’). These injunctions were supported by the threat of involuntary detainment which was also simultaneously an implicit prevention on commenting on the bind. Indeed, my walking out the ward led to the process that would eventually result in the ultimate restriction of freedom: involuntary detainment under the Mental Health Act.

It is interesting to note here that my walking out was due to fears based on the belief that I was going to be killed in the inpatient ward (S3:13-7). Whilst the clinical team would certainly not view involuntary detainment as punishment, it was perceived by me as punishment, based on my belief that this would be the mechanism through which the evil spirits would kill me. There is thus a confluence between double binds that had become self-perpetuating in my experience, and the double binds expressed by the mental health service in their interaction with me. At the point of the ward round, both processes meet.

The double binding communication from the mental health team, however, then went one stage further: voluntary admission was suggested under duress of involuntary detainment (‘May be sectionable if not attends regularly at Day Hospital and refuses inpatient treatment’; C3:66-8). In other words, the primary injunction that could be expressed as ‘you are a voluntary patient and you have the choice about whether you want remain’ conflicted with the secondary injunction that could be expressed as ‘you have the choice to be here until you decide that you want to leave and we disagree with you’. Again, this secondary injunction was supported by a tertiary injunction, the threat of involuntary detainment. As I have pointed out in my description of how double binding had become self-perpetuating in my experience, being involuntarily detained would be perceived by me as a form of punishment. The mental health team thus inadvertently forced on me another double bind that supplemented by existing processes. In addition, it was the tension generated by this bind that significantly contributed to my breakdown that night, followed by the self-harm everyone was concerned about. The clinical team’s concerns had thus enacted a self-fulfilling prophecy.

It perhaps also needs to be pointed out here that the double binding communication evidenced throughout this episode represented more than just a change of medical opinion that was revised on the basis of new information. There was always the possibility that the mental health team could have intervened in more coercive ways, if they deemed it necessary, because this is a core feature of mental health law and practice (Rogers & Pilgrim, 2010). Thus, the previously identified primary injunctions around voluntarism and choice were, at all times, liable (at least potentially) to be contradicted by implicit secondary injunctions that can be enacted at any time based on the opinion of psychiatrists. The double binding thus goes to the very heart of the culture of the psychiatric system itself.

6.2.2 In-patient

This conflict between the explicit messages and the implicit reality surfaced again upon admission. Having become an inpatient, it became very clear that the ward itself was a chaotic and potentially dangerous place where bullying was rife. This reality had already been indicated by Day Hospital patients (S3:8-10) but was also confirmed by my experience of the first night (S4:2-6). There appeared to be very little in the way of monitoring or checks, as I was able to get out of the ward several times, once at great personal risk (S5:9-44). The staff appeared to be unaware of, unconcerned by, or incapable of stopping, some of the more disturbing interpersonal interactions between patients (S4:6-8; S5:1-7). However, paradoxically, being admitted to the ward was precisely on the grounds that I was a ‘suicide risk’ (C3:101) and that the ward was therefore a ‘place of safety’.

Taken together, the ward did not appear to be a ‘safe place’ at all, and yet this was its primary stated purpose and the reason for me to be compelled to stay. This incongruence thus revealed another double bind at the centre of the psychiatric system: a conflict between the primary injunction that ‘you need to be in hospital for your own health and safety’ with the secondary injunction of ‘this is not a safe or healthy place’. Further, escape from this bind was only possible by submitting to another bind: downplay my symptoms and pretend to improve (thus getting discharged), at the cost of revoking any chance at getting help. As I will show later in this chapter, eventually the pretence of improvement to get discharged, and giving up any chance at help in the process, became a more compelling option to me than to be honest and try and get help.

Once in the system, escape becomes very difficult without submitting to a range of other double binds. For example, after numerous attempts at leaving in Part 5, one of the nurses transferred me into the Psychiatric Intensive Care Unit (PICU) through a pretence of friendship, inviting me into a room ‘for a chat’ (S5:57-63) that turned out to be a locked ward. Curiously, this event was written up in the notes as a planned transfer (C5:67-9) at 8pm on 3/10, although the next clinical note at 9:50pm on the same day contradicted this earlier note by putting the plan in the future tense (‘patient *to be* moved to Woodbrook II’ [italics added]; C5:83-86). This whole episode thus presented another double bind, which could be expressed by the primary injunction of ‘we are here to care for you’, with a secondary injunction of ‘we will do what we like with you, even if it is distressing’. There was no escape from this situation as I was now in a locked ward, about to be placed under section, and there was no possibility of commenting on the situation as I had been ‘Diagnosed psychotically ill by the consultant’ (C5:87-8). The latter statement appeared to be as much a justification for the secondary junction (‘we can subvert his rights *because* he is psychotic and therefore cannot know what is best for himself’) than a rationale for action (‘we need to protect him for his own sake because he is vulnerable’).

As such, and as subsequent episodes showed, once capacity had been called into question then all my experience was considered questionable. For example, at the end of Part 6 I walked into what appeared to be an informal meeting between the night staff and patients. Whilst the purpose of the meeting was uncertain, it seemed to me then, and seems to me now reading it in the present, that something unusual was going on.

However, when I talked about it with a nurse, their response was to attribute it to my psychosis (‘he found it difficult to accept this might not have happened’; C6:94-96). In the same passage, the nurse also remarked upon my difficulties in being able to open up to staff (‘he found it hard to trust me enough to talk of all his experience’; C6:91-92). The double bind here could thus be represented in this way: we want you to talk to us about your experiences, and indeed this is essential (primary injunction), but you must also accept that your experiences are not trustworthy or valid. The context was such that any ‘insight’ into my ‘illness’ recognised in these terms was bound up with a system of reward and punishment (Goffman, 1959). Reward in this system is being granted more leave and eventually, ideally, discharge; punishment consists the deprivation of ‘privileges’ such as time off the ward.

The question of consent, and its double binding nature in the psychiatric system, surfaced again later when the question of ECT was raised. My response to being ‘offered’ ECT was a reflection of the internalisation of a double bind that had become self-perpetuating, in that both signing or not signing the consent form simultaneously felt like the wrong choice (S8:1-5, 13-17). However, the double bind was not just an ‘internal’ process ‘in my head’ but was constituted in the very request for consent in the first place. For example, the ECT Handbook (Royal College of Psychiatrists, 1995) states that ECT can be given without the patient’s consent ‘in the patient’s best interest, i.e. necessary to save life or prevent deterioration or ensure improvement in physical or mental health’ or ‘in accordance with a practice accepted at the time by a responsible body of medical opinion skilled in the treatment’ (p. 97). In other words, if the medical team deemed that ECT was necessary, it could have been used in absence of my consent. The question of what constitutes ‘saving life’ or, indeed, ‘the prevention of deterioration’ was left suitably vague and was open to considerable interpretation. One thing was clear however: the power to decide whether ECT was to be used, ultimately, was left in the hands of the responsible doctor. The primary injunction of consent (‘we would like your permission, before we give you this treatment’) was in fact contradicted by a secondary injunction (‘we don’t actually need your consent and may give you the treatment anyway, even if you refuse’). Although staff would have been highly unlikely to view this treatment as punishment, it was certainly perceived by me in these terms (S8:128-143) and thus supported the tertiary injunction that escape was impossible both physically (I was on a locked ward) and psychologically (I have no real choice).

6.2.3 Post-patient

As many of the above examples demonstrated, one consistent feature of being on the ward was that I was constantly being encouraged to view my experiences as ‘delusional’ and the product of an ‘illness’. At times this led to farcical statements. For example, on one care plan document (Document 7.5, bottom half of the page), the plan was to ‘offer the patient reassurance and a contact with reality’ whilst, just below this, the instruction is to ‘observe every fifteen minutes’. Being observed every fifteen minutes is a very unusual ‘reality’ to be in ‘contact with’. Again, this is a demonstration of double binding communication at several different levels: whilst the primary injunction of care may have appeared to be benign, the secondary injunction is that I was being asked to conform to a very rigid set of assumptions and rules regarding ‘reality’.

Indeed, it is the demonstration of ‘insight’, defined clearly in terms of accepting the clinical team’s judgement of my symptoms, that proved to be crucial in gaining discharge. For example, there appeared to be an immediate improvement in paranoia following ECT and this was mentioned in both my mother’s diary (M8:51-55) and the clinical notes (e.g. C8:60-65). However, the mere denial of my ‘paranoid’ symptoms did not appear to be enough; leave and discharge planning started after my ‘realization that he is mentally ill’ (C8:16-9), when I am able to ‘rationalise’ (C8:138) my paranoia and ‘reject’ it (C8:157). This was despite the obvious and clear continuing presence of paranoia, fear and depression (C9:13-16, 30, 66). Indeed, the depression is even explained by one of the psychiatric team as due to ‘the realization he is mentally ill’ (C9:39). That I was coached in this process by another patient who helped reinforce that I ‘did not see that’ (S8:83-98) indicated it was an accepted part of the culture of the ward.

Therefore, this latter example could be represented as an explicit, primary injunction, expressed as ‘we will let you go when you are well enough to leave and not a risk to yourself or others’, conflicting with a more powerful, implicit secondary injunction of ‘we will let you go when you accept that you are mentally ill’. The twin assumptions of ‘wellness’ and ‘insight’ are conflated together in the psychiatric discourse with safety and risk. ‘Escape’ from the ward in the form of ‘discharge’, and thus freedom from the double binding culture of the acute psychiatric hospital, was only made possible by submitting to this secondary injunction. This was at the cost of self-deception by downplaying my ‘real’ symptoms and ‘faking’ being well (S9:32-39).

Accepting this double bind therefore represented the paradox of accepting an illness identity, whilst simultaneously revoking the original reason I sought help in the first place. More so, this double bind becomes reconstituted in my experience as a self-perpetuating double bind in any further interactions with the psychiatric system. In other words, I would always be more likely to ‘play at being sane’ to avoid being detained again, even if I felt distressed or disturbed. The mistrust had thus become the cardinal feature of my experience. Goffman (1969) sufficiently summaries the characters of this particular double bind on the experience of the patient:

> The patient then must either embrace the notion of mental illness, which is to embrace what is likely to be a destructive conception of his own character, or find further evidence that his close ones have suddenly turned against him. (p. 385).

6.3 Staff Double Binds

So far in this chapter I have looked at double binds in my experience and, to a much lesser extent, my mother’s. However, the ‘transcontextual’ nature of experience is an important component of Bateson’s (1972) double bind theory. In other words, the double bind does not merely take into consideration one or two sets of interactions in isolation but, rather, it is about ‘determining the relations between larger and smaller contexts’ (p. 246) in the system as a whole. Thus, the ‘smaller’ context of my experience interacted with the ‘larger’ context of my family. In turn, the context of my family interacted with the even ‘larger’ context of the psychiatric system, sat within an even ‘larger’ context of society, defined according to the socio-political context of the time.

Therefore, according to Bateson (1972), ‘what can be studied is always a relationship or an infinite regress of relationships’ (p. 256). Within these relationships, causal influences of double binding communication can be observed. For example, in the wider context of mental health service provision in the early 1990s two important, and interrelated, events dominated. The first was the implementation of the Government’s ‘Care in the Community’ policy (Rogers and Pilgrim 2010). In the narrative this policy was in its later stages, whereby most psychiatric hospital provision had been moved from purpose-built asylums to repurposed inpatient psychiatric wards based in general hospitals (Jones, 1993). The second was high profile incidents involving psychiatric patients such as Clunis and Silcock (Hallam, 2002), often blamed upon the lack of provision in the community resulting from the former policy (Paterson and Stark, 2001). Media portrayals of these incidents were often lurid and blaming of staff for their ‘failures’ (Hallam, 2002).

Thus, there was increasing pressure on mental health staff to manage risk (Paterson, 2006). However, at the same time, traditional risk provision (e.g. the hospitals) had actually shrunk significantly since deinstitutionalisation (Turner et al., 2015). The narrative also took place in an era of emerging managerialism in the NHS where public sector labour could no longer be viewed as secure or guaranteed (Lloyd and Seifert, 1995). Finally, and following deinstitutionalisation (Jones, 1993), managerial pressures to relieve the lack of available inpatient beds resulted in staff feeling extra pressure to get patients moving quickly through the system (Onyett et al., 2007). However, there was not an adequate re-prioritisation of resources to cope with the significant new reality of this policy shift and costs associated with community service provision (Rogers and Pilgrim, 2010).

In terms of double bind theory therefore, there was a primary injunction placed upon staff via politicians (‘you will be liable for all potentially risky situations’) which conflicted with a secondary injunction from management (‘you must ensure that patients are moved quickly through the system’). As clinical staff were to some degree dependent on the wider organisation in terms of their livelihood and their professional organisation in terms of registration (and hence, therefore, also livelihood) the tertiary injunction of no (or little escape) would likely have prevented the staff from having too much power to change the fundamentally double binding nature of the psychiatric system. Alongside this, professional medical unions, and to some extent professional medical organisations, were in relative decline (Lloyd and Seifert, 1995), potentially reducing staff’s opportunity to comment upon dysfunctional practices. As Visser and van der Heijden (2015) observe from their analysis of double binds and nursing:

> the large differences in emotional intensity between life inside and outside their organization, the many competing and changing demands and tasks they face, and the confidential nature of many of their activities may limit the possibilities of commenting on their situation, both inside and outside their organization (p. 694).

This dilemma was most evident at the point of admission. Faced with such a situation, the staff were placed in a double bind: either mitigating risk by placing me under section there and then, but with the result of potentially violating my human rights as a citizen in the absence of clear risk markers; or allowing me to leave and re-engage at my discretion, but potentially missing, and then being accountable for, a risky situation. The final decision, a common strategy (e.g. Katsakou et al., 2012) of offering voluntary admission under threat of involuntary detention in the event of non-compliance (i.e. ‘may be sectionable’ if ‘refuses inpatient treatment’; C3:66,68), represented something of a comprise: maintaining my rights to a certain degree by giving me the ‘choice’ to come in willingly, but containing the risk somewhat through community mechanisms such as the DH. However, as a compromise, the move was arguably insufficient: my rights may have been retained but this was only in appearance, as I was required to be admitted ‘voluntarily’ under compulsion if I refused (so therefore I was not really ‘volunteering’ to attend); and the volatile situation following the ward round was not contained sufficiently, with my family left to deal with the fall-out from a stress-induced breakdown.

Therefore, the apparent contradictions in communication within the psychiatric system, and its effect on me as a patient, can be partially understood in terms of a system that itself was trying to manage irreconcilable double binds. On the ground level of the system, staff may have been unable to even identify and name some of the double binds they were subject to. These conflicts were also likely to be inadvertently passed downwards through staff interactions with patients. In terms of the original research question, performing inauthenticity became necessary for survival. Bateson (1972) summarises the dilemma for patients in such a system very clearly:

> There will be contradictions at times in sequences where actions are taken “benevolently” for the patient when actually they are intended to keep the staff more comfortable. We would assume that whenever the system is organized for hospital purposes and it is announced to the patient that the actions are for *his* benefit, then the schizophrenogenic situation is being perpetuated. This kind of deception will provoke the patient to respond to it as a double bind situation, and his response will be “schizophrenic” in the sense it will be indirect and the patient will be unable to comment on the fact that he feels he is being deceived. (p. 225)

SUMMARY

This chapter discussed the theme of double binds through the introduction of Bateson's (1972) six-component theory of double binds, which highlighted how systems can present conflicting and contradictory messages at multiple levels of communication. I discussed some of the research into the 'organisational double bind', noting that many of the studies departed from Bateson's (1972) original formulation. I then identified that a key application of Bateson's (1972) original theory was that it was an exploration of how ecologies function and not just individuals. I then examined several incidents from the narrative across pre-patient, in-patient and post-patient phases, exploring the ways in which the psychiatric system reinforced already existing double binds and introduced a range of new ones. Finally, I examined how the social and political context of the early 1990s may have contributed to placing staff in double binds, therefore suggesting that such double bindings were 'transcontextual' across the narrative.

CHAPTER 7. MIS/RECOGNITION

INTRODUCTION

In the last chapter, I analysed the events in the narrative according to Bateson's (1972) double bind theory. I first showed that double binds were already present in my experience through my 'voices', and also reflected in the communication between me and my mother, as represented in her diary. I then showed, through a series of events encapsulating my journey through admission to discharge, that the mental health system enforced its own double binds upon me as a patient. At the end of the chapter, I explored some of the wider 'transcontextual' double binds that may have been impacting staff within the system, with issues such as risk and managing 'throughput'. In terms of how this chapter related to the overall thesis question, that is, what is an authentic representation of madness and what it can show us about madness in its social context, it suggested that unacknowledged conflicts and contradictions in communication across the system were manifested in my experience of madness.

This chapter builds on the analysis of the last chapter by developing the second theme from the data: mis/recognition. In doing so, I will be extending Bateson's (1972) double bind theory by drawing on Lyotard's (1988) concept of the 'the differend'. In this chapter therefore, I will begin with an outline of two of Lyotard's (1978; 1983) key concepts relevant to this chapter: the 'differend' and 'language games', showing how these concepts relate to the theme of psychiatric mis/recognition. I will then demonstrate how mis/recognition, defined in this way, was reflected in key areas of psychiatric discourse and practice presented in the narrative.

7.1 The Differend and Language Games

In his analysis of culture, Jean-François Lyotard (1978) rejects the grand, overarching metanarratives from modernity, including the discourses of science and religion, where meaning is universalised according to predetermined assumptions (e.g. salvation of humankind through faith, inevitable progress, the dictatorship of the proletariat etc.). Instead, he argues that meaning is localised within the culture and language of different community subgroups, constituted and sustained according to distinct rules and procedures. In these 'language games', the operations are established so that 'each of the various categories of utterance can be defined in terms of rules specifying their properties and the uses to which they can be put' (Lyotard, 1978/1984, p. 10). These rules and procedures can be observed in action within the language community, 'in exactly the same way as the game of chess is defined by a set of rules determining the properties of each of the pieces' (ibid).

Underlying these language games are different, sometimes incompatible, 'regimes of truth'. Such '*dispositifs*' are referred to by Foucault (1976a/77) as 'a system of ordered procedures for the production, regulation, distribution, circulation and functioning of statements' (p. 14). These discourses are supported by a 'circular relation to systems of power which produce it and sustain it, and to effects of power which it induces and which redirect it' (ibid.). In other words, truth regimes operate within frameworks constructed by the power relations through which subjectivity is constructed.

One consequence of this is that some truth regimes, in the interests of power, impose their own set of rules and procedures on the other. This is most evident through the violence inherent in some forms of representation, such as the ‘law’ or ‘justice’ or ‘mental illness’. As some groups and communities are forced to articulate their concerns according to the rules and procedures of these other dominant language games, it is impossible for them to express any grievances, particularly if their grievances conflict with the interests of the dominant truth regime (Held, 2005).

This exclusion of the grievances of some groups in the rules and procedures of the dominant discourse is what Lyotard (1983) referred to as a ‘differend’. According to Lyotard (1983/1988), a differend is ‘when the “regulation” of the conflict that opposes them is done in the idiom of one of the parties while the wrong suffered by the other is not signified in that idiom’ (p. 9). One way in which the differend can be observed is through the operation of colonialism on indigenous communities. In Australia, for example, there is an ongoing dispute between the aboriginals and the descendants of European colonialists about land ownership. According to the Australian Government, land ‘belongs’ to specific individuals or organisations who can claim this ownership via Australian property law. Any dispute or arbitration in relation to land ownership must be conducted within the Australian law courts according to this legal framework, which is based upon the legal systems of the European settlers. In contrast, native Australian aboriginals have a completely different relation to the land, one that lacks this propriety claim and, indeed, the notion that ‘land’ is property. Any ‘right’ to land is thus already a poorly formed claim.

The aboriginal perspective on the land is thus based upon an entirely different cosmology and conceptual underpinning than the one used by European settlers. However, the only way they can ‘claim’ the land back from the descendants of the European settlers is through the Australian courts, with its notion of land as property. The aboriginals are thus in a double bind in relation to the land: the only way to validate their claim is through a system that does not recognise their cosmology and, indeed, is opposed to it. The aboriginal claim to the land cannot therefore be voiced in law, the language game of the dominant community; it is a wrong that cannot be acknowledged, a ‘differend’ (Held, 2005).

It should be noted here that Lyotard’s (1983) double bind of the differend is different to the double bind developed by Bateson (1972) and which I explored in the last chapter through the theme of double binds. According to Bateson (1972), the double bind presents a logical contradiction in communication that creates no-win situations for communicants. Yet, despite this, it is still possible to both identify the double bind and find solutions for it within the boundaries of communication. An example Bateson (1972) cites is of a novice Buddhist monk who is asked a question by a master monk. The novice is told that if he answers the question he will be struck by a bamboo cane; he is also told that if he remains silent, he will also be struck. There is, however, a third choice: the Buddhist monk can take the cane from the master, and this is considered a legitimate move within the language game. Thus, the double bind in Bateson’s (1972) terms can, and does, lead to more advanced forms of learning as communicants find ways to escape the bind (Bateson, 2005).

However, Lyotard’s (1983) conception of the double bind in the differend is far worse for victims than Bateson’s (1972). One of the major differences is that, according to Lyotard (1983), there are no ways for victims to put the wrong into words. For example, in order to vouchsafe a claim upon the land, the aboriginal communities in Australia can only do this within the framework of the very system which robbed them of the land in the first place and which does not recognise their perspective on ‘land’. They therefore have no recourse to the law, for the rules and procedures of the law are framed according to Liberal notions of land ‘belonging’ or being ‘owned’ by particular individuals or entities in such a way to advantage the lawmakers (i.e. descendants of European colonialists). As Lyotard (1983/1988) elaborates, ‘the victim does not have the legal means to bear witness to the wrong done to him or her’ (p. 30). They are in a double bind, but unable to even express this bind in terms of the language game of the dominant discourse.

As I will show in this chapter, psychiatric discourse represented a differend to me and, to a lesser extent my mother, because our particular complaints could not find expression within the language game of psychiatric medico-legal terminology and its conceptual underpinnings. In using Lyotard’s (1983) concept of the differend in this way, I will argue that it extends Bateson’s (1972) theory of the double bind expounded in the last chapter because it shows that the double bind is not merely contradictory forms of communication that place the communicant in no-win situations, but is actually constituted in the form of the very discourse itself. Thus, all psychiatric patients subjected to psychiatric discourse are confronted with a differend by a system that does not allow them to frame their particular concerns in language that reflects their perspectives.

7.2 Mis/recognition in Psychiatry

One of the most important themes of the differend involves the question of recognition. Or, more precisely, the differend shows what happens when recognition does not, or indeed cannot, occur within a particular dominant discursive form. In identifying this problem of recognition at the core of psychiatry, it is not precise enough to call this process ‘misrecognition’ or ‘nonrecognition’. Whilst the term ‘misrecognition’ suggests that there has been a misconstrual of meaning in the act of recognition, and thus implies that there is an absolute standard of recognition to which this act of ‘misrecognition’ has somehow fallen short, the term ‘nonrecognition’ signals the absolute failure or denial of any attempt at recognition whatsoever. As I discussed in chapter two, it is not possible to point towards an essential reality to which this idea of ‘misrecognition’ would fall short. However, as I will show in this chapter, neither ‘misrecognition’ nor ‘nonrecognition’ capture what I argue is central to the psychiatric differend: namely, that there is an act of violence that occurs *within* the act of recognition itself which results in a silencing of the other. For this reason, I have represented the word ‘misrecognition’ as mis/recognition with an oblique between ‘mis’ and ‘recognition’ to indicate this.

Mis/recognition is therefore what happens when a complaint from one group does not find representation in the language game of a dominant discourse, in other words, when there is a differend. This is relevant to the thesis question in a number of ways. For example, the thesis question is interrogating what an authentic representation of madness might look like, and what this representation tells us about how society responds to human difference and distress. The concept of mis/recognition highlights an impossibility of recognition at the core of the representational framework of biomedical psychiatry and, indeed, shows how other language games become absorbed into its discursive forms.

The next section outlines mis/recognition in the narrative as it relates to key areas of mental health practice. The areas include: assessment, risk management, the case record, consent and discharge. These areas were selected because of their centrality to the practice of the mental health system (see Rogers and Pilgrim, 2010) and because they were also identified as being important in the last chapter on double binds. They are also the narrative pillars of the data.

7.2.1 Assessment

The interview with the psychiatrist in Part 2 is a good place to begin when analysing these differences between ‘misrecognition’, ‘nonrecognition’ and ‘mis/recognition’. One of the central features in this part of the narrative was that I used a very specific word to describe my symptoms (‘despair’). Not only did the psychiatrist recognise that I ‘fairly insistently’ used the word, he then subsequently adopted it, as evidenced in the letter which followed the interview (Documents 2.1.1 and 2.1.2). The letter not only provided a detailed exegesis of my current situation, but was very precise in its use of my language in its description of my symptoms.

This may have suggested that the psychiatrist was trying to give an account consistent with my experience, and was even working hard to represent my symptoms accurately, according to his understanding. In these terms therefore, this encounter represented an attempt at recognition. However, there is a crucial difference in terms of how my language was adopted by the psychiatrist. For example, there was no attempt to explore the meaning of the term ‘despair’ in my terms, according to how I might have been using the word. Instead, his employment of the term ‘despair’ was the opposite of this, as his subsequent line of questioning indicated (C2:13:ff). In the letter that followed (Document 2.1.1), his summary of my symptoms indicated his interpretation: ‘he [Simon] feels despaired half an hour in the morning and half an hour before going to bed’. In other words, the psychiatrist used the terms as if it were consistent with a psychiatric ‘symptom’ such as depression that could be measured numerically according to frequency and duration.

The psychiatrist thus ‘missed’ the qualitative dimension of my usage of the term despair and re-employed it in the discursive terms of the psychiatric language game. Having done so, the letter gave the appearance of recognition, which actually disguised the true extent to which the language game of psychiatry had absorbed and re-appropriated my language. The important thing to note here is that the psychiatrist did not merely misconstrue my meaning (‘misrecognition’) or ignore it (‘nonrecognition’); he transformed it, so that my meaning was lost, leaving me in the position of the differend, without the language to frame my complaint (mis/recognition).

His attempts to use my own language actually thus left me in a worse place than if he had merely dismissed my symptoms as ‘depression’. Indeed, in attempting to work hard to use my language, the psychiatrist may well have been making the mis/recognition worse because it left me with no recourse to complain. I will be exploring the nature of the quality of ‘despair’ in the next chapter, but subsequent interactions with the clinical team demonstrated how the mis/recognition became more pronounced the further I progressed through the system.

7.2.2 Ward Round

Mis/recognition, therefore, is when there is a differend and the complaint of one individual or group does not find representation in the language game of the dominant other. This issue, observed in the initial psychiatric assessment in Part 2, continued as I progressed in the ward system. It was observed very clearly in Part 3 in relation to the discourse of risk management through the mechanism of the ward round.

In the context of my experience it is easy to see how and why the ward round was so difficult. On encountering the ward round I was confronted with a particular language game, exemplified both in the organisation and style of the ward round itself. For example, there were more people in the room than I was expecting (S3:23-24) and the meeting was run entirely according to the clinical team’s agenda, with the doctors initiating the pace (S3:24-25). The doctors’ interview style was, to my perception, combative and intrusive (S3:31-38) and I also perceived them to be hostile and mocking (S3:45-48). The whole encounter made me feel increasingly anxious, to the point where I was unable to answer them properly (S3:39-45). When I left the room (S3:53), one of the doctors followed me and then guided me to a separate interview room (S3:53-5). Once in the room with the psychiatrist, he mentioned whether I would consider being an inpatient which connected with my belief that I was to be a human sacrifice (S3:58-69), no doubt also fed by the horror stories told to me by day hospital patients. When the doctor quickly returned to the ward round room, I interpreted his haste as an intention to ‘raise the alarm’ to get me dragged into hospital (S3:72). Unsure of what to do, and scared about becoming an inpatient, I left the hospital (S3:86). Overwhelming terror, along with a paranoid expectation that ‘they’ would be coming to take me to the ward, resulted in total psychological collapse (S108-10) where, in a fugue state, I cut my arm with a knife and set fire to my clothes (S111-13).

According to my perspective therefore, there is a certain way of understanding these events. Walking out was a reasonable response to my feeling threatened, intimidated and even humiliated by the doctors. It was also an attempt to try and forestall the terrible consequences that I believed would occur upon admission. However, even though psychiatric ward rounds are often experienced as intimidating for service users (Cappleman et al., 2015), patients do not generally leave without explanation. Walking out thus represented a radical departure from the normal conventions of what was expected in the situation. I was thus caught in a double bind, in the sense that I either remained in the ward round and was made to look increasingly foolish or ‘mad’, or I ended the interaction and at least saved face or gained some sense of autonomy but, at the same time, raising questions as to the appropriateness of my behaviour. It was not merely a double bind in Bateson’s (1972) sense of being caught between two contradictory demands; it was a double bind in that my representation of the situation was unable to be represented in the language game. It was an example of the mis/recognition of the psychiatric differend.

Perhaps this action also represented an example of De Certeau’s (1984) notion of a ‘tactic’ that was explored in Chapter 2, that is, an unconscious and unreflexive response to the other that was, nevertheless, an attempt to disrupt the functioning of unbearable strategy and a way of trying to gain some power back. However, as a tactic in the context of the language game of psychiatry it was a failure, as there was no adequate way of communicating both the reasons for my fear, or my frustrations at the ward round itself. If, for example, I had told them that evil spirits had possessed me and were directing me to become an inpatient so I can be a blood sacrifice, then they would probably have sectioned me there and then (that was certainly my fear); any attempts to communicate my displeasure with the ward were noted (‘Dr Cuthbert is too slick’, C3:36) but not actioned. Indeed, any of my attempts to frame my problems in my own language (“I just feel lonely”, C3:32; “sad about being sad”, C3:39) were met with similar fate.

Worse, walking out of the ward round became absorbed into the discourse of psychiatry and became used as part of the justification for admission. This problem can be seen very clearly in the language used in the clinical notes immediately following. For example, the arguments for admission appeared to be twofold: firstly, that I was ‘quite unpredictable’ (C3:53-4) and there was ‘risk of serious self-harm’ (C3:56). It is important to note that this was the first time that such discourses had emerged in the narrative. Before this, it was reported that I had no intention of self-harming (C1:61-2) and a similar statement was reiterated by the ward round team (C3:47-8). Although I was recorded as ambivalent in the DH (e.g. Document 2.2 under ‘MANNER’) and erratic in attendance (e.g., Document 2.5 entry dated 13/9 at 15:30) it was not really recorded as unpredictable in the sense of dangerousness. In fact, given my mother’s concerns expressed to the team (Document 2.5 dated 11:00, 12/9) and her concerns expressed in diary regarding my ‘engagement’ with services (e.g. M1:85, 121-2), it did not translate into a concerted plan of action response until after the ward round.

However, the discourse changed following my walking out of the ward round. It is interesting to note the signifiers used in the clinical notes, as I was ‘advised not to leave’ (C3:79), as if the action of walking out itself was significant in terms of risk. What is perhaps more noticeable, however, is how the absence of dangerousness becomes gradually transformed in the discourse, suggesting greater risk. For example, despite a clear denial of current suicidal intention in the beginning of the clinical team’s account (C3:46-7), it is then reported in the notes at a later juncture as ‘risk of serious self-harm’ (C3:53), ‘high suicide risk’ (C3:101) and, as reported in my mother’s diary, the clinical staff thought that ‘because of suicidal thoughts they felt he was unpredictable’ (M3:39-40). My behaviour was therefore clearly enough of a concern for the psychiatrists and clinical team to recommend admission, under duress of the MHA if necessary (C3:66-8), despite me denying any intentions to self-harm.

Thus, the interpretation of my walking out of the ward round provided a good example of mis/recognition in the psychiatric differend because it allowed for certain types of behaviour to become absorbed into the discourses of medico-legal psychiatry in relation to risk. Having become identified in this way, it left me with few options outside of admission. Therefore, it was likely that it was the ‘unpredictable’ aspect of my behaviour that triggered the change in tone, along with the conflation of unpredictability with the discourse of ‘risk’. It was also these discourses of ‘unpredictability’ and ‘risk’ that were recognised as requiring a response. However, it was not the symptoms, in and of themselves, that were necessarily important and required further exploration or discussion; it was what happened, or what was said, at the ward round that appeared to change things. This was, namely, my walking out.

However, within the language of game of psychiatry in the narrative, discourses of risk have to become established upon a medical basis. For example, although, according to my perspective, the ward round was intimidating and anxiety-provoking right from the start, I was described in the notes as ‘a little suspicious’ (C3:71-2), as ‘anxious’ (C3:73) and ‘uncomfortable’ (C3:83-4). These descriptors were not used neutrally to describe feeling states or behaviour, but were used as indicators of some prior mental health difficulty.

Further signifiers and symptoms were then used in the narrative to support this strategy. For example, despite reporting ‘no abnormalities in sleep, appetite, weight, no auditory hallucinations’ (C3:89-91) the psychiatrist concluded that my presentation was ‘probable early stage of schizophrenia’ (C4:49-50). Both doctors labelled my somewhat obscure and opaque visual symptoms ‘palinopsia’, a diagnostic extension of the ‘visual problem’ (C2:51-5) described by the psychiatrist in Part 2. Palinopsia literally means ‘to see again’ and is defined as a visual disturbance that causes afterimages to persist to some extent even after their corresponding stimulus has left. Although these occur in persons with normal vision, palinopsia is a symptom associated with early schizophrenia (Gates, Stagno and Gulledge, 1988) and is reported twice by the clinical team in association with this diagnosis (C3:45,97-8). The language game here therefore appeared to function as a method that staff needed to fit my experience into the pre-existing criteria of diagnosis.

The consistent highlighting of this symptom appeared to be important because of the absence of any other significant clinical markers for schizophrenia, thus making a recommendation for detainment somewhat difficult (Rogers and Pilgrim, 2010). In terms of the language game of psychiatry, diagnosis with risk appears to present a justification that, ‘all along he has been becoming sick, that he finally became very sick, and that if he had not been hospitalised much worse things would have happened to him' (Goffman, 1961, p. 135). As Foucault (2006) observed, psychiatric power does not so much consist of a process of differential diagnosis (as in physical medicine) but in establishing itself 'at the point of the decision between madness and non-madness' (p. 251). Once madness has been confirmed (i.e. 'probable schizophrenia'), the necessary procedures and actions can be enacted.

It also suggests that once a symptom such as paranoia is tied to an action such as walking out, and if this action is interpreted within a certain language game framed in terms of discourses such as risk and unpredictability, particular reactions are expected. As Foucault (2006) recognised, such discourses became 'a way of founding psychiatric power, not in terms of truth…but in terms of danger' (p. 250). The potentiality of self-harm, which was only potential at the point of the ward round, was thus tied to a diagnostic category where harm (self or otherwise) was more likely and in this way the discourse of madness and risk become conflated. As Iliopoulos (2012) has observed, 'With the notion of dangerousness, the psychiatrist is asked to produce scientific statements regarding an entity that is not clinical, just as legal authorities seek to identify, prevent, and punish a type of behaviour that is not legal, because it is conceived in its potentiality' (p. 55).

The tragedy of this episode is that the risk management approach of the psychiatric team contributed to an actual incident of self-harm which, before the ward round, was still only speculative. Iliopoulos (2012) observed that, 'apart from its attempt to offer plausible predictive marks of future risk in patients whose behavior is unintelligible (psychosis, impulsive behaviour), risk assessment may engender for mental health professionals exactly the problems it aims to prevent' (p. 55). In other words, the ward round, in its attempts to pre-empt risk, actually created the conditions through which it was likely to manifest. In these terms, as Foucault (2006) acknowledged, 'the function of psychiatric power is 'to give madness a reality, to open up a space for the realisation of madness' (p. 252) where 'the function of discipline is precisely to get rid of all the violence, crises, and, if necessary, all the symptoms of madness' (p. 252-3). According to the language game, the system exists to solve the crisis it created itself, despite what we can only assume were the best efforts of individual team members on the ground level to prevent this from happening.

My original complaints were therefore transformed by the language game of psychiatry into the discourses of diagnosis and risk, creating a differend which made it impossible for me to express this differend (what legitimacy can a risky, probable schizophrenic actually have?) and which eventually led to the very problem the system purported to avoid. However, it even made any interventions from staff actually worse, because to respond to a client on the basis of the terms of the differend was only likely to exacerbate any tensions between staff and patient. Once the threat of risk was highlighted, staff become obliged to respond in a certain way, according to the language game. Thus, ordinary language and descriptors of behaviour became used to support a diagnosis of severe mental illness, which could then be used to justify the taking of extreme measures to restrict freedom, deprive rights, and ultimately preventing any change of a complaint outside of the terms of the game.

Therefore, mis/recognition begins with a ‘spoiled’ interaction and ends as a discursive event that can later be used as justification for greater restrictions (e.g. the use of the MHA). What Hacking (2004) called a ‘looping effect’ is very much evident: interaction and discourse is made complete in the differend of the double-binding ward round whereby ‘risk’ and ‘management’ become self-perpetuating. It thus becomes impossible for patients to frame their complaints against the situation without it being interpreted against them using the discourse of risk and psychopathology. The language of ‘voluntary’ and ‘involuntary’ in terms of admission represent a perfect illustration of the psychiatric differend here: in the double-bind that results in admission either way, there is no language to voice an alternative without it becoming evidence of the very thing which justifies the admission in the first place.

It is therefore not the fact that the interpretation of risk by the clinical team was necessarily wrong, or even unjustified; it is that it was the only interpretation that was able to be considered and voiced within the terms of their dominant language game. In essence, and as Swerdfager (2016) argues, ‘certain types or forms of discourse—such as the medical or scientific—are positioned above others—such as the experiential or anecdotal’ (p. 291). In other words, what matters here is the interpretive practice of medical diagnosis and its associated discourse of risk management, over and beyond experiential and contextual markers. It is a discursive tendency to dominate ‘weaker’ registers and silence them. The fact that such interpretations were backed by powerful legal injunctions, such as the ability to compel someone to stay in hospital against their will, makes the effects of mis/recognition that much more marked. Thus, ‘the former defines the truth of the latter’s experience and, in so doing, *patients* them’ (Swerdfager, 2016, p. 291). Indeed, it is this latter practice this is central to the aims and methodology of this thesis, in terms of attempting to redress the balance between the dominant strategy of biomedical psychiatry and the academy, and those tactics derived from service user and survivor experiences.

However, it is also easy to overstate the power of the psychiatrists, falling into the opposite trap of caricaturing them as all-powerful and omniscient. As the last chapter on double blinds explored, staff were also subject to powerful strategy, including the obligation to abide by professional conduct, hospital and organisational policies on risk and, ultimately, Governmental policies and procedures. There was also the pressure of the media, as evidenced through the high-profile contemporary cases such as Clunis and Silcock (Hallam, 2002). Iliopoulos (2012) summarises the dilemma at this time for the mental health professional succinctly:

> But this new context of community health care set traps for its providers as a result of its own demand for total security, accountability, and efficiency. Advanced sophistication renders the system vulnerable to failures, accidents, and exposure to

> even higher public expectations, which may put it in check. In fact, its high efficiency risks the possibility of bringing about exactly those effects which it attempts to prevent (stigmatization, violation of human rights). (p. 53)

However, two things need to be noted here. The first is that the double bind facing the staff is not a differend in the terms outlined in this chapter, as staff already possess the necessary power to function in the language game. They could, for example, rely on trade unions and professional societies, amongst other things, in order to express their complaints and clinical decisions can be adequately justified, and very often are, in the language of risk (Iliopoulos, 2012). Perhaps the true extent of mis/recognition for staff is their collusion in adopting these frameworks in preference for others which are less likely to silence patient voice.

7.2.3 The Case Record

At the point of admission to hospital, I was then caught up in what Goffman (1959) refers to as ‘the heavy machinery of mental hospital servicing’ (p. 124) which began almost immediately upon arrival to the hospital. For example, upon admission by a taking of an inventory of personal items prior to admission, some of which were taken and stored (Document 3.2); the generation of an assessment checklist (Document 3.4); and another, more detailed, assessment by a psychiatrist that also included a separate interview with my mother. As Goffman (1959; 1969) and others (e.g. Scheff, 1967) have observed, this process involves a stripping away of the individual's identity through a series of 'mortification rituals' (Capps, 2016). A key mechanism in the development of mis/recognition through identity stripping is via the bureaucratisation of experience. As Goffman (1961) argued, 'The handling of human needs by the bureaucratic organization of whole blocks of people - whether or not this is a necessary or effective means of social organization in the circumstances - is the key fact of total institutions' (p. 18). This aspect of the reduction of the subject to data in the case file thus represented a form of 'identity trimming' or 'programming' (Goodman, 2013). In other words, the central identity markers used in everyday interaction are taken away or subjected to the regime of the ward and then transformed into the language games of psychiatry.

As I will argue in this section, these rituals form the very core of psychiatric mis/recognition. I will argue this occurred in three main ways: firstly, the generation of a vast corpus of information for its own sake, and not for purposes immediately relevant to the clinical situation; secondly, the extension of medical bureaucracy beyond the boundaries of the psychiatric system to incorporate other institutional contexts such as the school; and, thirdly, the insinuation of the psychiatric system into every area of the patient's experience. Taken together, these three areas of the case record further reinforced the reality of the psychiatric differend explored in the previous section.

To begin with, there was a vast amount of documentary material on my life generated in the form of a psychiatric case study as exemplified in my clinical notes and accrued as a part of routine practice. These were developed from first contact with the GP and extended beyond discharge into the community. However, many of these documents did not appear to be immediately relevant to the task of guiding a treatment plan. For example, whilst the GP account was relatively brief in terms of information provided, the psychiatrist's notes from Part 2 covered a range of material, including the development of current symptoms, educational history, childhood experiences and family history (including parent's occupations), cognitive state, mood, sleep, appetite, weight, current vocational situation, birth, current and past substance misuse (including smoking), sexual and relationship history. Indeed, the list is so comprehensive, with many details seemingly irrelevant to the purpose of addressing mental health needs, that it echoes Goffman's (1961) observation that 'No segment of his past or present need to be defined, then, as beyond the jurisdiction and mandate of psychiatric assessment' (p. 143).

However, whilst the written records often showed little relevance to the immediate clinical situation, there was significant development in terms of the generation of other forms of information. This was mostly evidenced in terms of the supporting documents cited throughout the narrative. These documents incorporated a range of data: blood tests, urine samples, x-rays, toxicology reports, etc. Alongside these documents were a wealth of treatment-related information: medication charts, care plans, an ECT report, a seclusion record. Taken together therefore, this vast corpus of archival material presented an overarching picture of my biological, physical and mental state of mind.

Arguably however, the sheer quantity of such information stood in stark contrast to the distinct lack of development of data on a qualitative level. For example, the case record first described in Part 2 underwent very little development in the narrative in terms of content from the first assessment. Although the diagnosis seemed to change somewhat, from 'personality disorder', to 'early schizophrenia', 'psychotic depression', 'drug induced psychosis' etc. the same symptomology was described frequently, and very little actual new information regarding my past experiences was really generated. There was frequent repetition in terms of the psychiatric clinical data, with further assessments from psychiatrists merely repeating the same information from earlier assessments. One exception to this occurs in Part 7 when I told a nurse about my belief that I was possessed by evil spirits (C7:0-10); however, this represented an isolated reported incident that, somewhat bizarrely given its significance to me at the time, never got mentioned in the clinical notes again.

On an interactional and personal level therefore, there was a lack of a development of an understanding of my experience reflected in the clinical notes. Thus, the further I progress through the mental health system, the more information is generated but this serves to take the focus away from my subjectivity and towards the generation of information for its own sake. Therefore, one of the significant aspects of my subjective experience is passed over. The practice here thus did not appear to be about generating new knowledge but providing confirmation of existing psychiatric categories. A crucial question regarding such material is thus the purpose it actually serves. As Foucault observed, 'The psychiatric hospital doesn't exclude individuals: it attaches them to an apparatus of correction, to an apparatus of normalization of individuals' (Foucault, 2002, p. 78).

However, in relation to mis/recognition, two main aspects seemed to be significant about this material. The first relates to the nature of the data generated by these documents: they were all mostly based upon statistical or discursive notions of normal distributions or trends. In other words, the mechanisms used to generate information about my health were linked to scientific notions relating to an assumed population mean or general trend. At this point, the case study went beyond a narrative-discursive construction of an individual's psychological history developed from the interaction between psychiatrist and patient, to a vast web of largely numerical data. This data comprised what Foucault called 'biopower', a technology 'that exerts a positive influence on life, that endeavors to administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations' (Foucault, 1976/1998, p. 137). It is knowledge generated as a matter of much wider societal processes of information collection and dissemination and one that is not necessarily reduced to the individual case. Indeed, the individual case even becomes irrelevant. As Deleuze (1992) recognised: 'We no longer find ourselves dealing with the mass/individual pair. Individuals have become "dividuals," and masses, samples, "banks"' (p. 5). In terms of mis/recognition in the psychiatric differend, it generates a complex language game in which it is impossible for the service user to find representation.

The second aspect of mis/recognition in the material of the case file relates to how this information was used by clinicians. What appears to be significant here is that these documents were rarely referenced in the clinical process notes or used in the development of care planning. Perhaps this was due to the fact that the majority of the reports came back as ‘negative’ and so therefore were not worthy of clinical attention. In other words, once the ‘norm’ was established and my data was related negatively to the population mean, it ceased to become relevant as an object of clinical attention. However, as I have already discussed, the nature of the case record was ‘no longer organised in terms of presence and absence, of existence and non-existence; it was organised around the norm, in terms of what was normal or not’ (Foucault, 2002, p. 59). in other words, what mattered was establishing the criteria for treatment. It also reinforces Foucault’s (2006) suggestion that the purpose of psychiatric assessment differs from physical medicine in that establishing differential diagnosis is secondary to the establishment of an ‘absolute’ diagnosis which is about ‘marking the difference between what is madness and what is not’ (p. 266). In terms of the differend, the language of the number, based as it is entirely on professional medical expertise, is one that naturally excludes patient discourses.

This more adaptable and porous form of power appeared to perform another function in relation to the theme of mis/recognition: that of transforming my experience into different forms related to wider discursive formations. For example, my raw experience was subsumed into a discursive structure from the GP visit (note, for example, the use of the term ‘underlying personality disorder’; C1:108). This latter function was seen most clearly in the episode concerning my choice of signifier for my symptoms: I chose the word ‘despair’, which the psychiatrist also adopted, but in the terms of the psychiatric nomenclature of frequency and duration. Thus, the content is changed but the form is retained resulting, ultimately, in my word (and thus *de facto*, my experience) being treated as if it actually was the same as the diagnostic category of depression. More so, this shift is from qualitative meaning to quantitative frequency, from word into number and, ultimately, a measure. Thus, these mechanisms of mis/recognition ‘are inseparable variations, forming a system of variable geometry the language of which is numerical’ (Deleuze, 1992, p. 4). The existential wrong signified by the experiential term ‘despair’ in thus transformed into a numerical value.

The case history, therefore, extends beyond the unique particulars to generalities. In Foucault’s (2006) treatment of this process, its purpose involves ‘pinning the individual to his social identity and to the madness ascribed to him by his own milieu’ (p. 234). In such generalities, greater information is taken without recourse to the individual and the individual’s experience is sublimated to the discursive categories which then define and frame the interactions that follow. My attempt at subverting this psychiatric ‘strategy’ with a ‘tactic’ (De Certeau, 1984), for example by introducing the word ‘despair’ in the assessment in Part 2, was only partially successful; although the word was initially adopted, its meaning in my terms was left unexplored and was ultimately absorbed into the wide discursive strategy of diagnostic medicine. In terms of the differend, the ability to speak about one’s problems in one’s own terms becomes diminished.

However, the nature of the case record in terms of mis/recognition is established according to another feature, that of cross-institutional referencing. For example, right from the GP’s assessment in Part 1, previously educational attainment is stated (C1:80-83), seemingly without reference to any clinical information that proceeding it. In Part 2, during the assessment with the psychiatrist, the question of education is explored again (C2:98-104), but significantly expanded from the GP interview to include early schooling and conduct (‘truancy’). In the ward round schooling was raised almost immediately in the second question (C3:15-25) and also included a question in relation to relationships with peers (‘had friends at school’). Questions about schooling were again mentioned at admission (C4:15-16), this time with the conduct and social aspects foregrounded (results of GCSEs are followed by a question mark) and details regarding school also emerged in the interview with my mother by the same psychiatrist (C4:19-20). Even during the time of transfer, when I had left the ward twice and there were concerns about my safety, the ward round doctor somehow thought it relevant to mention my schooling again (C5:58-59). When the sectioning papers are being prepared, school is mentioned again in the social work report (Document 6.2.1). This is the last time the reference to school is made (the discharge summary, Document 9.4.1, advises to see previous summaries under ‘Family History, Personal History).

The reference to schooling is thus another example of the gradual bureaucratisation of experience, echoing Sarangi and Slembrouck’s (1996) point that ‘The labels change and proliferate, but the bureaucratic process continues as participation in the events in one institution leads someone to get caught up in those of another’ (p. 4). However, it is again apparent that the boundaries between such institutional spaces are not fixed and analogical as in the case of the disciplinary apparatus of the asylum. Rather, participation in different institutions is more akin to ‘a modulation, like a self-deforming cast that will continuously change from one moment to the other, or like a sieve whose mesh will transmute from point to point’ (Deleuze, 1992, p. 4). The language game of psychiatry thus blends into other institutional games.

According to Foucault (2006), the form of psychiatric power is inseparable from the physical disciplinary apparatus of the asylum, so that ‘the function of psychiatric power, which is exercised within and fixes individuals to the asylum, is to realize madness’ (p. 253). However, what is observed here are mechanisms of control that move beyond the physical boundaries of the asylum to extend into routine practice in what Deleuze (1992) characterised as ‘Societies of Control’. According to this conceptualisation, mis/recognition extends beyond the walls of the hospital and become, instead, generalised procedures realised in every interaction between staff and patient, prior to formal legal powers being established.

The language game thus becomes porous, instituting itself into the mechanisms of everyday life, even before contact with the psychiatric service is made. It is interesting to note, for example, my fear of straightjackets and indefinite interment (S3:83-85). Such tropes are reminiscent of horror films, or dramatisations such as One Flew Over the Cuckoo’s Nest, and not of a modern psychiatric unit which neither uses straightjackets nor keeps patients for extended spells. However, something of psychiatry’s power is retained by these images, with its notions of the ability to restrict or detain against one's will, and its capacity to judge the 'rightness' of one's mind.

Nowhere in the narrative, however, is the insinuation of the psychiatric language game into everyday day observed as clearly as in my mother's diary. For example, it was clear in the narrative by the time I had been moved to the PICU my mother had been in close proximity with the clinical team, relaying information from the home to them (e.g. C7:45-52). However, a subtler change in her narrative occurred towards the end. For example, the final entry in Part 4 was very personal and very human, but also bleak: my mother reported her and my father's sense of desperation at my presentation and their fear of no prospect of change (M4:44-69). Her diary was then silent for almost a month, across Parts 5 and 6 during some fairly significant events in the narrative, including my absconding from the ward, the transfer to the PICU and being placed on Section 3 under the MHA. When her diary spoke again, in Part 7, the style and content of her writing changed dramatically. From here, her diary entries were recorded in the form of short comments (e.g., M7:1-3) on a narrow range of observations, including the medication I was using (e.g., M7:105-9), my behaviour (e.g., M7:45-6), and my symptoms such as mood and paranoia (e.g., M3:79-83). Indeed, she even reverted to what I assume is a short-form ('P') to denote 'paranoia' (M7:29-30). Her diary style now mimicked the clinical notes in both form and content: she no longer referred to me in terms of her son, but almost as if I was 'just' a patient. Perhaps in the same way that clinical discourse in the hospital could be seen as a response to the anxieties of contingency and unpredictability, so it also performs the same role for my mother (who was also a nurse, albeit not a psychiatric nurse). Perhaps this contributed to the sense that she was helping, or doing something, or even charting things for evidence of improvement for her own sake.

However, it also demonstrated quite powerfully the implicit requirement for her to adopt the language of the dominant psychiatric discourse in order to voice her complaint (in this case, presumably, anxiety about my welfare). There is thus, as Goffman (1959) noted, an ‘emergent unintended exchange or reciprocation of functions’ (p. 131) between the roles of staff and my mother but these ‘reciprocation of functions’ extended even to the terms she used to talk about me (her discourse). The impression generated of the psychiatric service therefore is one of a ‘fluid, amorphous picture of power’ (Swerdfager, 2016, p. 291) that ‘flows through and around bodies and objects in a complex network of relations’ (ibid, p. 291). The family forms part of this porous nexus or complex, one of ‘the ‘innumerable points’ that make up the psychiatric apparatus’ (ibid p. 291). As part of such a network, the family becomes an important site whereby both power and surveillance are continually operated.

The patient’s self is thus ‘not the property of the person to whom it is attributed, but dwells rather in the pattern of social control that is exerted in connexion with the person by himself and those around him’ (Goffman, 1961, p. 154). In this pattern of social control, it is only the elements that were consistent with the biomedical details of the case record that were seen as valid and acted upon. Or, as Foucault (2006) puts it, ‘the Psy-function is precisely what reveals that familial sovereignty belongs profoundly to the disciplinary apparatus' (p. 86). Only here, the control is not so much exercised by disciplinary power with its emphasis on the domination of space, but in terms of a discursive control that assimilates and transforms other discourses, including that of the family, orientates itself around the number and ties itself to wider discursive categories such as psychiatric diagnosis and the discourses of risk. Within this differend, there is no space for the subjectivity of the patient.

7.2.4 Consent

In the previous sections, the main feature of mis/recognition identified was the dominance of the psychiatric discourse over other discourses. In the last section, I showed that this dominance was characterised less by what Foucault (1977) called 'disciplinary power', with its focus on a fixed space with impermeable boundaries typified by the asylum, and more through Foucault's later work on 'biopower' and Deleuze's notion of 'control societies' where power is based on a numerical value that permeates through all aspects of social interaction, even before 'entry' to the disciplinary space of the hospital has been formally effected. The presence of disciplinary forms of mis/recognition are also very much evident in the use of ECT. Before exploring this area in more detail, it is important to contextualise the use of this treatment at the time when the narrative takes place.

The ECT Handbook, produced in 1995 (RCP, 1995), recommended the use of ECT for a range of conditions including 'treatment-resistant' (i.e. drug-resistant) depression and schizophrenia. For the former, the Handbook advised that ‘depressed patients who had not responded to antidepressant drug treatment could recover if treated subsequently by ECT’ (RCP, 1995, p. 3). For the latter, the Handbook advised that there was no evidence that ECT was effective in so-called ‘Type II schizophrenia’ although ‘marked depressive symptoms arising in the context of a Type II syndrome may respond to ECT’ (RCP, 1995, p. 8).

As I have highlighted earlier however, it was never really clear in the narrative what my diagnosis actually was, or what the doctors believed to be my primary problem: whether my ‘depressive’ symptoms were associated with a psychotic illness, or whether my psychotic symptoms were associated with a depressive illness. This may indeed have been irrelevant. As Foucault (2006) demonstrated through his analysis of psychiatric power, the question of diagnosis is often irrelevant to the primary concern of establishing whether someone is mad or not. In other words, ‘the only real question is posed in terms of yes and no’ (p. 266) and not in terms of what or why.

Whilst the question of diagnostic uncertainty is therefore perhaps a moot point (and may even have reflected the doctors’ unwillingness to ‘label’ me as a first-time service user), the lack of a clear outline of the clinical decision-making process was more marked. For example, ECT was first suggested in the narrative in the ward round dated 14/11/94 (C8:19-20) and also mentioned in my mother’s diary the day after (M8:1-3). However, the rationale for its use was not stated. In absence of a clear clinical reason, one assumes it was because the clinical team felt that all other treatment options had been exhausted; if so, this is difficult to reconcile with the relatively short time between admission and when ECT was first suggested (just over one month) and with the fact that the only other treatment offered, aside from medication, was occupational therapy. Even more so, occupational therapy was only offered after the first course of ECT (C8:144 ff.). The original request for psychotherapy was never acted upon at any time, despite the existence of contemporary accounts of the use of psychotherapy with severe psychosis (Jackson and Williams, 1994).

The main issue, however, with ECT and mis/recognition coalesced around the issue of consent, which also happened to be the first time I mentioned ECT in the narrative (S8:1-5). Regarding consent, the ECT Handbook (1995) clearly stipulates that ‘Valid (real) consent is required before ECT can be given’ (p. 97) and also outlines the conditions under which consent should be procured. In the narrative itself, the clinical notes document that consent was procured verbally (C8:24-5) and Documents 8.2 and 8.3 both provided signed evidence from myself and the doctor that consent was gained. It would seem, therefore, that appropriate practice was followed according to the guidelines of the time.

However, this notion of consent provided another example of mis/recognition and raises further questions around the meaningfulness of how consent is conceptualised in acute mental health contexts. For example, I considered ECT to be a form of punishment masterminded by ‘spiritual beings’ that I believed were controlling all activity on the ward (S8:7-11). There was no ‘choice’ here in my mind, as giving ‘consent’ for ‘treatment’ was a meaningless exercise: those procuring consent were themselves controlled by beings they were unaware of, but subject to. Whether I gave consent or not was irrelevant; the evil spirits would have their way regardless.

Consenting to ECT therefore represented a double bind for me, a contradictory injunction that led to the same outcome regardless. However, when considered as a differend the problem is even more pronounced than the double bind framework outlined by Bateson (1972). My core dilemma, which I outlined above, was inexpressible in the discourse of the language of medico-legal terminology as its liberal assumptions of rights and autonomy did not apply to my framework of understanding. Even further, expressing my dilemma in the terms outlined by medico-legal psychiatry (remembering that this was the only language game permitted) would have only reinforced the psychiatric discursive register, in that the discourse of ‘evil spirits’ would be judged as evidence of a delusion and therefore supported a diagnosis of paranoid schizophrenia. It is worth noting out here Foucault’s (1961) point that there was a long, and internally perfect, rational framing of ‘madness’ in spiritual terms in European culture, before the advent of medicine. What is often labelled ‘madness’ in Western psychiatry is framed very differently in other cultures (Bentall, 2003).

As we have seen in the preceding sections, the diagnosis of ‘schizophrenia’ was used to justify coercive risk management strategies. The expression of such ideas may then have provided further evidence of the severity of my ‘illness’ and thus the greater necessity for ECT (and for overriding patient ‘choice’). The discourse of consent, in the context of the psychiatric differend, was to effectively silence my capacity to express the dilemma and even to transform it into its own categories to justify the actions of the clinicians, as I had ‘given’ ‘consent’ to the treatment. Therefore, the differend is not just the inability to put into a language a dilemma that is inexpressible, but a key feature of the discourse of psychiatry itself that underpins mental health services.

Further analysis of the processes of consent highlight the presences of mis/recognition and the differend in different ways. For example, the unintentionally comical ‘naked finger puppet’ explanation provided by the nurse (S8:19-29) appeared to be used in absence of any sufficient explanation what ECT actually does, or even why it was being used in the first place. This suggestion of a laissez-faire approach to giving information and gaining consent was further reinforced by the supporting documents in Part 8. For example, Document 8.3, which was obtained immediately prior to the first ECT treatment, stated consent to treatment was gained after ECT ‘was explained to him a week ago’. Whilst this statement does not preclude the fact that the psychiatrist may have explained the process with me again, it also suggests that explaining the treatment to me a week prior was considered ‘enough’ legally and therefore sufficient in the language game of consent. There were even times where it is explicitly reported in the clinical notes that I did not want to continue treatment (C8:139-141), which would imply the withdrawal of consent, yet this was not acted upon in any way. This appeared to contravene the notes on consent from the Handbook (1995) which clearly states that ‘consent can be withdrawn at any time and that fresh consent is then required before further treatment may be given’ (p. 97).

The process of gaining consent thus appeared to be handled in a way that was less than rigorous. However, as discussed, although consent for ECT was required, it could be overridden by the doctor, if he or she deemed it was necessary. Like the process of admission therefore, where I was encouraged to come in voluntarily but under threat of compulsion if I refused, consent to ECT was something of a chimera. It was a double bind that resulted in the same outcome regardless, but also represented a differend: not only are there contradictory injunctions at different levels of communication (Bateson’s double bind), the language of consent is effectively used implicitly as a means to silence (e.g. ‘we have offered him a choice, so what could his problem be?). There was thus no facility in the dominant discourse of medico-legal language for me to express the impossibility of this dilemma (to say, in effect, that the rules of consent were invalid). I could have refused treatment, but refusal would be taken as a sign of the illness and could still have been administered regardless of my ‘consent’.

The mis/recognition in this process was thus couched in the legal fiction of consent at the heart of liberal law, but which could only be expressed by me in the disavowed language of delusion. Under such compulsion, the only recourse left to me was drinking water the night before (S8:32-4), an example of a tactic of De Certeau (1984), to prevent the procedure (or strategy) from going ahead. As a tactic it was fairly ineffectual, as point 3 on Document 8.4 indicated (‘On Monday and Thursday Simon to have a nurse with him to ensure he doesn't take food or fluid prior to E.C.T. treatment’). All of these processes echo Goffman’s (1961) observation that hospital procedures ‘sustain the legal fiction that whilst the patient does not actually have his rights he somehow actually has not lost them’ (p. 132).

7.2.5 Discharge

The process of consent was thus marked by mis/recognition as framed within the conceptual framework of Lyotard’s (1983) differend. However, the discharge process also provided many examples of mis/recognition and this is most clearly evident in the incongruences both within and between accounts. For example, my mother’s response following treatment were immediately positive: her son was now ‘wearing his glasses’ (M8:51-5) and ‘still had paranoia though but not so bad & persistent’ (M8:64-5). She also remarked upon sudden changes in my behaviour, including talking to people (M8:62-4), self-care (M8:79-80) and mood (M8:96-7). The clinical notes also attested to this change, with mood (C8:61-3), suicidal thoughts (C8:82-3), paranoia (C8:114-16) and ‘mixing with other patients’ (C8:180-3) all cited as examples of positive change. Even my account indicated this to some degree: for the first time in the narrative, I spoke with other patients (S8:67-70), began to question previously-held paranoid beliefs (S8:76-9) and started to manage myself differently with the staff, becoming more ‘cooperative’ (S8:195-8).

However, closer analysis of the clinical notes suggests a somewhat more complex picture, as contradictory statements about my condition were juxtaposed together in the clinical and my mother’s account. For example, one nurse stated that they ‘spoke with his father and he said that Simon is

1000 times better than he was before ECT, but he is indecisive and paranoid most of the time' (C8:166-71). The idea that I could be both '1000 times better' and yet 'paranoid most of the time' is not logically possible, but the language game somehow seemed to be able to contain these discrepancies. Similarly, my mother's diary in Part 9 referred to me as 'depressed' (M9:13) and 'lonely' (M9:39), along with the remark that her son 'now believes that he has a serious mental problem that may be permanent' (M9:32-4). My mother also reported that her son still 'hallucinates' (M9:29) and 'doesn't like himself' (M9:23).

These statements could have reflected the variability of my presentation, or her potentially changing standards of comparison. Either way, they were in stark contrast to the 'so much improved' (M8:95) from the previous section. A possible explanation is offered in the clinical notes to these seemingly contradictory reports: I 'became a bit depressed' possibly due to my 'realisation that he is mentally ill' (C9:36-9). In other words, the depression is an understandable response to my 'insight' that I have a mental illness, a perspective which, presumably, I did not have before this time when I was 'ill'. This remark is often supported by the wealth of research on 'post-psychotic depression' (Birchwood et al., 2000), the notion that some lowering of mood inevitably follows once 'delusions' in psychosis has subsided and the patient now has 'insight'. However, the phrasing here is reflective of the differend: I was ill before I had 'insight' (and indeed, this was a sign that I was ill), but even though I have insight I am still ill, though presumably with a better form of illness than when I did not have insight. Either way, I am still ill. This statement is further qualified later in the narrative when it is stated in the notes that the patient ‘Now realises that he has been mentally ill and accepts that he may fall ill again if he does not continue with the medication’ (C9:116-9).

The logical contradiction in the discourse here is thus clear: I must be ill if I am taking medication, but I will get ill again if I do not take medication. Within this discourse, there is no position by which to be ‘not ill’, or to dispute the nature of my condition. It is, indeed, another differend. As Goffman (1961) observes, the ward system ‘is an extreme instance of how the physical facts of an establishment can be explicitly employed to frame the conception a person takes of himself’ (p. 139). The use of props such as admission forms, seclusion rooms, PICU, ECT etc. are all geared towards reinforcing the patient identity that they are someone who is medically sick. Within this system, ‘The patient must ‘insightfully’ come to take, or affect to take, the hospital’s view of himself.’ (ibid, p. 144). There is thus no room, or language, to express something outside of this if one is to proceed through the system.

The mis/recognition was therefore the requirement for me to conform to a particular view of myself, above anything else. In this language game, the continuing presence of psychotic (and even risk) symptoms appeared to have been secondary to the importance of me showing acquiescence to a psychiatric view of myself. It is this explicit taking up of the role of the ‘mentally ill’ patient that seemed even more important in getting discharged than the mere reduction of clinical symptomology. As Foucault (2006) summarises in terms of this perspective on behalf of the dominant discursive strategy of psychiatry:

> I am prepared to relieve you of legal and moral responsibility for what you have done or for what happens to you, or for the feelings you experience, on the one condition that you subjectively accept the reality of all of this, on condition that you give all these facts back to me as subjective symptoms of your existence, of your consciousness. (p. 273)

The function of the hospital system is thus to get the patient to voluntarily offer up to them his or her identity in exchange for the moral responsibility that is usually considered the key feature of being human. However, and as De Certeau (1984) recognised, the effects of disciplinary strategy are often superficial and can be undermined to some degree through the use of tactics, often performed unconsciously and unreflexively by the 'users'. Laing (1960/1990) recognised this feature of psychiatric discourse when he observed, 'I am quite sure that a good number of 'cures' of psychotics consist in the fact that the patient has decided, for one reason or another, once more to *play at being sane*' (p. 148).

Therefore, rather than feeling genuinely 'better', or even seeing a significant reduction in symptoms, I finally learnt how to play the game of getting out of the ward by telling them that I was feeling better and no longer believed my paranoid ideas, despite still feeling very depressed and very paranoid (S9:32-9). In other words, I maintain this façade of saying that I am unwell and that I now realise this, even though I fundamentally believe I am not. To perform this act required a certain skill in ‘tactical authenticity’ (Clarke & Wright, 2019): giving the nurses and doctors enough ‘real’ symptoms, whilst also concealing the true extent of my endorsement of these paranoid and depressive experiences (S103-13). A large part of my behaviour from here on was ‘playing at being sane’ (e.g. ‘Good eye contact, good rapport, appropriate in his behavioural & emotional response’; C9:88-91), which at some level also seemed to be tacitly understood by the clinical team as the reported levels of paranoia and depression remain high, even prior to discharge.

Acquiescing to the rules of this language game thus represented something of an exchange that had variable gains and losses. In terms of gains, I got what I wanted, which was to be discharged from hospital; the staff, in turn, got a free bed that could be used to meet the ever-pressing demand for services (S9:24-30), whilst also gaining an apparently compliant patient. My mother and my family, also, had me returned to them with the medical stamp of approval that I was now ‘well’. However, the costs for the service was that I had effectively become another ‘revolving door’ patient and the cost for me was that I never gained any sense of a resolution of the problem that I originally presented with, namely ‘despair’. My family also had to live with the contradiction that I was apparently ‘well’, whilst seemingly still depressed and sometimes paranoid.

There is thus a certain sense of hopelessness that comes as a result of submitting to the differend. Indeed, one could even say that the despair resulting from submitting to the differend is another aspect of the psychiatric differend itself. In the next chapter I will be looking at the subject of despair, and its expression in the narrative, in more detail.

SUMMARY

This chapter extended the work of the previous chapter on double binds by utilising the concepts of 'language games' and the 'differend' developed by Lyotard (1978, 1983). These concepts illustrated the second theme of the thesis, namely mis/recognition, which argued that psychiatric discourse in the narrative imposed a differend on my experience through depriving me of the language to effectively voice my complaints. One significant aspect of the psychiatric differend was that the language I used to describe my experiences were transformed into terms consistent with psychiatric discourse. I also argued that these processes of mis/recognition could be observed through key psychiatric practices in the narrative such as assessment, diagnosis, the ward round, gaining consent for ECT and discharge planning.

CHAPTER 8. DESPAIR

INTRODUCTION

Whilst chapter 6 looked at double binds understood in terms of Batson's (1972) conceptualisation of a communicative framework whereby the 'victim' is asked to respond to conflicting injunctions both of which result in the same outcome, the last chapter focussed on the theme of 'mis/recognition'. It argued that mis/recognition in the narrative operated according to what Lyotard (1983) called a 'differend', which is a 'language game' that works by depriving the other from effectively framing their complaints outside of the dominant discourse. Mis/recognition was thus exhibited through a structure of discursive conformity, where mine and my mother's discourses became increasingly absorbed into the language game of the psychiatric system, albeit my conformity was less about my acceptance of the truth of psychiatric discourse and more about a tactical response to the psychiatric differend (i.e. performing an appearance of 'wellness' in order to get discharged). The chapter concluded by recognising that my discursive conformity was a balancing of relative gains and losses, and that by gaining discharge by playing at being sane, I lost the opportunity to explore the initial reason why I presented to psychiatric services in the first place.

In this chapter, I argue that one of most important reasons for my initial presentation, and which was lost in the language game of psychiatric discourse, was an experience of despair. As I will show in this chapter, I used the term 'despair' as a signifier to describe my experience fairly early on in the narrative and this term provided an important qualitative representation of my experience throughout. I will show that ‘despair’ is markedly different compared to other, arguably equivalent, terms such as ‘depression’ or ‘anxiety’. However, as I will also show in this chapter, the representation of my experience of despair became more marginalised the further I progressed through the mental health system. Psychiatric discourse here thus represented a disavowal of despair in preference for anxiety and depression, presumably as these representations are more compatible with a medical model where chemical imbalances and disordered biology are the main causal explanations (Bentall, 2003), which could be corrected through the use of medication and, to a lesser extent perhaps, ECT.

In this chapter, I begin with an exploration of the meaning behind the term ‘despair’, particularly in terms of how I used the word in the narrative with its singularity of meaning in my experience. I then move on to contrast my experience of despair with how my ‘despair’ was represented in the psychiatric discourse. I then provide alternative theoretical accounts of despair in contrast to biomedical psychiatry, namely Bion’s (1957) psychoanalytic concept of ‘nameless dread’ and Laing’s (1960) existential concept of ‘ontological insecurity’. In doing so, I will show that both Bion’s (1957) and Laing’s (1960) theories provide accounts of despair that are experientially richer than biomedical psychiatry but more importantly in terms of this thesis’ questions, provide representations of despair that segue very closely with my experience in the narrative. However, I will also show that both frameworks ultimately miss important qualitative elements of despair as represented in my account and, in doing so, potentially neglect aspects of the experience of despair in madness more generally. I then conclude the chapter by offering the possibility of another conceptualisation of despair in madness by returning again to the concept of ‘tactical authenticity’.

8.1 Formulating Despair

Despair is an affect-state akin to dread, the etymological roots of which signify the absence of hope, or ‘bad hope’. However, language in madness can be a very singular and unique experience (Leader, 2014), and idiosyncratic uses of language for an experience such as despair is not uncommon in first-person representations of madness. Whilst a full review of ‘despair’ in first-person accounts would be beyond the scope of this chapter, a paper by Bouricius (1989) provides a useful illustration of this singularity of language use, especially because of the similarities with my account. Bouricius, a mental health social worker who was also a carer for her son diagnosed with schizophrenia, included excerpts from her son’s diary to illustrate the differences in his emotional life compared with how his experience was represented in the psychiatrist’s clinical notes. A few relevant examples of his diary from Bouricius’ (1989) paper is provided below:

> I am a lonely nothing, a being, but pass me by.
> Forever pass me by. Strangers, I don't see you. My
> afflictions fill the place that was meant for sharing love.
> I am crying in despair. (p. 202)

> Pain is in my chest. Sorrow is in my head and neck. Anguish is in my shoulders. All suffering is truly in me. (p. 204)

> Pain prevents me from moving in any direction. I am where I am in the condition I am in. There is no escape, no way to heal this huge scar and be reborn. (p. 206)

As these examples show, only a close examination of Bouricius' son's language helps elucidate the idiosyncratic way in which terms such as 'despair' are used. For example, Bouricius' son uses 'despair' in multiple ways: as a form of social isolation, i.e. the feeling of being cut-off from other people ('I am a lonely nothing'); an inability to love or feel love ('My afflictions fill the place that was meant for sharing love'); an expression of 'anguish' that is akin to physical pain ('All suffering is truly in me'); the feeling of being trapped ('there is no escape'); being unable to repair this existential wrong ('no way to heal this huge scar and be reborn'). However, a blanket use of the word 'despair' (or, indeed, 'depression' or 'anxiety') misses this important singular mode of expression. Such idiosyncrasy suggests a move against generalisable theories of despair that is applicable to all subjects and suggests, instead, a need for an analysis of the individual case (Leader, 2014).

The issue, therefore, is one that is central to this thesis: that of representation, or the attempt to put into words something about the inexpressible nature of the experience of madness that, nevertheless, still needs to be expressed. As the Bouricius (1989) paper shows, despair can be a key aspect of this experience that other well-known first-person accounts of madness also address (e.g. Schreber, 1903; Greenberg, 1964; Barnes and Berke, 1990; Taylor, 2014). Moving away from first-person accounts to theories closer to this thesis, despair was also a central part of Bateson's (1972) double bind theory. As Bateson (1972) suggested, being caught in the double bind 'leads to the conclusion of despair, "there are no alternatives"' (p. 355).

However, the important issue here is about how this key aspect of experience can, or should be, represented in first-person accounts. Laing (1969), recognising this, argued that 'Schizophrenia cannot be understood without understanding despair' (p. 38). From the perspective of psychoanalysis, Henri Rey (1994) argued that 'Despair must be about the commonest feeling found in mental illness, in neurosis and psychosis' (p. 226), although the reference to despair in this work was only brief and Rey did not specify here what he meant by the term. Hinshelwood (1987), also coming from a psychoanalytic perspective, stated that 'Despair may not be recognised often enough' (p. 58), acknowledging despair's ubiquity in relation to clinical work with psychosis, as well as its neglect. Such neglect is also reflected in the research literature where, outside the work of some psychoanalytic and existential/phenomenological writers, the role of despair in psychosis has not been explored extensively from a theoretical standpoint (Steinbock, 2007).

Despair has also been considerably less researched in comparison to anxiety and depression. For example, in their systematic review on depression and anxiety in psychosis, Hartley et al. (2013) found 865 studies using the search terms ‘anxiety’ and ‘psychosis’, and 1,926 studies using ‘depression’ and ‘psychosis’ on PsycINFO. By contrast, I conducted a quick literature search on PsycINFO in September 2019 using the search terms ‘despair’ with ‘schizophrenia’ or ‘psychosis’, only getting 123 hits with all of these terms combined. The methodologies of the articles I found also differed substantially from Hartley et al. (2013): whilst articles for anxiety and depression were overwhelmingly quantitative, the articles for despair that I found were mostly case studies from psychotherapists (e.g. Margulies, 2016) or qualitative interview studies (e.g. Ben-David et al., 2014). What is worth noting here is that the latter studies do not map out a theory of despair based on the findings but take the meaning of the word ‘despair’ for granted. It is also worth noting that, to the best of my knowledge at least, there is no systematic review on despair and psychosis.

There is thus a significant disjunction in how despair is represented in the psychiatric literature and this disjunction provides an important rationale for its focus in the thesis, as well as demonstrating a novel contribution to knowledge. Indeed, there are important points of comparison between this thesis and the Bouricius (1989) paper. For example, she used her son’s diary entries to show the insufficiency of standardised psychiatric measures in capturing the emotional life of the service users they measure. In other words, whilst her son’s psychometric scores typically indicated ‘negative symptoms’ of schizophrenia such as ‘flattened affect’, his diary shows a turbulent emotional life that belied the diagnostic descriptions. At the conclusion of the paper, Bouricius (1989) invites the question, ‘Is it possible that many persons who suffer from schizophrenia and exhibit negative symptoms are actually experiencing strong emotions that they are unable or afraid to express?’ (p. 207). This is a clear example of what I formulated as mis/recognition in the last chapter in relation to my experience: her son was invited to express himself in idioms that transformed his experience into discursive formations which deprived him (and, indeed, his mother) of the opportunity to adequately express his complaints. In the next section, I will show how these processes also occurred in my experience.

8.2 Despair as Psychiatric Symptom

Like Bouricius’ (1989) son, my encounter with psychiatrists in the narrative showed similar processes of mis/recognition in terms of the emotional experience of despair. This is most noticeable in the Part 2, during my first encounter with a psychiatrist. I briefly discussed this encounter in the last chapter in terms of how my word ‘despair’ became incorporated into the discursive language game of psychiatry and, in doing so, effectively silenced me. In this chapter, however, I will examine in more detail the clinical use of language in comparison to my representations.

Before meeting the psychiatrist in Part 2, however, I had been assessed by the GP. As their account in Part 1 indicated, my problem in the referral letter to the psychiatrist was framed in medical terms: I was ‘definitely depressed’ (C1:109). The GP letter also provided a fairly detailed account of symptoms: I am described as ‘lacking sensitivity’ (C1:56) being ‘emotionally flat’ (C1:57) and the GP also took care to detail my symptoms in my own words, including a lack of ‘any sense of creativity’ (C1:60), motivation (C1:60), energy or pleasure or joy (C1:61-2). These symptoms, like those outlined in the Bouricius (1989) paper, are the typical ‘negative’ symptoms associated with depression or schizophrenia. It is also interesting to note that the GP recorded that I also ‘admitted’ (C1:63) to being depressed, implying that this was a question deliberately asked by the doctor and that perhaps the doctor was already using a ‘working’ diagnosis of depression.

However, as my account in Part 1 showed, my experiences could not be easily subjected to the categories employed by medicine. In the beginning of the account, for example, I was in the back garden of my parent’s house, pacing up and down and smoking. The pacing back and forth generates an impression of manic entrapment, almost like an animal in a zoo. The continual ingestion of cigarettes whilst pacing back and forth added further to a sense of futility and desperation. Undoubtably, the nicotine in the cigarettes would have also impacted on a physiological level, acting as both stimulant and sedative, reinforcing, and perhaps even adding to, the impression of fruitless repetition, up and down, back and forth. This sense of entrapment was further reinforced by the ‘mad roulette’ of ‘voices’ that were ‘rolling around’ my head at the time (S1:8-9). As I explored in chapter 6, the meaning connected with these voices were manifold: the threat of being pursued and hunted; being deceived or given a false sense of security; a mocking threat of going mad; the terror of nothingness; immediate annihilation or abuse; punishment; having to survive in the presence of something terrible; hopelessness and desperation. Taken together, the tone of the voices is unremittingly threatening and expressed a feeling that something terrible was about to happen at the hands of 'supernatural' agents more powerful than me.

The overall sense of foreboding was further reinforced in Part 1 in terms of my position with the rest of the world. I was separated from my parents, both physically in terms of my location 'at the back of the garden, slightly raised up from the house below' (S1:2-4); and psychologically, as I watch them 'move in and out of focus like fish in an aquarium' (S1:38-9). Their description as fish added an element of depersonalisation, as if I was no longer experiencing a commonality of feeling with my family, whilst the image of the fishbowl suggested that their life was one of familiarity and repetition that I no longer shared in. That they were clearly talking about me, anxiously, added another element to the fishbowl metaphor: that of being on display or feeling overly visible. Their movement back and forth in the 'fishbowl' of the kitchen window mirrored, to some extent, my pacing back and forth. When my mother came up to speak to me at the back of the garden, there was no sense of personal connection or that her words had any resonance with me. The fact that what she said was not recorded in detail added to this effect. The introduction of the medical team through my mother's question to me about my visit to the GP, and my 'noncommittal' response, served to highlight another aspect of my separation from the world, this time a separation from the medical team who occupied the institutional place of authority.

Whilst we were talking, apples fell from the tree with a loud noise on two occasions. Although apples falling are not in themselves strange or unusual, in this context, particularly with the metaphorical language used by the voices associated with feelings of dread and impending doom, they contributed to this impression of my experience of events, people, and objects seemingly out of place and not quite right. For example, in the narrative I was in a very familiar place, in fact the most familiar place of all, the home where I had grown up and spent all of my life. However, this once familiar environment had now been transformed into something unknown. The ‘voices’ reflected the words of writers which I knew well enough to recite from memory, but their meaning had now acquired something threatening and foreboding that was directed straight at me. This juxtaposition between the unfamiliar in the familiar produced something surreal and almost dreamlike but with a quality that was also disturbing and uncanny.

Throughout my account therefore, the impression of the uncanny and the strange feelings of dread and despair permeate throughout. For Freud (1919), the uncanny ‘belongs to all that is terrible—to all that arouses dread and creeping horror’ (p. 1). Freud (1919) provides a list of such phenomena, including the faces of dolls, dismembered limbs that are still moving, characters from fairy stories (e.g. The Sand-Man) etc. According to Freud (1919), what makes these things particularly unsettling is that the ‘effect is produced by effacing the distinction between imagination and reality' (p. 15). Following Freud (1919), the 'uncanny' effect in this first part of the narrative is thus indicated by the almost waking dreamlike quality of the early stages of psychosis when familiar objects (home, writings, voices) become unfamiliar and frightening. They are both familiar, yet unfamiliar, and this adds a sense of terror to the impression of hopelessness.

However, the concept only has a limited utility when applied to the narrative: 'uncanny' is an English word that was used for Freud's use of the German word 'unheimlich' which, literally translated, means 'unhomelike'. As Freud (1919) identified in the use of the word in his review of the term however, 'the word is not always used in a clearly definable sense, so that it tends to coincide with whatever excites dread' (p. 219). For Freud (1919), the uncanny was used to denote 'that class of the terrifying which leads back to something long known to us, once very familiar' (p. 219). It was thus tied specifically to Freudian concepts such as repression, castration fear and the Oedipus complex. Thus, to call my experience of despair 'uncanny' in the Freudian sense does not quite fit, even though there is definitely an 'unhomelike' quality to the despair, whereby everything familiar has now become strange, and there was also a palpable sense of dread and terror.

However, upon meeting the psychiatrist in Part 2 and explaining to him that 'despair' was the central problem, the psychiatrist retained my word 'despair' but then transformed it into a psychiatric diagnostic category. As I have noted in Chapter 6 on mis/recognition, my use of the term was insistent enough for the psychiatrist to subsequently use my words, but the meaning was subsumed by psychiatric discourse and treated as a clinical symptom formulated numerically in terms of frequency and duration. Indeed, the psychiatrist’s grammatical phrasing reinforced the argument that only one certain meaning was being extrapolated. In Document 2.1.1 for example, the word despair is used as a participle, and not a noun, to qualify the verb ‘feeling’ (‘he feels despaired for half an hour in the morning and half an hour before going to bed’). Either this was a grammatical error, or an unintentional slip giving grammatical primacy to ‘feeling’ (and thus to ‘mood’) over my more ‘existential’ use of the term ‘despair’. In doing this, the psychiatrist was perhaps unconsciously foregrounding the form of the feeling over its particular expression. In other words, the content of the word ‘despair’ was excluded as it did not fit the pre-existing form of psychiatric nosology. The meaning of the term, in relation to what it meant to me, was not explored at all.

In the context of this chapter therefore, it is possible to see what this particular discursive manoeuvre on behalf of the psychiatrist missed. My account in Part 1 provided a depiction of an experience of madness that could be understood in terms of a sense of complete hopelessness, affect characterised by dread, separation from the interpersonal world and a sense of things, including the natural world, as being depersonalised, unreal or uncanny. However, the psychiatrist seemed to assume that I was using the word to designate a mood state when my use of the term was quite clear: I was not ‘feeling’ despair, I was ‘in despair’ (S2:32). That is, the nature of my despair was something other than simply a mood disorder; it was an existential orientation towards the world characterised by a total loss of hope, informed by supernatural beliefs about my eternal destiny and influenced by aural hallucinations that served to enhance a feeling of separation from other people, nature and myself. Despair in my usage also included a social aspect, in that it was a feeling of isolation amongst other people. However, the psychiatrist appeared to be reducing my language entirely towards what would have responded better to medication: individual moods.

If the purpose of defining despair as a mood has an important function for psychiatry in terms of directing a treatment based on medication (and, incidentally, ECT), then it is necessary to turn to other frameworks that provide a fuller account of the subjectivity of madness that is resonant with the experience outlined in this thesis, and service users' experience of despair more generally. In first-person accounts, robust theoretical frameworks that segue with the highly personal experience of madness are often lacking (Hornstein, 2012). This is not surprising perhaps, as most first-person accounts are often not trying to develop theory or contribute to new knowledge. An attempt to account both theoretically and experientially for madness is, however, an important focus of this thesis and accounting for despair in this way represents a unique contribution to knowledge. In the next section therefore, I will turn to two noted theoretical examples, Wilfred Bion and R.D. Laing, where despair in the experience of psychosis was treated in detail.

8.3 Despair as ‘Nameless Dread’

An alternative to biomedical psychiatry in terms of an adequate conceptualisation of despair may be found in the British object-relations tradition of psychoanalysis (Hinshelwood, 2004), based on the works of Bion (1957), Menzies-Lyth (1959) and Hinshelwood (1999, 2009). Arguably, this strand of psychoanalysis attempts to provide a more contextualised account of mad experience, based upon the interactions between staff, carers and patients.

For Bion (1957), when unbearable infant anxiety is unable to be contained by the mother it is returned to the infant in the form of a ‘projective identification-rejecting-object’ (Hinshelwood, 1989). In this paranoid-schizoid state, the child ‘splits his objects, and contemporaneously all that part of his personality, which would make him aware of the reality he hates, into exceedingly minute fragments’ (Bion, 1957, p. 257). Eventually, these fragments turn on the personality, subjecting it to increasing attacks of envy and sadism. According to Bion, it is these processes that occur in the adult ‘psychotic’ and, in this state of fragmentation and self-attack, ‘the patient feels surrounded by minute links which, being impregnated now with cruelty, link objects together cruelly’ (Bion, 1957, p. 268). As a way of coping with the despair that results from the ‘psychotic's feeling that he cannot restore his objects or his ego’ (ibid., p.257), these feelings are displaced into other internal and external objects, becoming what Bion called ‘bizarre objects’. Bion (1957) elaborates:

> In the patient's phantasy the expelled particles of ego lead an independent and uncontrolled existence, either contained by or containing the external objects; they continue to exercise their functions as if the ordeal to which they have been subjected had served only to increase their number and provoke their hostility to the psyche that ejected them. In consequence the patient feels himself to be surrounded by bizarre objects (p. 257)

Thus, these ‘bizarre objects’ are the result of projected pieces of the personality into things, be it internal phantasies or external objects, which then return as psychotic symptoms bearing the character of the object projected into, along with feelings of dread that accompany this fragmenting process. In order to illustrate these processes, Bion (1957) gives a number of examples, including one case where a patient thought a gramophone was listening to them. According to Bion, they have projected their internal anxiety into an external object (the gramophone), which now returns back to them their dread in the form of the ‘bizarre object’ of a delusionary hallucination (the gramophone listening to them). When this occurs, the psychotic person’s affect becomes characterised by what Bion (1962) described as, ‘not a fear of dying made tolerable, but a nameless dread’ (p. 309). It is this ‘nameless dread’ which appears to be very close to my experience of ‘despair’ in the narrative.

For example, Part 1 of my account in the narrative illustrates how Bion’s (1957) ‘nameless dread’ approximates my experience of ‘despair’. In chapter 6, I outlined how the different ‘voices’ were represented and the ways in which, overall, they were sadistic and menacing, their meaning linked together to form sets of associations that were characterised by cruelty and threat of punishment. Most of the associations concerned the threat of dying, experienced by me as an unbearable dread that increased as the narrative progressed. The apples that dropped on the floor at random intervals were further interpreted in a foreboding way, as if they were symbolically ‘talking’ to me, reinforcing the sense of ‘nameless dread’ that permeated throughout the narrative. Further, this nameless dread was expressed as a despair of being left alone in a terrifying, meaningless world without the ability to control what seemed like the attack on the self from multiple directions. The focus of this dread may have been directed towards the voices themselves, but they remained allusive and spectral objects, occasionally offering solace but mostly suggesting threat of imminent annihilation.

According to Bion’s framework therefore, the objects of my experience (both the ‘internal’ objects such as the ‘voices’, and the ‘external’ objects such as the apples), had become examples of ‘bizarre’ objects signalling the instability of the psyche and its rapid dissolution. As particles of ‘ego’ that had become split off and were then operating virtually autonomously as separate personalities, the voices set about attacking the main personality with metaphorical threats of violence. Under these attacks, the personality gave way to an increasing fear of death that was expressed in a ‘nameless dread', an anticipation that something terrible was about to happen, but there was no clear idea of what this terrible event would be. Once the hospital became the 'container' for all of these projected fears in terms of being the object that I anticipated would kill me, the stress of the ward round proved to be the breaking point.

Bion (1957) thus captures the degree to which despair in madness encompasses the total subjectivity of the person's experience and is not merely isolated to just one aspect such as mood, as in the biomedical model. Bion (1957) also captures the sense of despair in the narrative, which is associated with the experience of disintegration, whereby the person going mad feels like everything is coming apart in a succession of increasingly strange ways. The perception of being under imminent attack from spectral 'objects', the extreme emotions of hatred and envy, the terror of dying – all of these aspects, present in the narrative, were outlined in detail in Bion's (1957) theory of unconscious development. Finally, Bion's (1957) account is close to my account in the sense that my 'voices' were experienced as independent personal beings, operated in the hinterland between conscious awareness and unconsciousness, whereby the objects themselves had become experienced as autonomous, 'part-objects' that were experienced as both omniscient and threatening.

However, there are some issues with Bion's (1957) rendering of psychosis, and these issues are perhaps reflected in wider strands of some psychoanalytic thinking (Parker, 2007). For example, there is a tendency of Bion's (1957) account to *essentialise* the subject's experience. Parker (2015) defines essentialism in psychology and psychoanalysis as the tendency to ‘generate internal categories of personhood that are unchanging and timeless, that come to be thought inescapable, and that hence bear a determining influence on the subject.’ (p. 7). Essentialising the experience of the person in this way then gives rise to an individualistic conception of human subjectivity. For example, Bion (1957) thus takes as a starting point the individual’s ‘internal’ processes, separated from the ‘external’ environment and other people. Indeed, the only environmental influence that is considered at length is the subject’s relationship with the mother in infancy (and, indeed, as per much of his particular brand of psychoanalysis, the mother’s breast). When the fragmentation of the personality occurs under the psychotic onslaught of ‘bizarre objects’ and ‘nameless dread’ it does so in relative isolation from the subject’s present world as a whole. This problem of essentialism is further demonstrated by Bion’s (1957) account of the development of psychosis: the ‘projective’ processes described above were first inscribed in infancy and operate invisibly in the unconsciousness as ‘objects’, which then inevitably work themselves out in adulthood. There is a sense of inescapable fatalism which belies the subject’s agency.

However, the main problem with such an approach is that it minimises the impact of the world in terms of ameliorating or exacerbating the experience of despair. In other words, things are often more fluid, dynamic and provisional in *the present moment* than Bion’s theory would allow for. There are events in the world whereby ‘objects’ are changed and altered. This point can be demonstrated consistently throughout my experience in the narrative. In the last chapter for example, I pointed out how the form of the ward round itself (e.g. interrogation, amount of people etc.) generated some of the problems it then had to resolve. In other words, the threat of being an inpatient, handled in the way it was by the staff outlined in the last chapter, intensified my sense of hopelessness to the point where I finally broke down. Thus, the somewhat vague belief informed by the voices of being attacked or killed now becomes concretised around the notion that the method used by the 'voices' (or evil spirits) to harm me will be the hospital itself (S3:13-15). When I was incapable of answering the psychiatrists, and the threat of being an inpatient was verbally raised by the other psychiatrist when alone with me (S3:58-60), this became further confirmation of the truth of the voices. When I left the hospital utterly convinced that I was going to be forced to be an inpatient, with the belief that this was to be the mechanism through which I was to be killed, full mental collapse effectively followed.

Thus, the intensification of my despair, and what it led to, could not be really appreciated without taking into account the nature and the form of the environment which segued with my own experience of the world. Since Bion (1957), attempts have made to relate his theories of the unconscious to social practices and organisations (Hinshelwood, 2004, 2009). As Hinshelwood (1999) argues, this perspective implies that 'a special attention needs to be given to the mental health staff, and to their specific need for support, since, in an important sense, the staff's experiences are a c*ri de coeur* on the part of their patient.' (p. 18). The most notable of these was Menzies-Lyth (1959) who, based on Bion's (1957) work, characterised much of nursing practice as a 'social defence against anxiety'.

Put simply, Menzies-Lyth (1959) argued that nurses often face intolerable emotional burdens in their training. Patients get sick, die, make intolerable demands that cannot be met, are often truculent or excessively needy. Nurses are often confronted with the most elemental and primitive forms of human experience: bodily fluids, sickness, disease, pain and death. This experience connects with nurses’ unresolved unconscious conflicts, causing unbearable anxiety for them, often resulting in emotional burn-out and nurses quitting the profession. In order to regulate and deal with this sense of anxiety, systems are developed to distance professional from patients: these include such things as checklists, schedules, uniforms etc. They thus develop as ‘social defences’ against the horror of working with distress, sickness and death. However, these systems fail because they create emotional distance between patient and practitioner; indeed, this is their express purpose. But creating artificial barriers between patient and practitioner does not address the conflict generated in nurses’ unconscious as a result of the work. As many nurses enter the profession because of the opportunity it affords to provide emotional solace to their patients, these defences are experienced as intolerable.

She thus argued that a ‘significant factor in the training problems of the nursing school derived from unconscious sources, the primitive sense of horror’ (Hinshelwood, 2009, p. 511). Could the same argument be made against the psychiatric system in the narrative, except as a defence against anxiety the system represented a defence against despair? This was an argument put forward by Hinshelwood (1999), who argued that ‘If we are truly to think about our institutions and how they might be constructed for more therapeutic effect, we need to take into account the circulatory system of emotions, especially of despair' (p. 22). These 'circulatory systems' take place as unconscious communication between the psychotic in despair, and the individual or teams working with them. As Hinshelwood (1999) elaborates:

> Shared distress in the work arises from the nature of psychosis itself — or, perhaps we should say, from the nature of psychotic personalities themselves. Typically that distress is not formed or articulated in words; meaning itself gives way to an experience of meaninglessness. And this is contagious. It has a direct effect on others and, in fact, percolates through the whole system. (p. 17)

It is clear from the quotation above that similar problems to Bion (1957) can be observed. It is still an individualistic way of thinking that locates the source of despair and its effects within individuals and thus essentialises the relationship between sufferer and carer ('from the nature of psychotic personalities'). This tendency can be observed also in Menzies-Lyth (1959) as well when she observes that, 'The social defence system of the nursing service has been described as an historical development through collusive interaction between individuals to project and reify relevant elements of their psychic defence systems' (p. 115). It is thus the individuals' unconscious defence mechanisms that impact upon other individuals' unconscious mechanisms and the net result of this is what gives rise to a social defence system. Indeed, Menzies-Lyth (1959) is fairly explicit about this when she points out that, ‘Defences are, and can be, only operated by individuals. Their behaviour is the link between their psychic apparatus and the institution’ (p. 115). As Laing (1960/1990) observed however, if a theory ‘begins with man or part of man abstracted from his relation with the other in the world…the other becomes either an external or internal object or a fusion of both’ (p. 19). In other words, starting from a position as disconnected individuals results in a conceptual schema that misses important aspects of despair in mad experience.

The idea of a ‘social defence against despair’ conceived in these terms are also contradicted by key elements in the narrative. For example, according to Hinshelwood (1999), the despair is unconscious: it is not articulated in words and, indeed, this is part of the problem. However, in the narrative I was fairly explicit from the beginning of the assessment with the psychiatrist in Part 2 that my problem was ‘despair’. It was thus not ‘unconscious’ in the sense outlined by Hinshelwood (1999), although presumably there was also an unconscious emotional dimension to this experience. The key point however is that you do not need to evoke unconscious mechanisms in this way to address the issue of despair: it is there (not even) hiding in plain sight. The problem was that it was quickly converted into other modes of understanding (the terms of psychiatric diagnostics) without being explored properly.

This problem of experience and language becoming absorbed into other language games is also a major issue with the British object-relations school of psychoanalysis in its conception of despair. For Hinshelwood (1999) for example, the despair originates from the patient and operates almost as a disease that ‘percolates…through the whole system’ (p. 22). To ‘cure’ despair (or at least ‘treat’: one of the problems for Hinshelwood is that over-optimistic expectations from staff regarding a cure lead to burn-out) means to provide some way of the staff to ‘metabolise’ it through working through its counter-transferential effects in staff (Hinshelwood, 2004). However, in order to do this, the experience must first be converted into the language game of object-relations psychoanalysis, with its characterisation of human experience in the terms of defence mechanisms, objects, projection, ego and paranoid-schizoid personalities. Rather than take as a starting point the patient’s own language, it is the unconscious conceived of in these terms. This is another differend that produces mis/recognition of despair: the only way to meaningfully speak (or ‘metabolise’) one’s despair is to frame it in these terms and not the singularity of experience which this thesis is arguing for. Indeed, one of the more disturbing events in the narrative followed ECT when, through the David Bowie film, the immediate loss of despair is experienced as a catastrophic loss (S8:95-143). Removing symptoms comes at a cost; and this cost can only be worked through slowly and deliberately (Leader, 2014).

It is therefore important to return to the role of power in madness and how such discourses represent (or fail to represent) the context in which mental health service users find themselves. In many ways, the ward round was its own bizarre object: only the phantoms of fragmented and punishing parts of the personality were represented by the members of the mental health team. As this thesis is arguing, and which Chapter 2 outlined in detail with regards to the question of authenticity, the representation of madness needs to be framed in such a way as to consider the socio-political context in which madness occurs, whilst considering it in terms that recognise the radical singularity that is mad experience. Therefore, if we consider Bion's (1957), Menzies-Lyth's (1959) and Hinshelwood's (1999) theories in terms of a 'tactical' intervention in the 'strategy' of biomedical psychiatry, it raises important questions about how the mental health service can inadvertently create symptoms for patients, or at least make existing ones worse. Unfortunately, such a critique is not present explicitly in these accounts, without a deconstruction such as I have outlined here.

8.4 Despair as 'Ontological Insecurity'

Some strands of psychoanalytic thinking therefore do at least recognise that the nature of despair is more than a diagnostic category, and that its expression takes place within a social context. However, problems with how the individual is conceived lead to similar problems to biomedical psychiatry and create, potentially, another differend for the patient exploring their despair in singular terms. This problem was identified by Laing (1960/1990) who argued that both some strands of psychoanalytic thinking and biomedical psychiatry contain a common root whereby: 'The words of the technical vocabulary either refer to man in isolation from the other and the world…or they refer to falsely substantialized aspects of the isolated entity' (p. 19). In contrast, Laing (1960) developed another way of understanding despair in madness in terms of the person's being-in-world, called 'ontological insecurity'. As I will argue in this section, Laing's (1960) account is closer to my experience in the narrative than the previous two conceptualisations for a number of reasons.

To begin with, Laing (1960) contrasted the situation of people who experience 'ontological insecurity' with those who are 'ontologically secure'. Laing (1960/1990) argued that an 'ontologically *secure'* person 'will encounter all the hazards of life, social, ethical, spiritual, biological, from a centrally firm sense of his own and other people's reality and identity' (p. 39). An important aspect of being ontologically secure is a person having 'a sense of his integral selfhood and personal identity, of the permanency of things, of the reliability of natural processes, of the substantiality of natural processes, of the substantiality of others' (ibid). Thus, according to Laing (1960/1990), most people experience themselves and others in terms of the 'self-validating data of experience' (p. 41), providing a reassuring sense of their place in the world, their relation to others and their self. Such a security provides a buffer against the stresses and strains that occur as result of the 'ordinary circumstances of living' (ibid, p. 42).

However, Laing (1960) also argued that some people did not have this secure sense of being-in-the-world and, as result, feel that the ordinary circumstances of living pose a threat to their very existence. In other words, they had a 'low threshold of security' (Laing, 1960/1990, p. 42) for the pressures of existence and the anxiety such pressures exert. Once this low security of threshold had been met, Laing (1960/1990) argued that the individual would experience ‘ontological insecurity’, with some of the following effects:

> The individual in the ordinary circumstances of living may feel more unreal than real; in a literal sense, more dead than alive; precariously differentiated from the rest of the world, so that his identity and autonomy are always in question. He may lack the experience of his temporal continuity. He may not possess an over-riding sense of personal consistency or cohesiveness. He may feel more insubstantial than substantial, and unable to assume that the stuff he is made of is genuine, good, valuable. And he may feel his self as partially divorced from his body. (p. 42)

Daily living for the ontologically insecure person thus presents a ‘consistent and deadly threat’ (ibid., p. 42). According to Laing (1960), such an individual would then experience three kinds of anxiety (or dread – Laing uses the terms interchangeably in *The Divided Self*): engulfment, implosion and petrification. Engulfment is when the individual ‘dreads relatedness as such’ because ‘his uncertainty about the stability of his autonomy lays him open to the dread lest in any relationships he will lose his autonomy and identity’ (p. 44); implosion is the experience of ‘the full terror of the world as liable at any moment to crash in and obliterate all identity as a gas will rush in and obliterate a vacuum’ (p. 45); whilst petrification is when people ‘tend to feel themselves as more or less depersonalized and tend to depersonalize others' (p. 46), which they do by turning themselves and others into a thing (literally petrifying them) in order to manage the sense of being overwhelmed in relationships. Thus, Laing provides a schema for understanding the experience of madness that is grounded in the individual's relationships with other beings.

As Palmer (2001) argues, and as I have also argued throughout the thesis, such an approach makes sense in the context of mental health because symptoms are first recognised within social encounters. Psychiatric problems are initially problems that take place within a social context, amongst people. Returning to the narrative, it is clear that the situations in which my despair was intensified were under situations of interpersonal stress. As Laing (1960/1990) observed in considering engulfment in one of his patients, 'if you were to subject this patient to a type of psychiatric interrogation recommended in many psychiatric textbooks, within ten minutes his behaviour and speech would be revealing 'signs' of psychosis' (p. 43-44). Thus, it was following the ward round, a highly 'engulfing' intense interpersonal situation, that I developed full-blown psychosis which also included incidents of feeling, or even thinking I was, dead ('petrification', e.g. S3:112; S4:12-13). Similarly, upon entry to the ward round in Part 4, I experienced a sense of 'implosive' déjà vu (S4:41-5) which immediately followed the 'engulfing' fear that I would be eaten by other patients (S4:30-4). Throughout my stay on the ward, I viewed many of the patients and the staff as being puppets to the evil spirits I believed were present on, and running, the ward. This form of 'petrification' suggested that people were not experienced as being fully real or human but behaved almost like automata. Indeed, the self-harm incident that followed the initial breakdown following the ward round was perhaps a response to intense feelings of petrification, as the knife cuts were performed as an attempt to prove that my flesh was ‘dead’ (see S3:111-3; C:6:81-96).

The incidents of ontological insecurity were not limited merely to entry to the ward round and the initial breakdown. In Part 7, I was granted leave off the ward for the first time. It was clearly very stressful for me: being seen by people outside the ward, including the woman outside the hospital (S7:4-6) and my neighbours (S7:12-8), was experienced as ‘engulfing’, lending support to my paranoid ideas that others were aware of the plot that I believed was going on. Similarly, meeting with my friends and telling them about my hospitalisation proved to be overwhelming enough for me to leave soon after arriving (S7:50-2). Not long after this, I tried to force my way off the ward and was forcibly restrained and secluded (S/C7:105 ff). Arguably, such a reaction was connected with the ‘engulfing’ experience of being off the ward and returning to my ‘ordinary’ life.

There is thus a strong connection with my experience and Laing’s (1964) ideas. However, with regards to the sudden downturn in symptoms experienced in Part 7, the medical team offered another explanation: ‘poor compliance with medication on discharge’ (C7:96-8). This observation, which was not supported by any evidence in the notes, led to further coercive measures including restrictions of autonomy including, from this point onwards, the staff observing me taking medication (e.g. Document 7.5 under the section ‘specific goal’). However, this sudden remission is perhaps more comprehensible when considered according to Laing’s (1960) framework. In other words, being on the ward for some time and then returning to my home-life was clearly too much for me to manage, as the boundary between the ward and homelife became permeable.

Finally, and perhaps again in support of Laing, it is worth noting that my paranoid ideas at the time were almost always orientated around some form of perceived threat from relationships. In Part 1, I believed the works of dead writers had become possessed by evil spirits that were intent on destroying me; upon entry to the ward, the paranoid ideas became focussed on the other patients, that they would kill me spiritually, take all our money, frame me and my family as paedophiles and have me transferred to prison to be tortured. Taken metaphorically, all of these ideas expressed fears of engulfment, implosion and petrification. The sense of absolute hopelessness, and my conviction that these terrible things were about to happen, were based on the perceived threat from other people; the despair was in my perception that there was nothing I could do to stop them. As Laing (1960/1990) explains, ‘his uncertainty about the stability of his autonomy lays open to the dread lest in any relationship will lose his autonomy and identity’ (p. 44).

However, Laing’s (1960) theoretical framework also demonstrates some significant shortcomings in relation to madness more generally, and to the narrative in particular. I identify three main issues which, in all likelihood, stem from Laing’s (1960) extensive, and often uncritical, employment of existentialist theory (Shumann, 2003), with all the theoretical baggage associated with such approaches outlined in Chapter 2. These issues include the romantisation of despair, essentialising the self and the de-politicisation of despair.

The first issue is that, arguably, Laing (1960) simplifies the development of despair through over-stating the dialectical progression from one form of despair (‘schizoid’) to another (‘psychotic’). Laing was highly influenced by Christian Existentialism (Miller, 2009) and, indeed, cites Kierkegaard as one of the key sources in his development of ‘ontological insecurity’ in *The Divided Self* (Laing, 1960). However, Laing (1990) also replicates problems with existentialist approaches to understanding madness, some of which were discussed in Chapter 2 in reference to authenticity. As Laing (1960) cites an understanding of Kierkegaard as critical to understanding despair, I will discuss despair in the narrative in reference to Kierkegaard (1849) before moving on to how his account resonates with mine.

For Kierkegaard (1849), despair arises from the conflict in humankind’s nature between the finite and infinite and is thus fundamentally constitutive of human experience (Steinbock, 2007). Kierkegaard characterised three possible orientations towards despair: being unconscious in despair of having a self; not wanting in despair to be oneself; and wanting in despair to be oneself. However, it is the third orientation, ‘wanting in despair to be oneself’, that is closer to my experience. This form of despair is the awareness of the self’s ultimate relationship to the infinite whilst refusing the implications this awareness brings. According to Kierkegaard (1849), this latter despair, which he also called the ‘demonic’, is considered the ‘higher’ form (Laing, 1969) because it denotes a more authentic relationship to (infinite) reality whilst also representing humankind at their most defiant of the infinite. Kierkegaard’s (1849) notion of despair is therefore dialectical, whereby a person moves from a place of denial of despair, towards an increasing awareness of their ‘demonic’ despair in proportion to their apprehension of their infinite nature.

This form of ‘demonic’ despair outlined by Kierkegaard (1849) provides a nuanced qualitative account of despair that also resonates closely with my account in Part 3, at the point when my despair had reached its most acute phase. At this point in the narrative, following the ward round, the intensity of my despair had become so extreme that the feelings of hopelessness were all-encompassing. My ‘consciousness dissolved’ (S3:109-110) in total breakdown, immediately prior to the perception that death would provide no release: ‘You would kill yourself if that would make a difference. You know that it won’t.’ (S3:105-107). In contrast, consider this passage from Kierkegaard (1849/1989):

> For there is not the remotest possibility of dying of this sickness in the straightforward sense, or of this sickness ending in physical death. On the contrary, the torment of despair is precisely the inability to die. In this it has much in common with the contradiction of the mortally ill person who is in the throes of death but

> cannot die. Thus to be sick unto death is to be unable to die, yet not as though there were hope of life. No, the hopelessness is that even the last hope, death, is gone. (p. 47-49)

I thus became convinced that even suicide would not provide a way out: the despair had changed from a fear of death that was present in Part 1, to an overwhelming sense of the infinite through which death offered no reprieve. At this point, my despair truly became the ‘torment’ of the ‘inability to die’ and one which was consciously present in its immediacy. My experience of despair, at this point, appeared to be close to this account from Kierkegaard (1849).

However, whilst there are clearly qualitative parallels, there is a fundamental difference in my narrative account to Kierkegaard’s (1849) treatment of despair when it comes to the effect this despair brings. For example, according to Kierkegaard (1849), the more despairing a person is, the more ‘authentic’ they are: it is a despair that reflects an authentic attempt to become oneself, a necessary stage the self must progress through on its way to despair’s dissolution in faith. Thus, the acute awareness of despair is a reflection of the ‘dizziness’ of freedom (Kauffman, 1975) when one becomes aware of one’s ‘true’ nature which, if the self is to progress to higher levels of authenticity, they must acknowledge. At the highest point of despair, the ‘demonic’ to which Kierkegaard (1849/1989) points, the sufferer is defiant in their despair, the person ‘wants to be itself in hatred towards existence, to be itself according to its misery; it does not even want defiantly to be itself, but to be itself in sheer spite' (p. 105). Indeed, Kierkegaard (1849/1989) draws attention to this latter form as being almost a chosen form of despair associated with heroism, a despair 'only to be found in the poets, the real ones' (p. 104).

In contrast to Kierkegaard, my narrative contains this awareness of heightened despair but there is no sense of heroic defiance, or even the 'spite' that implies a Promethean struggle against the infinite. Rather, my account suggested extreme weakness and vulnerability in despair, confusion and anguish. In the passage quoted above for example, I had a clear perception of the infinite and this, coupled with a belief in my impending death that was, admittedly, based upon a delusion, constituted the nature of my despair. However, there was no sense of freedom in this awareness for me. Indeed, quite the opposite: I felt like I was totally at the whim and mercy of cruel and infinite spiritual forces. There was no 'dizziness' or 'freedom' in the face of anxiety or despair but, instead, a crushing sense of annihilating and incapacitating dread. The psychotic despair explicated in this chapter has no recourse to denial (the lowest form of despair in Kierkegaard's dialectic), no opportunity to sublimate despair into worldly affairs (the next stage) and no capacity to retain a defiance against the eternal (the highest form, discussed here). It is what Steinbock (2007) describes: 'absolute distance from the ground of hope is the experience of being abandoned, being alone, and being left to myself in the present' (p. 449).

Kierkegaard's (1849) account of despair, therefore, may be one of the few accounts that take seriously the qualitative nature of despair, and one that at times also resonated with my experience of despair. However, Kierkegaard’s (1849) depiction does not capture how the experience of despair literally freezes in fear. One does not need to be in denial of despair’s presence to be utterly incapacitated by it and, in many respects, the psychotic person experiencing despair may be in the worst position possible, in that they are keenly aware of their despair but without the galvanising sense of agency that presumably lies behind Kierkegaard’s (1849) ‘demonic’ despair.

Whilst Laing (1960, 1969) was often at pains to stress the suffering experienced by those diagnosed with schizophrenia, it is also worth noting that Laing was accused throughout his career of romanticising madness (Ferguson, 2018). What unites Kierkegaard and Laing’s account of ontological security perhaps, is a mis/recognition of the qualitatively unique situation of despair the person going mad may find themselves in, its singularity, but also how utterly horrible and incapacitating this experience may be. In contrast, the tactically authentic approach outlined in Chapter 2 is one that recognises the personal horror that so often accompanies madness but uses that experience to inform a political critique, a demand for a recognition of the singularity of experience. Otherwise, if one misses this dimension of unarticulated helplessness and how it is so often (dis)missed by professionals, one is at risk of returning again to mis/recognition, to a differend in which the opportunity to speak about madness is lost in a dominating discursive framework, albeit one that appears, at first glance at least, to be more benign than biomedical psychiatry or psychoanalysis.

Thus, it could be argued that here suffering is observed from a privileged distance. However, if there is a tendency to romanticise the suffering of the mad on the one hand, a related issue is that Laing (1960), like Bion (1957) and others, does not dispense with essentialist notions of the self. For example, crucial to Laing's (1969) theory of 'ontological insecurity' is the theory of 'the false-self system', which was developed from Sartre's notion of 'bad faith'. In this schema, Laing (1960) argued that a crucial response to ontological insecurity in the 'schizoid being-in-the-world' is a withdrawal from reality and the dichotomisation of the self into 'true' (the self in world, amongst persons) and 'false' (the self as it relates to itself, in phantasy). The opening of this fissure between true and false self is, indeed, what creates a sense of despair and dread in the psychotic (or schizoid) individual, as they struggle to deal with its impact:

> It is omnipotent and free only in phantasy. The more this phantastic omnipotence and freedom are indulged, the more weak, helpless, and fettered it becomes in actuality. The illusion of omnipotence and freedom can be sustained only within this magic circle of its own shut-up-ness in phantasy. And in order that this attitude be not dissipated by the slightest intrusion of reality, phantasy and reality have to be kept apart. (Laing, 1960/1990, p. 84).

As this short excerpt demonstrates, Laing (1960) distinguishes between 'real' and 'false' relationships with 'reality'. However, in employing terms that polarise distinct tendencies such as true/false, reality/phantasy and freedom/contingency, it treats these categories as if they were mutually exclusive and not intimately connected. The schema thus falls prey to essentialising tendencies: the ‘real’ self is different from an assumed ‘true’ self with the former existing in a Cartesian vacuum, separate from the social. One is true, authentic, free; the other is false, inauthentic and trapped.

However, the reality from the narrative is that neither the social nor the personal are separate or free: they are both interlocked and they both encapsulate the experience of being trapped. In my narrative, what was particularly distressing was not being able to represent this feeling of existential dread in an adequate framework, without it being lost or absorbed into something else. One could also argue that some of the supposedly ‘secure’ individuals such as the psychiatrists and nurses behaved in ways that were less than secure, such as the ‘creepy nurse’ who tricked me into going to the PICU (S4:47-78). The position of the ‘schizoid’ individual is therefore either one thing or another; one ‘chooses’ freedom and contingency or submits to ‘bad faith’ and necessity. However, such characterisations belie the lack of choice inherent in such a position: people cannot really ‘choose’ to be mad in such an obvious way, particularly if circumstances have arisen which make choice either limited or even contradictory (e.g. being invited into the ward on a voluntary basis, under compulsion of section).

Romanticising madness, and essentialising the self, thus become linked in *The Divided Self*. As my narrative shows however, things such as ‘reality’ in the world of the mental health system are not quite as simple as this strict division between ‘true’ and ‘false’. For example, towards the end of the narrative my belief that I ‘would never be the same again’ (S9:38-9) was mentioned in all three accounts. This belief is repeated in both my mother’s account (M9:35-6) and in the clinical notes (C8:130-1). In other words, I showed despair about ever really ‘recovering’ from the episode, that something fundamental had changed in me and would never be the same again. What is the ‘reality’ here? According to many biomedical models, schizophrenia is characterised by inevitable decline (Bentall, 2003). Was my despair towards the end of the narrative an accurate reflection therefore of how things ‘really’ were? Or was it a ‘delusion’ based upon previous ideas about spirit-possession and spiritual death where, following ECT, I compared myself in phantasy to the alien in the David Bowie film who has been permanently maimed (S8:95-143).

Indeed, one of the more disturbing things about the narrative is this unrelenting focus on psychotic symptomology in the clinical notes, to the exclusion of other factors. Many of these ‘other’ factors were perhaps those things which clinicians took for granted (e.g. jobs, partners, financial independence etc.). In this way, a quality of personal experience that was clearly important to me (and, arguably, my mother as she mentioned in her diary) was this ‘reality’ of hopelessness with regards to my life (M8:326). Yet, this ‘reality’ was never addressed by the mental health system, apart from vague and non-committal references to counselling that were then never followed up (C8:18-20).

The third and final issue follows on from this point, namely that a further problem with Laing's (1990) theory of 'ontological insecurity' is that it is largely apolitical. To some degree, this perhaps follows from both romanticising and essentialising the experience of madness. However, making the experience of despair an 'internal or 'interpersonal' quality ensures that despair is explored without recourse to the socio-political dimension of madness and, in particular, issues of power. Although Laing would become more politically involved later in his career (Kotowicz, 1997), in *The Divided Self* there is no discussion of how socio-political factors are linked with a diagnosis of schizophrenia (Sedgwick, 1982), or if the despair experienced by the 'schizophrenic' is exacerbated by socio-political factors such as poverty, ethnicity, stigma or the chronic underfunding of mental health services (Ferguson, 2018). This includes a lack of reference to the (in)adequacies of biomedical psychiatry or the hierarchical and coercive nature of the mental health system itself (Sedgwick, 1982). This issue has been concisely summarised by Rossdale (2015):

> The claim to ontological security, to a core space of being which operates as the condition of possibility for engaging with or encountering the world, is liable to foreclose the politics and power relations involved in the constitution of such spaces (p. 375).

In my narrative, the socio-political aspects were perhaps less at the forefront due to my status as a white, middle-class male from a relatively comfortable background. However, the relatively depoliticised tone of ‘ontological insecurity’ can be demonstrated through one feature of Laing’s ontological insecurity, that of engulfment. According to Laing (1960/1990), engulfment occurs when ‘the individual dreads relatedness as such, with anyone or anything or, indeed, even with himself, because his uncertainty about the stability of his autonomy lays him open to the dread lest in any relationship he will lose his autonomy and identity’ (p. 44). Laing further argues that this fear of engulfment is often represented in a person’s experience through the use of images such as drowning, burning etc. In terms of my experience, this fear was represented in several ways, but principally through my belief in Part 3 that other patients were going to eat me alive (S4:31-34).

This could be interpreted according to Laing’s (1960) schema. However, to see this belief as being entirely the product of an ‘ontological insecure’ delusionary phenomenology is to miss the point that this belief was expressed in the context of a particular environment, an environment where there was very little autonomy (I was under Section 3 of the MHA and, even before this, voluntary status was under coercion) and relations with some of the other patients (and even staff) were characterised by bullying and intimidation. Indeed, instances of sexual abuse on the inpatient ward were openly discussed in the day hospital (S3:8-10). Further, the belief that I will be eaten alive was first mentioned in Part 3 just before the ward through the ‘voice’ of the Sylvia Plath poem (‘*O golden child the world will kill and eat’; S3:16-7*). At this point, the idea was vague; it only gained a concrete form in a specific context, namely with other patients on the ward (S4:32-4). Although the fear of being eaten alive could be seen as a ‘bizarre object’ of projective identification (Bion), or a metaphorical expression of the fear of being overwhelmed by relationships arising from ‘ontological anxiety’ (Laing), the inpatient unit was both bizarre and engulfing in nature. Indeed, the environment itself, with all of its tensions and contradictions, its double binds and mis/recognition, could be considered ‘ontologically insecure’.

Considering the wider socio-political context of the mental health system in the 1990s also lends weight to the idea that psychotic despair can only really be understood in relation to the wider socio-political context. As I observed in Chapter 6 on double binds, this context was framed in a political context of risk aversion, with a contradictory injunction to manage demand despite reduced capacity. The treatment offered was overwhelmingly biological, with limited occupational therapy and no talking therapies. As I showed in the last chapter, the use of ECT was suggested after only two months and clearly well before other treatment options had been considered. However, as I showed in Chapter 7, it is not only the double-binding environment that creates the conditions of ontological insecurity. The psychiatric discourse itself is constituted as a differend, whereby one is invited to discuss one’s complaint, but where the complaint itself becomes transformed into categories consistent with a language game constituted by power and domination.

This point can be illustrated with reference to my mother and father’s experience, which I touched upon briefly in the last chapter. In relation to despair, my mother’s account in Part 1 suggested at the time she was desperate in the face of my increasingly withdrawn behaviour, but this sense of desperation still retained a sense of hope (‘I told him he must go through the motions of living, to plod on and we will come through this’; M1:122-5). By the time of my admission in Part 4, her stoic sense of hope had given way to despondency:

> Richard and I felt distraught when we left, we felt we had lost him and felt so down, the future looked bleak. It’s like a bereavement, you’ve lost your son – he is there in body but [he’ll or will] never be the same again. (M4:43-9)

Like my narrative at the end of Part 3, where I had moved into a subjective space characterised by a sort of living death, her sense of despair was characterised as a form of bereavement, but one in which the dead person is still living. However, her account differed to mine in that the death for her appeared to be in the loss of a familiar personality, whilst my despair was precisely my inability to die and the prospect of eternal suffering. In some ways, this distinction shows the difference perhaps between despair and depressive despondency: both involve a loss of hope, but the former involves a significant disruption of the subjective experience of temporality (Steinbock, 2007).

My mother’s account at the end of Part 3 was bleak and emotionally raw. However, her diary was silent for a significant period following this entry. When her writing resumed in Part 7, the entries were shorter and less emotive. Indeed, as I observed in the last chapter, her entries were no longer focussed on her own experiences but on my behaviour alone, and the style and form of her observations mimicked the style and form of the clinic notes. By the time of discharge in Part 9, she was no longer talking of bereavement or loss but how ‘happy’ I was (M9:99-100). Thus, her initial despairing observations had all but disappeared and, in its place, was an impression of an appearance of wellness. This sense of progress, at least in terms of reduction of symptoms, was also reflected in the clinical accounts (e.g. C9:98).

In the last chapter, I argued this was evidence of how the psychiatric differend operated to colonise the language of patients and carers. However, there was also a change in my symptoms in my account and, indeed, one of the immediate effects following ECT was a questioning of my former paranoid beliefs (S8:167-179). I also learnt how to play the game of saying and doing the right thing in order to get discharged from the ward (S8:181-198). My ‘psychotic’ despair gave way to a depressive futility, expressed as a belief that I would never properly recover. This depression, also mentioned by my mother (M9:32-6), was interpreted by the medical team as ‘the realization that he is mentally ill’ (C9:38-41). The depression was thus seen as a normal response to my ‘illness’ that comes naturally from ‘insight’, or what some researchers call ‘post-psychotic depression’ (McGlashan and Carpenter, 1976). Therefore, in the course of my treatment, I moved from the position of ‘ontologically insecure’ to ‘ontologically secure’, at least in the eyes of the clinical team and my mother. I was no longer ‘paranoid’ (at least as much) and I was no longer a risk’. ECT had worked: I was wearing my glasses again and was more ‘alert’ (M8:53-5). The narrative became ‘that place sorted you out’ (S8:217-8) and I was now ‘much more better’ (C9:98).

My parents were, perhaps understandably, happy with the treatment. However, in this movement something fundamental was lost. As some recent narratological analysis of recovery stories have shown (Woods et al., 2019), in exchange for this tidy narrative of recovery, albeit with some regrettable but understandable after-effects such as depression, the real potential for change is lost. The silence in the psychiatric differend was so complete that the original complaint of despair, so raw and so loud, was finally allowed to disappear but with the cost of sense of futility and repetition (S9:114-128). The treatment can had effectively been kicked up the recovery road.

8.5 Despair and Tactical Authenticity

In summary, ontological insecurity prevents the possibility for thinking about ethical issues and political problems that might otherwise arise from the self as a contested space due to a too-forced dichotomy between ‘sane’ and ‘mad’ that locates the person in their relational world, but not their socio-political one. It also downplays the degree to which the discursive frameworks themselves might attenuate or even create the conditions that Laing (1960) grouped together under the conceptual banner of ‘ontological insecurity’. This leads the concept of ‘ontological insecurity’ past a sort of political blind spot, which then potentially risks creating another differend for service users, albeit one that is perhaps less brutal than the biomedical psychiatric one.

However, one of the key questions of this thesis is what constitutes an authentic representation of madness. Here, I used De Certeau’s (1984) distinction between ‘strategy’ and ‘tactics’ to argue that the cultural capital represented by the ideal of authenticity allows it to speak in the territory usually occupied by more dominant discourses. In this thesis, authenticity is thus defined as a tactical intervention in the strategy of psychiatry that, nevertheless, remains close to the subjectivity of madness. Defined as a radical singularity in experience, madness is then represented in the form of multi-layered narrative that occupies a place within academic and liberal discourses that valorise ‘patient voice’ and ‘user involvement’ (Rose, 2017).

Tactical authenticity thus represents an intervention in the field of psychiatry that is constituted precisely in trying to voice, however imperfectly, the original existential complaint that was marginalised in the psychiatric discourse. In doing so, the concept also offers a subversion of the strategy of the differend. Thus, through a framing of the unique singularity of despair as it represented in the quadrilogue, there is a possibility that this experience is given a voice. The process of exploring the despair in the narrative thus becomes a tactic, poaching on the territory of strategy.

In many ways, the approach central to this thesis, that of ‘tactical authenticity’ in the production of mad narratives, is absolutely symmetrical to the psychiatric differend. Whilst the differend represents the operation of strategy and how it works against ‘users’, tactical authenticity is a disruption of this strategy. Ultimately, and as this chapter has shown, my experience of despair was the absolute absence of any possible tribunal that could hear the existential wrong and which thus indicated a profound absence of hope regarding the possibility of a ‘representation’ of an experience. However, autoethnography more generally, and the quadrilogue in particular, offers such a representational framework and thus a forum to voice the existential wrong. Even more so, it offers a forum in which whereby the hurt caused by the psychiatric system can be evaluated and re-examined, therefore opening up the possibility of some form of ‘truth and reconciliation’ (Spandler and Mckeown, 2017).

Nowhere more clearly was this seen in the narrative in the interview with the psychiatrist in Part 2. Although, as I have shown, the phrase ‘despair’ was misused by the psychiatrist, it still found a place within the discourse, as represented in the psychiatrist’s subsequent report. Its presence here then allows for a critical examination of the processes through which psychiatric strategy colonises the experiences of service users. Ultimately, the experience cannot be entirely assimilated into the discourse of psychiatry, and this represents its power.

A tactically authentic treatment of despair, as depicted in this thesis, therefore offers the opportunity for a fresh analysis of the subjectivity of madness and its presentation in the social world. In doing so, it also offers a subversion of some academic models of ‘objective’ knowledge. By taking on the trappings of academia and the neo-liberal discourse of ‘lived experience’, tactical authenticity provides the basis through which the hegemony of biomedical discourses can be analysed, critiqued and, ultimately, disrupted. The experience of madness offers a radical heterogeneity and singularity that, whilst disruptive and potentially destructive, can also be *deconstructive* and reconstructive. My despair represented a possibility of challenging the false dichotomy that is often employed in many theoretical frameworks including biomedical psychiatry, object relations and existential psychology. Its representation in this thesis thus allows for a recovery of despair. In this way, it represents a novel contribution to knowledge and also the possibility for the development of future research.

SUMMARY

This chapter explored the third and final theme arising from the analysis of the narrative, despair. I began with an exploration of despair in the psychiatric literature, recognising that despair as a phenomenon has not been explored in detail outside of existential and psychoanalytic studies. I also identified that although despair was a key feature of my subjective experience of madness in the narrative, particularly prior to making contact with mental health services and which was articulated to the psychiatric team, the term became absorbed into the wider discursive framework of biomedical psychiatry. In doing so, the opportunity to explore its meaning for me was lost. I also identified that other frameworks, most notably psychoanalysis in the British object-relations tradition and existentialism in Laing’s (1960) work, provided treatments of despair that resonated with my own, if only because they took the experience of despair seriously and recognised the experience of absolute hopelessness, terror, dread that many people going mad feel. As I also showed throughout this chapter however, the discursive and social aspects of despair and madness were significant components of my overall experience, but these aspects were largely neglected in object-relations and existentialism. As I have shown in this chapter, despair in madness represents a differend and central to my experience of despair was an existential wrong that had occurred prior to my contact with mental health services. I thus concluded by advancing the notion of a ‘tactically authentic’ depiction of despair that was able to represent elements of my experience of the double binding nature of despair, whilst also putting into words the effects of psychiatric differend.

CHAPTER 9. CONCLUSION AND IMPLICATIONS

INTRODUCTION

This thesis was developed from my personal experience of going mad and being detained in a psychiatric inpatient unit, using an innovative qualitative, autoethnographical research method. It was not my original intention to focus on this topic area. I originally wanted to look at ‘change’ within two therapeutic environments, using a longitudinal, mixed methods design. However, doing an autoethnography as a preliminary exercise re-connected me with a significant time in my past. This led me to an entirely new subject area, one that included madness, psychiatric detainment, the question of authenticity and, ultimately, the nature and status of mental health service user and survivor narratives. As the quotation in the prologue suggests, the past is never truly past but a living history which still speaks.

However, it was not just the need to represent the past, but to be in a position to learn its message. For me, the most important issues were around the question of ‘why’: why I felt so let down by the care I received at the hands of the psychiatric system; why, in our society we treat what we call ‘madness’ in this particular way; and why it is so difficult to represent these experiences adequately. I wanted to be faithful to the experience without falling into many of the traps that it seemed to me others had, without realising it. My hope is that this thesis represents at least a partial success.

Did I find any satisfactory answer to these questions? I believe my thesis found a way to represent an experience of madness that was true to its principles. I think it also showed that mad narratives and autoethnography can provide a valuable source of knowledge that can build towards a critique of established discourses. I identified some of the main issues with a psychiatric view of the world and how these issues could be conceptualised according to theories that were developed from the experience of a psychiatric survivor and not from the professionalised perspectives of psychiatry or clinical psychology. This final chapter will discuss to what degree the thesis has succeeded in its original intention.

The last three chapters presented the results of the analysis from my methodology, ‘the quadrilogue’, developing three themes from the data that spoke to the main research questions: double binds, mis/recognition and despair. I will first revisit the main research questions and the key themes emerging from the literature. I will then summarise the main findings in relation to the three key themes of double binds, mis/recognition and despair, before moving on to an analysis of the implications of the results in terms of the theoretical, methodological and practical issues arising from the thesis. Finally, I will discuss the main limitations of the thesis and directions for future research.

9.1 Research Questions and Literature Themes Revisited

The thesis was guided by an overarching question: what is an authentic representation of madness and what can this representation tell us about the social context in which madness presents? By trying to address this question, I identified a paradox at the heart of narrative accounts of madness: they were predicated on an argument that first-person narratives provide an essential form of knowledge of human subjectivity, over and against positivist forms of research; however, it was difficult to substantiate these claims without recourse to an essentialist, and thus theoretically inconsistent, version of authenticity. I called this particular tendency in autoethnographical research ‘the argument from authenticity’. The paradox of this argument, in my opinion, led to unsatisfactory attempts to portray human subjectivity in autoethnographic research, particularly with madness.

In contrast, I argued for a ‘tactical authenticity’, based on De Certeau’s (1984) distinction between ‘strategy’ and ‘tactics’. According to this conceptualisation, authenticity is used in a tactical, non-essentialising way to provide a critique of established ‘strategy’ in the form of psychiatric and psychological discourses. In my review of autoethnographies, I identified several methodological issues in poststructuralist and postmodern uses of autoethnography that my method of autoethnography aimed to overcome. These issues included an arbitrary division between ‘evocative’ and ‘realist’ accounts that enforced an unnecessary binary on autoethnographic research; a ‘failure of nerve’ (Atkinson, 2013) in textual representation; and the potential for voyeurism over-and-against political engagement (Costa et al., 2012). All of this meant there was a paucity of studies that have attempted to represent madness in a way consistent with the experience that can provide a critique of the discourses and practices of psychiatry, whilst remaining consistent with its theoretical and methodological principles.

In order to address some of these issues, I developed an innovative autoethnographical method called ‘the quadrilogue’. This method was then applied to my experience of a psychotic breakdown and psychiatric detention in the period from September 1993 to January 1994. This narrative account included the employment of different ‘voices’ in order to provide contrast and counterpoint in terms of how madness is constructed differently according to patient, carer and clinical accounts. The narrative thus employed three main sources: my reconstructed account, my mother’s diary and my NHS clinical notes. A fourth voice was generated through the process of building this narrative, a reflective account, which offered a commentary on the other three perspectives. This fourth voice also provided a bridge from the data in the narrative to the formal process of analysing its contents using a critical form of Thematic Analysis.

Taken together therefore, this thesis showed that a tactically authentic account of madness is able to generate new knowledge in terms of first-person experiences of severe distress and its social context. In particular, this thesis provided new knowledge on the experience of going mad and being detained in an inpatient unit. These were revealed in the three main themes developed from the data: double binds, mis/recognition and despair. These themes utilised existing theory to refine, develop and construct theory to critique biomedical psychiatry and some practices in mental health. The next section discusses these findings in relation to the main thesis questions in more detail.

9.2 Summary of Findings

I showed that the experience of madness could be illustrated in reference to three main themes. The first, ‘double binds’, employed Bateson’s (1972) original theory to demonstrate how communication in the mental health system was characterised by contradictory and conflicting messages that produced no-win situations for patients, carers and staff. The second theme of ‘mis/recognition’ used Lyotard’s (1978) concept of the ‘differend’ to argue that psychiatric discourse actively prevents service users and carers from adequately framing their complaints by absorbing their discourse, according to the rules of the dominant ‘language game’. Finally, the third theme of ‘despair’ argued that a core, constitutive feature of my experience in the narrative could be conceived as a form of hopelessness that was linked to beliefs about death, but which were also, nevertheless, largely dismissed by the discourse of biomedical psychiatry. I also argued that the few attempts to conceptualise ‘psychotic despair’ with more depth than biomedical accounts, in particular Bion (1957) and Laing (1960), failed to avoid the essentialising and apolitical tendencies that afflicted theories of authenticity. I argued instead for a ‘tactically authentic’ account that retained the truth of the despair in the narrative, but which also exposed the repressive tendencies of the mental health system.

9.2.1 Double binds

One of the first themes identified from the analysis was that the communication within the narrative could be characterised in terms of

Bateson's (1972) double bind theory. According to Bateson (1972), double binds occur when there are contradictory injunctions made at different levels of communication. Although the theory had been developed as an explanation for how people diagnosed with schizophrenia may develop symptoms in the context of disturbing family communication (Bateson et al., 1952), it has more recently been applied to organisational communication (Visser, 2010). Most notably, this strand of research argues that certain organisational contexts, particularly in health, place contradictory demands upon their employers and the demands can be characterised according to double bind theory (Visser & van der Heijden, 2015).

However, three main issues with this strand of research were identified. The first was that they are not consistent in how they apply Bateson's (1972) original theory, with all kinds of contradictory communication being labelled as 'double binds', rather than the six-component theory advocated by Bateson (Visser & van der Heijden, 2015); secondly, they locate communication between individuals and not, as Bateson (1972) intended, as a theory of wider ecological communicative disturbances (Bateson, 2005); and, lastly, the research does not look at double binds from multiple perspectives concurrently (focussing particularly on staff, independently from patients or carers). Somewhat surprisingly, given its origin in schizophrenia research, there were also a lack of studies looking at double binds in mental health services (Visser & van der Heijden, 2015).

As my thesis showed, communication within the mental health system were frequently double binding, and this extended to most areas of practice including admission, gaining consent for treatment and discharge planning. However, I also showed that, consistent with Bateson’s (1972) original theory, the double bind had already been internalised by me and my ‘voices’ were communicating with me in double binding ways. The communication between me and my mother, prior to contact with mental health services, could also be characterised as double binding. Finally, I also showed that the double binding communication styles of the mental health team merely compounded, and made worse, the communicative confusion.

As Bateson (1972) observed in his later research, double binds are the result of interactions between macro and micro levels of a social system. In other words, double binds can be passed down the organisation from ‘higher up’ the management ladder. Considering this, I discussed whether some of the more perplexing aspects of the narrative, in particular what seemed to be an over-responsive focus on risk and too-quick use of ECT, was the result of double binding standards from Government policy in light of deinstitutionalisation. Namely, this double bind towards staff was conceptualised as the requirement from the Government to manage risk at all costs, in the context of shrinking resources and the requirement on staff to move patients quickly through the system. The final consideration in this theme was therefore whether staff too were as much subject to double binds as patients and carers. Indeed, the question was posed if the psychiatric service as a whole could be conceived of as a complete double binding system.

9.2.2 Mis/recognition

If the psychiatric system could be conceived of as double binding, then the next theme of mis/recognition considered the extent to which this double bind occurred. Using Lyotard’s (1978) concepts of language games and the differend, I showed that the very discourse of the psychiatric system was, in effect, double binding, but in a more comprehensive way than Bateson (1972) conceived, leading to what I called ‘mis/recognition’: where the other is effectively silenced by a violence inherent in the act of recognition.

In terms of the narrative, I showed that key aspects of psychiatric practice, including assessment, the ward round, admission, consent to treatment and discharge, were couched in medico-legal terminology that contained certain presumptions and rules that ensured that the psychiatric service remained dominant. In other words, mis/recognition occurred because there was no way for me substantiate my concerns without further sanctions being placed on me. For example, I was unable to talk about my experience of ‘despair’ without the term being absorbed into psychiatric discourse and transformed into something other (e.g. a diagnostic category framed numerically).

The final result of this mis/recognition was that I had to ‘play at being sane’ in order to get discharged. This ensured a final double bind according to the psychiatric differend, whereby I had to disavow my ‘mad’ experiences publicly to the mental health team, whilst at the same time holding onto these beliefs in private. Unfortunately, this also meant my original reason for my presenting to psychiatric services, my ‘despair’, went unaddressed. I was thus unable to frame this existential complaint in language and could only express my symptoms in the terms of psychiatry, i.e. as an ‘illness’.

9.2.3 Despair

The final theme that emerged from the analysis was despair, and this related to my main stated reasons for presenting to psychiatric services. I identified that ‘despair’ as a clinical and theoretical construct in mental health research has largely been side-lined in favour of a focus on depression and anxiety, although a form of despair is represented in both existentialist and psychoanalytic literature. In discussing my own experience of despair and the experience of Bouricius (1989), a mother of a son diagnosed with schizophrenia, I formulated despair as an example of the radical singularity of madness, characterised by a form of extreme psychological and social isolation and the complete absence of hope.

When considering despair in these terms, it is possible to consider how different theorists have attempted to account of this experience in madness. I looked at two in particular: Bion’s (1957) psychoanalytic theory of ‘nameless dread’, along with Menzies-Lyth’s (1959) and Hinshelwood’s (1999) ‘social defence’ theory; and Laing’s (1960) existential theory of ‘ontological insecurity’. Whilst both psychoanalytic and existential treatments appeared to chime with my experience of despair, they were also found lacking in capturing the social effects of madness, particularly in a political context dominated by biomedical psychiatry.

In conclusion, I argued that a theoretical account based on De Certeau's (1984) distinction between 'strategy' and 'tactics' may provide a more robust treatment of despair, with the subjective experience of despair anchored firmly within its socio-political context. Here, despair provides a 'tactic' to disrupt the 'strategy' of biomedical psychiatry, along with an opportunity to address the existential complaint that had previously found no tribunal for its representation. Such tactics constitute the main form of the quadrilogue in providing an 'authentic' representation of both madness and the social context in which it occurs, the key research questions.

9.3 Implications

This thesis has a number of implications for research and theory in critical mental health, as well as implications for methodologies such as autoethnography. There are also implications for mental health practice, including with alternatives to mainstream mental health services and for mental health policy. The key purpose in drawing together the findings is to explore the unique and challenging aspects of the data and how it relates to the theories discussed in the analysis.

9.3.1 Research and theory

As I have argued in this thesis, and which I believe represents a novel contribution to knowledge, the specific political and social circumstances of the 1990s, whereby injunctions to manage risk at all costs was concurrent with conflicting injunctions to encourage faster throughput in a system that had already seen significant cuts, may have accounted for some of the clinical decision-making seen in the narrative. These potential relationships require more extensive analysis. For example, how does this period compare with that immediately prior to deinstitutionalisation from the perspectives of staff, carers and service user experiences? Although there have been extensive and nuanced work on staff and patient experiences in the old asylum era from an oral history perspective (Calabria, 2016), to the best of my knowledge there has not been extensive work on this time period from people’s experiences of this time in their own words, i.e. through autoethnography.

Similarly, many of the features of the narrative, such as coerced admission under the pretence of voluntary status, extended detainment without clear pretexts, ‘faking normality’ to get discharged etc. seem very much of their time. In today’s mental health climate, where rapid cutbacks to health and social care have led to drastically reduced mental health service provision, psychiatric neglect may be more of an issue (Spandler, 2016), with service users needing to exaggerate psychiatric symptoms in order to be able to access any care at all. How do these experiences compare with earlier eras? What are the key similarities and differences? Again, further research is needed to begin exploring these links between subjective experience of practice and policy and service implementation, in which a modified autoethnography approach as outlined in this thesis, could provide some helpful input.

However, other aspects of the narrative remain pertinent to today's mental health situation. For example, the continued use of forced restraint, often due to underfunding (Duxbury et al., 2019); the lack of alternatives outside of medication and ECT (Kinderman, 2014), with the latter particularly on the rise (Davis and Duncan, 2017); rises in involuntary detentions under the MHA, again potentially due to chronic underfunding of services (Smith et al., 2010); the presence and threat of sexual abuse (Sweeney et al., 2019); the lack of information given to patients about their rights, particularly with admission (Rushmore and Carver, 2017). What this thesis provided was a lens into the subjectivity of a particular (white, lower middle-class) mad person and the psychiatric system at a particular point in history. What is needed is further autoethnographies that can provide a similar lens into the experience of madness and its social context at different points in the development of mental health care and from different perspectives. This would also necessitate the analysis of different issues and tensions within the system and, ideally, from the perspectives of service users, staff and carers. Ideally, these perspectives should be integrated together to provide important points of comparison and discussion.

Another significant finding in the thesis was that the presence of double binds in the psychiatric system went well beyond the specific ecological interactional or policy context, constituted, as it was, in the very discourse of psychiatry itself. I characterised this particular aspect of the psychiatric discourse as mis/recognition by drawing upon Lyotard's (1978) concept of the differend and identified that the psychiatric differend extended to all aspects of psychiatric discourse, including consent and 'choice', as well as specific areas of psychiatric practice including assessment, diagnosis, the ward round, ECT and discharge. This finding offered a novel contribution to knowledge and highlighted the challenges of future research in this area.

However, these findings could be extended. For example, it is still an open question as to how the differend occurs within each area of practice. For example, how differential and (dis)proportionate effects of the differend relate to issues to do with class, ethnicity or gender. Future studies therefore may need to explore how the differend in psychiatry is experienced according to personal identity constellations and across practice areas. Whilst a tactically authentic approach was developed in response to, and as a way of avoiding, some of the pitfalls inherent in identity politics (Clarke and Wright, 2019), there are still structural inequalities in the mental health system that need to be explored in terms of their differential impact upon service user and survivor subjectivities (Wilson, 2016).

With regards to a biomedically-dominated mental health system, a focus on differential levels of the system, be they discursive, micro or policy-orientated, necessitates an interdisciplinary research paradigm that can analyse the interrelation of different subjectivities between people who occupy different positions within the system. Hacking (2004), for example, identifies the mutual influence between micro interactions observed via ethnographical observations, and the macro processes that can be traced via historical-discursive analysis. Such ‘looping effects’ within a particular social system can be observed in many possible ways: through such operations as receiving a diagnosis of schizophrenia, or the decision to establish power of attorney in clinical decision-making. Whilst this thesis has produced a preliminary analysis of such effects, thus producing new knowledge on the impact of wider psychiatric processes and interventions upon subjectivity, future studies could go further to analyse in more detail how specific psychiatric interventions and practices affect, and are in turn affected by, service user, staff and carer subjectivities.

Along with critiques of the psychiatric system, the other possibility is the use of autoethnography in the service of developing an analysis of forms of organisation around what is called ‘madness’ or ‘mental health’ on a different conceptual basis to biomedical, or even ‘social’, psychiatry. Indeed, there has been a resurgence of interest in ‘recovery narratives’ (Llewellyn-Beardsley et al., 2019) although some authors (e.g. Send and Sexton, 2016; Woods et al., 2019) have cautioned against a too-ready acceptance of ‘recovery’ concept and practice with its more recent co-option into the mental health mainstream. Alternatively, developing a database of autoethnographies with treatment approaches that are framed with a different value system to biomedical psychiatry, such as Open Dialogue (Olson, 2015) or therapeutic communities (Clarke et al., 2016) offer the possibility of a ‘recovery’ technology from alternative services, grounded in the experiences of those that have used them.

The final novel contribution to knowledge made by this thesis was in the recognition of the role of despair in madness. As Russo (2016c) has identified, it is important that theoretical frameworks of ‘madness’ are grounded in the experience of survivors and services users. Despair as an affect state tends to be under-represented in the research literature more generally and, despite many references to despair in first-person accounts of madness, there has yet to be a fully developed theoretical account of despair by people who have been, or are, mad. This thesis provided a detailed analysis of despair as it was represented in the narrative and provided the beginnings of a theoretical development of despair grounded in my experience of madness. However, there needs to be further research on the role and function of despair in madness more generally. How common, for example, is this experience for those people going mad? What are the similarities and differences of this experience between accounts? Is despair the appropriate word, or does it link with other experiences and affect-states? If so, how? Finally, to what degree to mental health services listen to the way people frame their experiences, especially when it is outside their frameworks? How does one ‘recover’ from despair?

An important finding in relation to despair, and which offered a unique contribution to knowledge, was that the experience of despair is moderated and exacerbated by the social environment, as well as the socio-political context (if we consider the space of biomedical psychiatry a politicised arena). Recovery narratives are an important resource for investigating the experiential and social determinants of distress, but are arguably skewed towards overly positive stories (Woods et al., 2019). How then can narratives and autoethnographies provide an analysis of how an experience such as despair is constitutive of its social field? Which environments are more despair-inducing and why, and which environments offer the possibility of its overcoming?

Finally, thesis also recognised that carers, and perhaps staff as well, experience despair in the face of experiences that they cannot understand or help with, a point that has been recognised by some, including Hinshelwood (1999, 2004) and Winship (1995). One of the significant aspects of this thesis was that it utilised service user, carer and staff experiences together, and this gave a unique, and sometimes unexpected, perspective on different aspects of mental health practice. What is needed in future research projects is an analysis of how experiences of different people within the system converge with that of service users and survivors, and to what degree despair is a common factor.

9.3.2 Practice, policy and education

As has been suggested throughout this thesis, there were sustained and widespread problems with psychiatric practices. There are thus potentially several practical and policy implications suggested by the results of this thesis. In this section, I will discuss the implications of the thesis for mental health education, policy and practice.

Firstly, the potential of the quadrilogue as an educative tool in the subjectivity of madness and using mental health services has already been piloted. I have used the style of the quadrilogue (i.e. different people reading out the different ‘voices’) in presentations and in teaching sessions, to good effect. What the quadrilogue perhaps offers is a democratic experience of mental health service use. The reader is encouraged to find their own way through the document, and audiences are invited to comment upon what they experience, rather than being asked to take sides. In this respect, the quadrilogue is similar to Boal's (1979) Forum Theatre, in which the spectators become active participants in the performance (in this case, the performance of the representation of the data). Indeed, Forum Theatre has already been used to educate mental health professionals in a university setting (Wilson, 2013). Such a democratic approach avoids some of the pitfalls of service user involvement in mental health professional training, including exploitation and co-option (Beresford, 2000; Landry and Church, 2016).

The first is that systemic frameworks need to be applied to double binding communication in all its forms within the psychiatric system. It should be noted here that this does not entail the elimination of double binds. As Bateson (1972) himself, and those who have developed his work subsequently, have argued, double binds are an inescapable feature of communication. Indeed, they offer opportunities for what Bateson called 'deutro', or higher, learning (Visser, 2003). For example, in his research with dolphins, Bateson (1972) recognised that structuring double binds into the learning environment enabled the dolphins to find creative and novel solutions to the problems posed by the double bind. Indeed, what characterised the situation of those diagnosed with schizophrenia according to Bateson (1972), was the lack of resources and support available in helping them work through some of the familial problems that had established the binds in the first place (Bateson, 1978).

However, the results of this thesis suggest that double binds are not merely the result of familial communication disorders, but a systemic problem arising as much from the mental health system than the family. Therefore, a whole service approach is required to enable staff, service users and family members to be able to work through more unhealthy binds and find alternative, more constructive, ways of working through them. One such approach is Open Dialogue (OD). Originating in Finland, OD is an approach whereby people are met within 24 hours of a crisis and contact is maintained daily until the crisis is resolved (Seikkula, 2011). All those who are part of the service user's network (including family and mental health service), and wish to contribute, are invited to these meetings, and over time a shared meaning is developed that establishes a context for the experiences (Olson, 2015). Mental health experiences are conceptualised as something for which there has been no language (and are usually, but not always considered traumatic or stressful) and hospitalisation is avoided (Seikkula, Alakare and Aaltonen). The team meets in the service user's house and the use of medication is discouraged (Seikkula, 2011).

In the context of my narrative, it is possible to see how such an approach may have avoided the traumatic experiences of the ward round and the admission, for both me and my family. It is also possible to envisage how a team set up in this way might have helped me put into words, and conceptualise, the double binding experiences of my voices which, in turn, may have helped me see the ways in which I was interpreting events around me, including in my relationships with family and staff. An OD approach may have also helped my family contextualise my experiences and helped them develop alternative ways of communicating that would not reinforce stultifying double binding processes. Without the imminent threat of forced admission, and with a supportive and skilled team providing a scaffold of support, it is very possible that I could have begun the process of de-escalating my panic and working through the double binds I was clearly entrapped in. Indeed, autoethnographies of people's experience have highlighted these particular benefits (Olson, 2015)

OD is now used in services across Finland instead of medicalised approaches, with significant reductions in major outcomes including hospitalisation, self-harm and the use of medication and other coercive measures (Seikkula, Alakare and Aaltonen, 2011). There are also positive signs of OD being implemented across western health services, including those in the UK (Seikkula, 2011). However, caution needs to be exercised in the enthusiastic embracing of OD as a service model in the UK. One key finding from the thesis was that double binds in the psychiatric system were not merely communicative disturbances that could be corrected through more democratic practices, but were constituted in the discursive structure of the system itself. Such systems, by their very structure, are often unable to accommodate other conceptual frameworks, or perspectives (Held, 2005). In such a system, the encouragement to speak, a key aspect of OD, may actually lead to worse outcomes for service users in the system, if what service users say is judged to be constitutive of pathologising diagnostic labels, or used as a justification for the use of coercive practices such as forced admission or ECT. As Seikkula (2011) has observed, much depends upon the service's willingness to incorporate all the main values of OD, and not just the parts that are less disruptive, or more conducive, to its core ideology or practice.

Adopting OD whilst maintaining the power structures of existing service structures may therefore actually lead to more subtle forms of coercion. The fate of recovery in the UK may provide a useful analogous example of this: arguably, ‘recovery’ approaches have since supported neo-liberal policies and practices, including individualism (Winship, 2016) and austerity (Recovery in the Bin, 2019). Thus, what began as grassroots, service-user led movement has since become, to many, the antithesis of its original intention when adopted by a medical-led health service (Send and Sexton, 2016). Therapeutic communities in the UK, whilst offering the potential for radical alternative critique in the 1960s, never quite resolved its relationship with the medical model and psychoanalysis, eventually positioning itself as a treatment for the medical condition of ‘personality disorder’ (Spandler, 2006). In addition, the original asylum model developed by Tuke and others in the Quaker movement, quickly became the model for the old asylums under the supervision of medical superintendents becoming, at their worst, warehouses for the insane (Jones, 1993).

Based on the arguments from this thesis, it is therefore imperative to construct services on the basis of alternative discursive frameworks and resist medicalised conceptualisations to avoid the problem of the psychiatric differend. Both Laing’s Kinsley Hall and Loren Mosher’s Soteria House were firmly rooted in existential phenomenology (Soteria Network, 2011), whilst La Borde in France was conceptualised according to Guattari’s own unique take on therapeutic process, avoiding some of the traps of both the medical model and psychoanalysis (Goffey, 2016). More recently, Trauma Informed Services (TIS) have emerged as a framework for developing services around a psycho-social model, conceptualising psychological distress as an understandable response to adversity and not as an illness (Sweeney et al., 2016). User-led service models exist and offer structures that are grounded first and foremost in the experiences of service users and survivors (Beresford, 2016).

The above approaches differ according to their relationship to established services. Whilst therapeutic communities based on Laing’s and Guattri’s approaches were firmly placed outside of established psychiatry, TIS are para-service approaches that seek to inform the development of existing services along more humane and psycho-social lines (Sweeney et al., 2016). Whether this can overcome problems with the psychiatric differend as identified in this thesis remains to be seen. As long as service structures are grounded in the experiences of those that use them (Beresford, 2016), and are sensitive to true democratic principles (Spandler and McKeown, 2017), then there is hope.

TIS, therapeutic communities and user-led approaches offer alternatives beyond a limited biomedically-driven mental health service. Such approaches need not alienate mental health staff working at the coalface; in fact, nurses and mental health staff can be active agents in supporting a more democratic mental health system (McKeown & Carey, 2015; Cresswell and Spandler, 2016). It is likely that my mother’s experience of the admission process as represented in this thesis is not untypical (Stuart et al., 2020), yet very few initiatives seek to involve all parties in a democratic way. If this lack of involvement is in part because the psychiatric system's embedded power structures, then perhaps alternative systems may offer more success. As Spandler and McKeown (2017) have argued, a process of 'truth and reconciliation' in psychiatry may be the first necessary step to building a truly democratic mental health system.

9.4 Study Limitations and Final Conclusions

Tactical authenticity in autoethnographic accounts of madness can provide a useful way of identifying the limitations in the strategy of the dominant discourse of psychiatric medicine. Nevertheless, the thesis was limited in several ways. The first was in the exclusive use of first-person perspectives. Although using my clinical notes and my mother's diary overcame some of the issues with autoethnography identified in Chapter 3 such as methodological solipsism, the thesis still used only first-person sources. Although using other sources such as interviews (e.g. family members) and archive material (e.g. oral history accounts from staff and patients in the 1990s) would have generated too much data for this thesis, and there were also ethical issues around interviewing family members, it is a pertinent reminder to recognise the limitations of only using autoethnography exclusively in health research (Chang, 2016).

Another potential issue is that the thesis is relentlessly negative, focussing on a particularly difficult and traumatic time where there was very little apparent hope, even at the end. As I mentioned in Chapter 1, I decided not to look at the ‘recovery’ aspects of my narrative from my time spent in a therapeutic community with regret, because this focus would have been outside the remit of this current project. However, this aspect of my narrative may offer insight into a range of ‘recovery technologies’ (Woods et al., 2019) outside of limited biomedical or mental health service narratives. Combined with other sources of data such as interviews (e.g. of other therapeutic community members) and archive data of other therapeutic communities (e.g. Soteria House or Kingsley Hall) for comparison, this could provide a valuable outline of how community approaches to what is called ‘psychosis’ may offer substantial benefits outside of the biomedical psychiatric system.

However, despite these limitations the thesis was able, I believe, to resolve some of the key identified issues in mental health autoethnographies, whilst providing an answer to what an authentic representation of madness can look like. I also think the thesis was able to provide valuable insight into how a particular social context, in this case a psychiatric service in the 1990s, responded and made sense of madness. The thesis was thus able to provide novel contributions to knowledge in the form of autoethnographic methodology, critical theory and critical mental health.

REFERENCES

Adorno, T. W. (1973), *Negative Dialectics*. Translated by E. B. Ashton. London: Routledge.

Adorno, T. W. (2003) *The Jargon of Authenticity*. Evanston: Northwestern University Press.

Allen-Collinson, J. (2011) Intention and epochē in tension: autophenomenography, bracketing and a novel approach to researching sporting embodiment*. Qualitative Research in Sport, Exercise & Health* 3(1): pp.48-62.

Amering, M., Mikus, M. and Steffen, S. (2012) Recovery in Austria: Mental health trialogue. *International Review of Psychiatry* 24(1): pp.11-18. DOI: 10.3109/09540261.2012.655713

Anderson, L. (2006) Analytic autoethnography. *Journal of Contemporary Ethnography, 35*(4): pp.373-395.

Anderson, L. and Glass-Coffin, B. (2013) I learn by going: Autoethnographic modes of enquiry. In: Jones, S.H., Adams, T.E. and Ellis C. (Eds.) *Handbook of Autoethnography*, pp. 57–83. Walnut Creek, CA: Left Coast Press.

Aronson, Jeffrey K. (2000) Autopathography: the patient's tale. *BMJ* 321: pp.1599

Ashmore, R. and Carver, N. (2017) Informal mental health patients: what are they told of their legal rights?. *Mental Health Review Journal* 22(1): pp. 51-62. https://doi.org/10.1108/MHRJ-09-2016-0019

Atkinson, P.A. (2009) Illness narratives revisited: the failure of narrative reductionism. *Sociological Research Online* 14(5). Available at: http://www.socresonline.org.uk/14/5/16.html. [Accessed 4 September 2016].

Atkinson, P.A. (2013) Ethnographic writing, the avant-garde and a failure of nerve. *International Review of Qualitative Research* 6(1): pp.19-35.

Baker C., Crawford P., Brown, B.J., Lipsedge, M. and Carter R. (2010) *Madness in Post-1945 British and American Fiction*. London: Palgrave.

Baldwin, C. (2005) Narrative, ethics and people with severe mental illness. *Australian and New Zealand Journal of Psychiatry, 39*: pp.1022–1029.

Barnes, M. and Berke, J.H. (1990). *Two Accounts of a Journey Through Madness.* London: Free Association Books.

Bateson, G., Jackson, D.D., Haley, J., and Weakland, J. (1956). Toward a theory of schizophrenia. *Behaviour Research 1*: pp.251-264. doi:10.1002/bs.3830010402

Bateson, G. (1972) *Steps to an Ecology of Mind*. San Francisco, CA: Chandler

Bateson, G., (1978). The Birth of a Matrix, or, Double Bind and Epistemology. In: Berger M. (Ed.) *Beyond the Double Bind: Communication and Family Systems, Theories, and Techniques with Schizophrenia*. New York: Brunner/Mazel.

Bateson, M.C. (2005) The double bind: pathology and creativity. Cybernetics and Human Knowing 12(1): pp. 11-21.

Ben-David, S., Birnbaum, M.L., Eilenberg, M.E., DeVylder, J.E., Gill, K.E., Schienle, J., et al. (2014) The subjective experience of youths at clinically high risk of psychosis: a qualitative study. *Psychiatric Services* 65(12): pp.1499–1501.

Bennington, G. and Derrida, J. (1993) *Jacques Derrida*. Translated G. Bennington. Chicago: University of Chicago Press.

Bentall, R. (2003) *Madness Explained: Psychosis and Human Nature*. London: Penguin.

Beresford, P. (2000) Service users' knowledge and social work theory: conflict or collaboration? *British Journal of Social Work* 30(4): pp. 489-503.

Beresford, P. (2007) The role of service user research in generating knowledge-based health and social care: From conflict to contribution. *Evidence & Policy* 3(3): pp. 329 - 341.

Beresford, P. (2016) The role of survivor alternatives in creating alternatives to psychiatry. In: Russo, J. and Sweeney, A. (Eds.) *Searching for a*

Rose Garden: Challenging Psychiatry, Fostering Mad Studies, pp.25-34. Monmouth: PCCS Books.

Biddulph, M. (2006) Sexualities equality in schools: why every lesbian, gay, bisexual or transgender (LGBT) child matters. *Pastoral Care in Education* 24(2): pp.15-21. DOI: 10.1111/j.1468-0122.2006.00367.x

Biddulph, M. (2008). Stolen intimacies: (auto)narratives of *MSM, HIV, spaces and sexualities* men who have sex with men. *Auto/biography Yearbook* 2008: 171-193.

Biddulph, M. (2010) Can only Dorothy's friends speak for Dorothy? Exploring issues of biographical positioning in qualitative research with gay/bisexual men. In Huber, T. (Ed.) *Storied inquiries in international landscapes: an anthology of educational research.* Charlotte, NC: Information Age Publishing.

Bion, W.R. (1957) Differentiation of the psychotic from the non-psychotic personalities. *International Journal Psycho-Analysis* 38: pp.266-275.

Bion, W.R. (1962) The psycho-analytic study of thinking. *International Journal Psycho-Analysis* 43: pp.306-310.

Bion, W.R. (1997) *War Memoirs (1917-1919)*. London: Karnac.

Birchwood, M., Iqbal, Z., Chadwick, P., and Trower, P. (2000) A cognitive approach to depression and suicidal thinking in psychosis. I: the ontogeny of post-psychotic depression. *British Journal of Psychiatry* 177: pp.516–521.

Boal, A. (1979) *Theatre of the Oppressed*. London: Pluto Press.

Bochner, A. (2001) Narratives virtues. *Qualitative Inquiry* 7(2): pp.131-157

Bouricius, J.M.S. (1989) Negative symptoms and emotions in schizophrenia. *Schizophrenia Bulletin* 15(2): pp.201-208 https://doi.org/10.1093/schbul/15.2.201

Burstow, B. (2015) 'A Rose By Any Other Name'. In: LeFrançois, B.A., Menzies, R. and Reaume, G. (Eds.) *Mad Matters,* pp. 79-90. Toronto: Canadian Scholars' Press.

Braun, V., and V. Clarke. (2006) Using Thematic Analysis in psychology. *Qualitative Research in Psychology* 3(2): pp.77–101. doi:10.1191/1478088706qp063oa.

Braun, V. & Clarke, V. (2019) Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health* 11(4): pp.589-597. DOI: 10.1080/2159676X.2019.1628806

Bruner, J.S. (1990) *Acts of Meaning*. Cambridge: Harvard University Press.

Calabria, V. (2016) Insider stories from the asylum: peer and staff-patient relationships. In: Davidson, J. and Saber, Y. (Eds.) *Narrating Illness: Prospects and Constraints.* Oxford: Inter-Disciplinary Press.

Campbell, E. (2016) Exploring autoethnography as a method and methodology in legal education research. *Asian Journal of Legal Education* 3(1): pp.95–105. doi: 10.1177/2322005815607141.

Cappleman, R., Bamford, Z., Dixon, C., and Thomas, H. (2015) Experiences of ward rounds among in-patients on an acute mental health ward: a qualitative exploration. *BJPsych Bulletin 39*: pp.233-6.

Capps, D. (2016) The mortification of the self: Erving Goffman’s analysis of the mental hospital. *Pastoral Psychology* 65: pp. 103–126. https://doi.org/10.1007/s11089-015-0665-1

Cederström, C. and Spicer, A. (2009) *The Wellness Syndrome*. London: Polity.

Chang, H. (2008) *Autoethnography as method*. Walnut Creek, CA: Left Coast Press.

Chang, H. (2016) Autoethnography in Health Research: Growing Pains? *Qualitative Health Research*, *26*(4): pp.443–451. https://doi.org/10.1177/1049732315627432

Church, K. (1995) *Forbidden Narratives: Critical Autobiography as Social Science*. Newark, NJ: Gordonand Breach.

Clarke, J.M. and Waring, J. (2018) The transformative role of interaction rituals within therapeutic communities. *Sociology of Health and Illness* 40(8): pp.1277-1293. doi:10.1111/1467-9566.12773

Clarke, S.P., Clarke, J.M., Brown, R., and Middleton, H. (2016) Hurting and healing in therapeutic environments: how can we understand the role of the relational context? *European Journal of Psychotherapy & Counselling* 18(4): pp.384-400. doi: 10.1080/13642537.2016.1260620.

Clarke, S.P., and Wright, C. (2019) Tactical authenticity and autoethnographic mad narratives. *Social Theory & Health*, https://doi.org/10.1057/s41285-019-00092-2

Clarke, V. and Braun, V. (2013) *Successful Qualitative Research: A Practical Guide for Beginners*. London: Sage.

Clarke, V. and Braun, V. (2018) Using thematic analysis in counselling and psychotherapy research: A critical reflection. *Counselling and Psychotherapy Research Journal* 18(2): pp.107-110. doi:10.1002/capr.12165

Clarke, V., Braun, V. and N. Hayfield. (2015) Thematic Analysis. In: Smith, J. (Ed.) *Qualitative Psychology: A Practical Guide to Research Methods*, pp. 222–248. London: Sage

Congress of Qualitative Inquiry. (2007) Position statement on qualitative research on IRBs [online]. Available at: http://www.c4qi.org/PositionStatement.pdf [Accessed 1 September 2018]

Costa, L., Voronka, J., Landry, D., Reid, J., Mcfarlane, B., Reville, D. and Church, K. (2012) “Recovering our stories”: a small act of resistance. *Studies in Social Justice* 6(1): pp. 85-101.

Cresswell, M. and Spandler, H. (2016) Solidarities and Tensions in Mental Health Politics: Mad Studies and Psychopolitics. *Critical and Radical Social Work* 4(3): pp. 357-373

Cullin, J. (2006) Double bind: much more than just a step ‘Toward a Theory of Schizophrenia’. *Australian and New Zealand Journal of Family Therapy* 27(3): pp.135-142. doi:10.1002/j.1467-8438.2006.tb00711.x

Danius, S., Jonsson, S. and Spivak, G.C. (1993) An interview with Gayatri Chakravorty Spivak. *Boundary 2*, 20(2): pp. 24-50.

Davies, W. (2015) *The Happiness Industry: How the Government and Big Business Sold Us Well-Being*. London: Verso.

Davis, N. and Duncan, P. (2017) Electroconvulsive therapy on the rise again in England. The Guardian. 17 April [online]. Available at: https://www.theguardian.com/society/2017/apr/17/electroconvulsive-therapy-on-rise-england-ect-nhs [Accessed 5 May 2017].

Davis, W.E., Hicks, J. A., Schlegel, R. J., Smith, C. M., and Vess, M. (2015) Authenticity and self-esteem across temporal horizons. *The Journal of Positive Psychology* 10(2): pp.116-126

De Certeau, M. (1984) *The Practice of Everyday Life*. Translated by S. Rendall. Los Angeles: University of California Press.

Deleuze, G. (1992) Postscript on the societies of control. *October* 59: pp.3-7.

Denshire, S. (2014) On auto-ethnography. *Current Sociology* 62: pp.831-850.

Denzin, N. K., & Lincoln, Y. S. (2000) Introduction: The discipline and practice of qualitative research. In: Denzin, N.K. and Lincoln, Y.S.

(Eds.) *The SAGE Handbook of Qualitative Research* (2nd Ed.), pp. 1-28. Thousand Oaks, CA: Sage.

Derrida, J. (1972) 'The Ends of Man', *Margins of Philosophy*. Tranlated by A. Bass, 1982. The University of Chicago Press: Chicago.

Derrida, J. (1976) *Of Grammatology*. Translated by G. Spivak. Baltimore, MD: Johns Hopkins University Press.

Dickson, A. and Holland, K. (2017) Hysterical inquiry and autoethnography: a Lacanian alternative to institutionalized ethical commandments', *Current Sociology* 65(1): pp. 133–148. doi: 10.1177/0011392115623603.

Duxbury, J., Thomson, G., Scholes, A., Jones, F., Baker, J., Downe, S., Greenwood, P., Price, O., Whittington, R. and McKeown, M. (2019) Staff experiences and understandings of the REsTRAIN Yourself initiative to minimize the use of physical restraint on mental health wards. *International Journal of Mental Health Nursing* 28(4): pp.845-856. doi:10.1111/inm.12577

Eliot, T.S. (2004) *The Complete Poems and Plays*. London: Faber & Faber

Ellis, C. (1996) Maternal connections. In: Ellis, C. and Bochner, A. (Eds.) *Composing Ethnography: Alternative Forms of Qualitative Writing*, pp. 240-243. Walnut Creek, CA: AltaMira Press.

Ellis, C. (2004) *The Ethnographic I: A Methodological Novel about Autoethnography*. Walnut Creek, CA: AltaMira Press.

Ellis, C., Adams, T.E., and Bochner, A.P. (2011) Autoethnography: an overview. *Forum: Qualitative Social Research,* [online] *12*(1): Art. 10. Available at: http://www.qualitativeresearch.net/index.php/fqs/article/view/1589/309. [Accessed: 7 March 2014].

Ellis, C., & Bochner, A.P. (2000) Autoethnography, personal narrative, reflexivity: researcher as subject. In: Denzin, N.K. and Lincoln, Y.S. (Eds.) *In Handbook of Qualitative Research (2nd Ed.),* pp. 733-768. Thousand Oaks, CA: Sage

Ellis, C., & Bochner, A.P. (2006) Analyzing analytic autoethnography: an autopsy. *Journal of Contemporary Ethnography* 35(4): pp.429-449.

Empson, W. (2001). *The Complete Poems*. London: Penguin

Engeström, Y. and Sannino, A. (2011) Discursive manifestations of contradictions in organizational change efforts: a methodological framework. *Journal of Organizational Change Management* 24(3): pp. 368-387. https://doi.org/10.1108/09534811111132758

Etherington, K. (2004) *Becoming a Reflexive Researcher: Using Ourselves Within Research.* London: Jessica Kingsley Publishers.

Faulkner, A. (2017) Survivor research and Mad Studies: the role and value of experiential knowledge in mental health research. *Disability & Society* 32(4): pp.500-520

Faulkner, W. (1951/1996) Requiem for a Nun. London: Penguin

Ferguson, I. (2018) Making sense of madness: revisiting RD Laing. *Critical and Radical Social Work* 6(1): pp.67-76.

Ferrara, A. (2009) Authenticity without a true self. In: Vannini, P. and Williams, J.P. (Eds.) *Authenticity in Culture, Self, and Society*, pp.21-36. Farnham, UK: Ashgate

Frank, A. (2005) What is dialogical research, and why should we do it?. *Qualitative Health Research* 15(7): pp. 964-974.

Frank, A. (2010) *Letting Stories Breathe: A Socio-Narratology*. Chicago: University of Chicago.

Freud, S. (1919) The “Uncanny”. *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume 17 (1917–1919): An Infantile Neurosis and Other Works*, pp. 217–56. Tranlated by A. Strachey, 1955.

Foucault, M. (1961) *Madness and Civilization: A History of Insanity in the Age of Reason.* Translated by R. Howard. London: Routledge.

Foucault, M. (1976a) The political function of the intellectual. *Radical Philosophy* 17: pp. 12–14. Translated by C. Gordon, 1977.

Foucault, M. (1976b) *The History of Sexuality. Volume I: The Will to Knowledge*. Translated by R. Hurley, 1998. London: Penguin

Foucault, M. (1977) *Discipline and Punish: The Birth of the Prison*. Translated by A. Sheridan. New York: Vintage

Foucault, M. (2001) *Power.* Translated by R. Hurley. New York: The New Press.

Foucault, M. (2002) *Power: Essential Works of Foucault 1954–1984, Vol. 3*. London: Penguin Books.

Foucault, M. (2006) *Psychiatric Power: Lectures at the College de France, 1973–1974.* Translated by G. Burchell. New York: Palgrave Macmillan.

Fox, R. (2010) Tales of a fighting bobcat: an “auto-archaeology” of gay identity formation and maintenance. *Text and Performance Quarterly* 30(2): pp.122-142.

Fox, R. (2014) Auto-archaeology of homosexuality: a Foucauldian reading of the psychiatric–industrial complex. *Text and Performance Quarterly* 34(3): pp.230-250. DOI: 10.1080/10462937.2014.903429

Gannon, S. (2006) The (im)possibilities of writing the self- writing: French poststructural theory and autoethnography. *Cultural Studies ↔ Critical Methodologies, 6*(4): pp.474-495.

Gates, T.J., Stagno, S.J., Gulledge, A.D. (1988) Palinopsia posing as a psychotic depression. *The British Journal of Psychiatry* 153(3): pp. 391-393.

General Medical Council (2013) *Good Medical Practice* [online]. Available at: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice. [Accessed: 3 December 2017]. Manchester, UK

Goodman B. (2013) Erving Goffman and the total institution. *Nurse Education Today* 33: 81–2.

Goffey, A. (2016) Guattari and transversality: institutions, analysis and experimentation. *Radical Philosophy* 195: pp.38-47

Goffman, E. (1959) The moral career of the mental patient. *Psychiatry* 22(2): pp.123-142. DOI: 10.1080/00332747.1959.11023166

Goffman, E. (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. London: Penguin.

Goffman, E. (1969) The insanity of place. *Psychiatry* 32(4): pp.357-388. DOI: 10.1080/00332747.1969.11023600

Grant, A. (2014) Troubling ‘lived experience’: a post-structural critique of mental health nursing qualitative research assumptions. *Journal of Psychiatric and Mental Health Nursing, 21*(6): pp.544-549. doi:10.1111/jpm.12113

Grant, A., Leigh-Phippard, H. and Short, N.P. (2015) Re-storying narrative identity. *Journal of Psychiatric and Mental Health Nursing* 22(4): pp.278-286. doi:10.1111/jpm.12188

Grant, A., Short, N. P. and Turner, L. (2013) Introduction: storying life and lives. In: Short, N.P., Turner, L. and Grant A. (Eds.) *Contemporary British Autoethnography,* pp.1-16. Rotterdam, NL: SensePublishers,.

Grant, A.J., and Zeeman, L. (2012) Whose story is it? An autoethnography concerning narrative identity. *The Qualitative Report* 17(36): pp.1-12.

Greenberg, J. (1964) *I Never Promised You a Rose Garden*. New York: Rinehart and Winston

Guignon, C. (1984). Heidegger's "authenticity" revisited. *The Review of Metaphysics,* [online] *38*(2): pp.321-339. Available at: www.jstor.org/stable/20128154. [Accessed: April 12, 2014].

Guignon, C. (2008) Authenticity. *Philosophy Compass* 3(2): pp.277-290. doi:10.1111/j.1747-9991.2008.00131.x

Hacking, I. (2004) Between Michel Foucault and Erving Goffman: between discourse in the abstract and face-to-face interaction. *Economy and Society* 33(3): pp.277-302 http://dx.doi.org/10.1080/0308514042000225671

Hallam, A. (2002) Media influences on mental health policy: long-term effects of the Clunis and Silcock cases. *International Review of Psychiatry* 14(1): pp.26-33. DOI: 10.1080/09540260120114032

Harter, S. (2005) Authenticity. In: Snyder, C.R. (Ed.) *Handbook of Positive Psychology,* pp.382-394. Cary, NC: Oxford University Press.

Hartley, S., Barrowclough, C. and Haddock, G. (2013) Anxiety and depression in psychosis: a systematic review of associations with positive psychotic symptoms. *Acta Psychiatrica Scandinavica* 128(5): pp.327-346. https://doi.org/10.1111/acps.12080

Heidegger, M. (1998) *Being and Time*. Translated by J. Macquarrie and E. Robinson. Oxford: Blackwells.

Held, J.M. (2005) Expressing the inexpressible: Lyotard and the differend. *The Journal of the British Society for Phenomenology* 36(1): pp. 76-89.

Hinshelwood, R.D. (1987) *What Happens in Groups*. London: Free Association Books.

Hinshelwood, B. (1989) *A Dictionary of Kleinian Thought*. London: Free Association Books.

Hinshelwood, B. (1999) Creatures of each other: some historical considerations of responsibility and care, and some present undercurrents. In: A. Foster and V. Zagier (Eds.) *Managing Mental Health in the Community: Chaos and Containment*, pp. 1-22. London: Routledge.

Hinshelwood, R.D. (2004) *Suffering Insanity*. London: Brunner Routledge

Hinshelwood, R. D. (2009) Do Unconscious Processes Affect Educational Institutions?. *Clinical Child Psychology and Psychiatry* 14(4): pp. 509–522. doi: 10.1177/1359104509338880.

Holman Jones, Stacy (2005) Autoethnography: Making the personal political. In: Denzin, N.K. and Yvonna, L.S. (Eds.) *Handbook of Qualitative Research*, pp.763-791. Thousand Oaks, CA: Sage

Holman Jones, S., Adams, T.E. and Ellis, C. (2013) Introduction. In: Holman Jones, S., Adams, T. E. and Ellis, C. (Eds.), *Handbook of Autoethnography*, pp.17–47. Walnut Creek, CA: Left Coast Press.

Hook, D. (2001) Discourse, knowledge, materiality, history: Foucault and discourse analysis*. Theory and Psychology* 11(4): pp.521-547.

Hornung, S., Lampert, B. and Glaser, J. (2016) Dealing with organizational double binds: three-way interactive effects of role stressors and coping on worker exhaustion. *Psychological Reports* 118(2): pp.487–509. doi: 10.1177/0033294116637732.

Hornstein, G.A. (2008) *Bibliography of First-Person Narratives of Madness in English (4th Ed.)*. Available at: http://www.mtholyoke.edu/acad/assets/Academics/Hornstein_Bibliography.pdf [Accessed: 6 July, 2016].

Hornstein, G.A. (2012) *Agnes's Jacket: A Psychologist's Search for the Meanings of Madness*. Ross-on-Wye: PCCS Books.

Iliopoulos, J. (2012) Foucault's notion of power and current psychiatric practice. *Philosophy, Psychiatry, & Psychology 19*(1): pp.49-58. doi:10.1353/ppp.2012.0006.

Jackson, M. and Williams, P. (1994) *Unimaginable Storms: A Search for Meaning in Psychosis*. London: Karnac

Jackson, S., Backett-Milburn. K, and Newall, E. (2013) Researching distressing topics: emotional reflexivity and emotional labor in the secondary analysis of children and young people's narratives of abuse. *SAGE Open,* [Online] 3(2): pp.1-12. Available from: http://classic.sgo.sagepub.com/content/3/2/2158244013490705.full.pdf+html [Accessed: 22 June 2014]

Jago, B. (2002) Chronicling an academic depression. *Journal of Contemporary Ethnography* 31(6): pp.729-756. doi:0.1177/089124102237823

Jones K. (1993) *Asylums and After: a Revised History of the Mental Health Services from the Early 18th Century to the 1990s*. London: Athlone Press.

Joseph, S. (2015) *Positive Therapy: Building Bridges between Positive Psychology and Person-Centred Psychotherapy*. Hove: Routledge.

Kafka, F. (2004) *Zurau Aphorisms of Franz Kafka*. Translated by R Calasson. New York: Schocken.

Katsakou, C., Rose, D., Amos, T. et al. (2012) Psychiatric patients' views on why their involuntary hospitalisation was right or wrong: a qualitative study. *Social Psychiatry and Psychiatric Epidemiology* 47**:** pp.1169–1179. https://doi.org/10.1007/s00127-011-0427-z

Kaufmann, W. (1975) *Existentialism from Dostoevsky to Sartre*. New York: New American Library

Kerosuo, H. (2011) Caught between a rock and a hard place: from individually experienced double binds to collaborative change in surgery. *Journal of Organizational Change Management* 24(3): pp.388-399, https://doi.org/10.1108/09534811111132767

Kierkegaard, S. (1849) *The Sickness Unto Death*. Translated by A. Hanney, 1989. London: Penguin.

Kinderman, P. (2014) *A Prescription for Psychiatry: Why We Need a Whole New Approach to Mental Health and Wellbeing*. London: Palgrave Macmillan.

King, C. (2016) Whiteness in psychiatry: the madness of European misdiagnosis. In: Russo, J. and Sweeney, A. (Eds.) *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies*, pp.69-76. Monmouth: PCCS Books.

Kotowicz, Z. (1997) *R.D. Laing and the Paths of Anti-Psychiatry*. London: Routledge.

Laing, R.D. (1960) *The Divided Self*. Reprint 1990. Penguin: London.

Laing, R.D. (1969). *Self and Others*. Penguin, London

Landry, D. and Church, K. (2016) In: Russo, J. and Sweeney, A. (Eds.) *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies*, pp.172-182. Monmouth: PCCS Books.

Landry, D. and Maclean, G. (1996). *The Spivak Reader*. London: Routledge.

Lather, P. A. (2009) Against empathy, voice and authenticity. In: Jackson, A.Y.M. and Mazzei, L.A. (Eds.) *Voice in Qualitative Inquiry:*

Challenging Conventional, Interpretive, and Critical Conceptions in Qualitative Research, pp. 17–26. London: Routledge.

Lather, P. and Smithies, C. (1997) *Troubling the Angels: Women Living with HIV/AIDS*. Boulder, CO: Westview/HarperCollins.

Leader, D. (2014). *What is Madness?* London: Penguin.

Le Roux, C.S. (2017) Exploring rigour in autoethnographic research. *International Journal of Social Research Methodology* 20(2): pp.195-207, DOI: 10.1080/13645579.2016.1140965

Leroy, H., Dierynck, B., Anseel, F., Simons, T., Halbesleben, J.R.B., McCaughey, D., Savage, G.T. and Sels, L. (2012) Behavioral integrity for safety, priority of safety, psychological safety, and patient safety: a team-level study. *Journal of Applied Psychology 97*(6): pp.1273–1281. https://doi.org/10.1037/a0030076

Lenton, A.P., Bruder, M., Slabu, L. and Sedikides, C. (2013) How Does “Being Real” feel? The experience of state authenticity. *Journal of Personality* 81(3): pp.276–289.

Lenton, A.P., Slabu, L., Sedikides, C. and Power, K. (2013) I feel good, therefore I am real: Testing the causal influence of mood on state authenticity’. *Cognition & Emotion* 27(7): pp.1202-1224.

Llewellyn-Beardsley, J., Rennick-Egglestone, S., Callard, F., Crawford, P., Farkas, M., Hui, A., et al. (2019) Characteristics of mental health recovery narratives: Systematic review and narrative synthesis. *PLoS ONE* 14(3): e0214678. https://doi.org/10.1371/journal.pone.0214678

Lloyd, C. and Seifert, R. (1995) Restructuring in the NHS: the impact of the 1990 reforms on the management of labour. *Work, Employment and Society* 9(2): pp.359-378. doi.org/10.1177/095001709592008

Lyotard, J.F. (1978) *The Postmodern Condition: A Report on Knowledge*. Translated by G. Bennington and B. Massumi, 1984. Manchester: Manchester University Press.

Lyotard, J.F. (1983) *The Differend: Phrases in Dispute*. Translated by G. Van Den Abbeele, 1988. Minneapolis: University of Minneapolis Press.

Margulies, A. (2016) Hidden in plain sight on locked wards - on finding and being found. *American Journal of Psychotherapy* 70(1): pp.101-116.

Mazzei, L.A. and Jackson, A.Y. (2009) The limits of voice. In: Mazzei, L.A. and Jackson, A.Y. (Eds.) *Voice in Qualitative Inquiry: Challenging Conventional, Interpretive, and Critical Conceptions in Qualitative Research*, pp. 1-13. London: Routledge.

McGlashan, T.H and Carpenter, W.T. (1976) Postpsychotic depression in schizophrenia. *Archives of General Psychiatry* 33(2): pp.231–239. doi:10.1001/archpsyc.1976.01770020065011.

McKeown, M. and Carey, L. (2015) Editorial: democratic leadership: a charming solution for nursing's legitimacy crisis. *Journal of Clinical Nursing* 24(3-4): pp.315-317. doi:10.1111/jocn.12752.

McWade, B. (2019) Was it autoethnography? The classificatory, confessional and mad politics of lived experience in sociological research. *Social Theory & Health*. https://doi.org/10.1057/s41285-019-00090-4.

Medlock, G. (2012) The evolving ethic of authenticity: from humanistic to positive psychology. *The Humanistic Psychologist* 40(1): pp.38-57

Menzies-Lyth, I. (1959) The functioning of a social system as a defence against anxiety. *Human Relations* 11: pp.95–121.

Miller, G. (2009) R.D. Laing and theology: the influence of Christian existentialism on The Divided Self. *History of the Human Sciences* 22(2): pp.1–21. doi: 10.1177/0952695108101284.

Miller, G. (2017) Madness decolonized?: madness as transnational identity in Gail Hornstein's Agnes's Jacket. *Journal of Medical Humanities* 39: pp.303–323. https://doi.org/10.1007/s10912-017-9434-8.

Morrison, J. (1990) *Wilderness: The Lost Writings of Jim Morrison*. London: Penguin.

Nietzsche, F. (2003) *Beyond Good and Evil*. Translated by R. Hollingdale. London: Penguin.

O'Hagan, M. (1996) Two accounts of mental distress. In: Read, J. and Reynolds, J. (Eds.) *Speaking our Minds: An Anthology*, pp. 44-50. London: Macmillan.

Olson, M. (2015) An auto-ethnographic study of “open dialogue”: the illumination of snow. *Family Process* 54(4): pp.716-729. doi:10.1111/famp.12160.

Onyett, S. (2011) Revisiting job satisfaction and burnout in community mental health teams. *Journal of Mental Health* 20(2): pp.198-209. DOI: 10.3109/09638237.2011.556170.

Palmer, D. (2001) Identifying delusional Discourse: issues of rationality, reality and power. In: Busfield, J. (Ed.) *Rethinking the Sociology of Mental Health*. Oxford: Blackwell Publishers.

Parker, I. (1990) Discourse: Definitions and contradictions. *Philosophical Psychology* 3(2-3): pp.187-204, DOI: 10.1080/09515089008572998.

Parker, I. (2007) *Revolution in Psychology: Alienation to Emancipation*. London: Pluto Press.

Parker, I. (2013) Discourse analysis: dimensions of critique in psychology. *Qualitative Research in Psychology* 10(3): pp.223-239. DOI: 10.1080/14780887.2012.741509.

Parker, I. (2015) *Critical Discursive Psychology (2nd Ed.)*. London: Palgrave Macmillan.

Paterson, B. (2006) Newspaper representations of mental illness and the impact of the reporting of ‘events’ on social policy: the ‘framing’ of Isabel Schwarz and Jonathan Zito. *Journal of Psychiatric and Mental*

Health Nursing 13(3): pp.294-300. doi:10.1111/j.1365-2850.2006.00953.x

Paterson, B. and Stark, C. (2001). Social policy and mental illness in England in the 1990s: violence, moral panic and critical discourse. *Journal of Psychiatric and Mental Health Nursing, 8*(3): pp.257-267. doi:10.1046/j.1365-2850.2001.00392.x

Pelias, R.J. (2000) The critical life. *Communication Education* 49(3): pp.220-228. DOI: 10.1080/03634520009379210

Riessman, C.K. (1993) *Narrative Analysis*. London: Sage.

Rambo, C. (2007) Handing IRB an unloaded gun. Qualitative Inquiry, 13(3): pp.353-367. doi:10.1177/1077800406297652.

Rambo, C. (2013) ‘Twitch’: A performance of chronic liminality. In: Jones, S.H., Adams, T.E. and Ellis, C. (Eds.) *Handbook of Autoethnography*, pp. 627-638. Walnut Creek, CA: Left Coast Press Inc.

Recovery in the Bin (2019) *Neorecovery: a survivor led conceptualisation and critique*. International Mental Health Nursing Research Conference. The Royal College of Nursing, London, 13 September 2019.

Rey, J.H. (1994) *Universals of Psychoanalysis in the Treatment of Psychotic and Borderline States*. London: Free Association Books.

Rogers, A. and Pilgrim, D. (2010) *A Sociology of Mental health and Illness*. Maidenhead: McGraw-Hill.

Rogers, C.R. (1961) *On Becoming a Person: A Therapist's View of Psychotherapy*. New York: Houghton Mifflin.

Rose, D., Wykes, T., Leese, M., Bindman, J. and Fleischmann, P. (2003) Patients' perspectives on electroconvulsive therapy: systematic review. *BMJ* 326(7403): pp.1363-1368.

Rose, D. (2008) Madness strikes back. *Journal of Community & Applied Social Psychology* 18(6): pp. 638-644. DOI: 10.1002/casp.981.

Rose, D. (2015) The contemporary state of service-user-led research. *The Lancet Psychiatry* 2(11): pp.959-60.

Rose, D. (2017) Service user/survivor-led research in mental health: epistemological possibilities. *Disability & Society* 32(6): pp.773-789. DOI: 10.1080/09687599.2017.1320270.

Rose, D. (2019) On personal epiphanies and collective knowledge in survivor research and action. *Social Theory & Health.* https://doi.org/10.1057/s41285-019-00087-z.

Rose, N. (1999) *Governing the Soul: The Shaping of the Private Self* (2nd Ed.). London: Free Association Books.

Rossdale, C. (2015) Enclosing critique: the limits of ontological security. *International Political Sociology* 9(4): pp.369 386 https://doi.org/10.1111/ips.12103.

Royal College of Psychiatrists (1995) *The ECT Handbook: The Second Report of the Royal College of Psychiatrists' Special Committee on ECT*. London: RCP.

Russo, J. (2016a) In dialogue with conventional narrative research in psychiatry and mental health. *Philosophy, Psychiatry, & Psychology* 23(3): pp. 215-228.

Russo, J. (2016b) Establishing first-person knowledge of madness: must this undertaking elide our differences? *Philosophy, Psychiatry, & Psychology* 23(3): pp.237-240.

Russo, J. (2016c) Towards our own framework, or reclaiming madness part two. In: Russo, J. and Sweeney, A. (Eds.) *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies*, pp.59-68. Monmouth: PCCS Books.

Saks, E. (2007) *The Center Cannot Hold: My Journey through Madness*. London: Virago.

Sarangi, S. and Slembrouck, S. (1996) *Language, Bureaucracy and Social Control*. London: Routledge.

Sartre, J.P. (1948) *Existentialism and Humanism*. Translated by P. Mairet. London: Methuen.

Scheff, T.J. (1967) *Being Mentally Ill: A Sociological Theory*. Chicago: Aldine.

Schreber, D.P. (1903) *Memoirs of my Nervous Illness*. New York: New York Review of Books, 2000.

Sedgwick, P. (1982) *Psychopolitics*. London: Pluto Press

Seligman, M.E.P. (2002a) *Authentic Happiness*. New York, NY: The Free Press.

Seligman, M.E.P. (2002b) Positive psychology, positive prevention, and positive therapy. In: Snyder, C.R. and Lopez, S.J. (Eds.) *Handbook of Positive Psychology*, pp. 3-9. New York: Oxford University Press.

Seligman, M.E.P. and Csikszentmihalyi, M. (2000) Positive psychology. *American Psychologist* 55(1): pp.5-14.

Sens and Sexton (2016) In: Russo, J. and Sweeney, A. (Eds.) *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies*, pp.163-171. Monmouth: PCCS Books.

Schulman M. (2003) R.D. Laing and existential psychoanalysis: a blast from the past. *The Psychoanalytic Review* 90(3): pp. 293-301. https://doi.org/10.1521/prev.90.3.293.23622

Seikkula, J. (2011) Becoming dialogical: psychotherapy or a way of life? *The Australian and New Zealand Journal of Family Therapy* 32(3): pp.179–193.

Seikkula, J., Alakare, B. and Aaltonen, J. (2011) The comprehensive open-dialogue approach in western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care. *Psychosis* 3(3): pp.192–204.

Short, N.P., Grant, A. and Clarke, L. (2007) Living in the borderlands; writing in the margins: an autoethnographic tale. *Journal of Psychiatric and Mental Health Nursing* 14(8): pp.771-782. doi:10.1111/j.1365-2850.2007.01172.x

Smith, S., Gate, R., Ariyo, K., Saunders, R., Taylor, C., Bhui, K., Mavranezouli, I., Heslin, M., Greenwood, H., Matthews, H., Barnett, P. and Pilling, S. (2020) Reasons behind the rising rate of involuntary admissions under the Mental Health Act (1983): Service use and cost impact. International Journal of Law and Psychiatry 68: 101506. https://doi.org/10.1016/j.ijlp.2019.101506.

Snyder, C.R. and Lopez, S.J. (2006) *Positive Psychology: A Scientific and Practical Exploration of Human Strengths*. Los Angeles, CA: SAGE.

Soteria Network (2011) *Soteria Network: an international movement of service users, survivors, activists, carers and professionals fighting for more humane, non-coercive mental health services*. [Online]. Available at: http://www.soterianetwork.org.uk/resources/files/Soteria-Network-Booklet.pdf [Accessed: 10 November 2017].

Spandler, H. (2006) *Asylum to Action: Paddington Day Hospital, Therapeutic Communities and Beyond*. London: Jessica Kingsley Publishers.

Spandler, H. (2016) From psychiatric abuse to psychiatric neglect? *Asylum Magazine* 23: pp.7–8.

Spandler, H. and McKeown, M. (2017) Exploring the case for truth and reconciliation in mental health services. *Mental Health Review Journal* 22(2): pp.83-94. https://doi.org/10.1108/MHRJ-01-2017-0011.

Spandler, H. and Poursanidou, D. (2019) Who is included in the Mad Studies Project? *The Journal of Ethics in Mental Health* 10.

Sparkes, A.C. (2007) Embodiment, academics, and the audit culture: a story seeking consideration. *Qualitative Research, 7*(4): pp.521-550.

Speedy, J. (2013) Where the wild dreams are: fragments from the spaces between research, writing, autoethnography, and psychotherapy. *Qualitative Inquiry* 19(1): pp.27–34.

Spivak, G. C. (1988) Subaltern studies. In: Guha, R. and Spivak, G.C. (Eds*.)* *Selected Subaltern Studies*, pp. 3-32. Oxford: Oxford University Press.

Spivak, G.C. (1990) *The Post-colonial Critic: Interviews, Strategies, Dialogue*. New York: Routledge.

Stahlke Wall, S. (2016) Toward a moderate autoethnography. *International Journal of Qualitative Methods* 15(1). doi: 10.1177/1609406916674966.

Starkman, M. (2015) The Movement. In: LeFrançois, B.A., Menzies, R. and Reaume, G. (Eds.) *Mad Matters,* pp. 27-37. Toronto: Canadian Scholars' Press.

Steinbock, A.J. (2007) The Phenomenology of despair. *International Journal of Philosophical Studies* 15(3): pp.435-451, DOI: 10.1080/09672550701445431.

Stone, B. (2004) Towards a writing without power: notes on the narration of madness. *Auto/Biography* 12: pp.16-33.

Stuart, R., Akther, S., Machin, K., Persaud, K., Simpson, A., Johnson, S., and Oram, S. (2020) Carers' experiences of involuntary admission under mental health legislation: Systematic review and qualitative meta-synthesis. *BJPsych Open, 6*(2): E19. doi:10.1192/bjo.2019.101.

Sweeney, A., Clement, S., Filson, B. and Kennedy, A. (2016) Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal* 21(3): pp.174 192. https://doi.org/10.1108/MHRJ-01-2015-0006.

Sweeney, A., Perôt, C., Callard, F., Adenden, V., Mantovani, N. and Goldsmith, L. (2019) Out of the silence: towards grassroots and trauma-informed support for people who have experienced sexual violence and abuse. *Epidemiology and Psychiatric Sciences 28*(6): pp.598-602. doi:10.1017/S2045796019000131.

Swerdfager, T. (2016) Theorizing resistance: Foucault, cross-cultural psychiatry, and the user/survivor movement. *Philosophy, Psychiatry, & Psychology 23*(3): pp.289-299. doi:10.1353/ppp.2016.0033.

Tavory, I. and Timmermans, S. (2014) *Abductive Analysis: Theorizing Qualitative Research*. University of Chicago Press.

Taylor, B. (2014) *The Last Asylum: a Memoir Of Madness in Our Times*. London: Penguin.

Taylor, C. (1991) *The Ethics of Authenticity*. Cambridge, MA: Harvard University Press.

Tolich, M. (2010) A critique of current practice: ten foundational guidelines for autoethnographers. *Qualitative Health Research 20*(12): pp.1599–1610.

Tomm-Bonde, L., Schreiber, R.S., Allan, D.E. *et al.* (2013) Fading vision: knowledge translation in the implementation of a public health policy intervention. *Implementation Science* 8(59): https://doi.org/10.1186/1748-5908-8-59

Turner L. (2013) The Evocative Autoethnographic I. In: Short, N.P., Turner, L. and Grant A. (Eds.) *Contemporary British Autoethnography*, pp. 213-229. Rotterdam: SensePublishers.

Trilling, L. (1972) *Sincerity and Authenticity*. Oxford: Oxford University Press.

Vannini, P. and Williams, J.P. (2009) Authenticity in culture, self, and society'. In: Vannini, P. and Williams, J.P. (Eds.) *Authenticity in Culture, Self, and Society,* pp.1-20. Farnham, UK: Ashgate.

Visser, M. (2003) Gregory Bateson on deutero-learning and double bind: a brief conceptual history. *Journal of the History of Behavioral Science* 39(3): pp.269-278. doi:10.1002/jhbs.10112.

Visser, M. and van der Heijden, B.I.J.M. (2015) Nursing under inconsistent organizational conditions: Evidence of double bind situations? *Journal of Organizational Change Management, 28*(5): pp. 689-703. https://doi.org/10.1108/JOCM-10-2013-0201

Visser, M. (2010) Constructing organisational learning and knowledge socially: an interactional perspective, International Journal of *Knowledge and Learning* 6(4): p.285-294.

von Peter, S. and Schulz, G. (2018) 'I-as-We' – Powerful boundaries within the field of mental health coproduction. *International Journal of Mental Health Nursing* 27(4): pp.1292-1300. doi:10.1111/inm.12469.

Voronka, J. (2016) The politics of 'people with lived experience: experiential authority and the risks of strategic essentialism. *Philosophy, Psychiatry, & Psychology* 23(3): pp.189-201.

Wagner, J.A. (1978) The organizational double bind: toward an understanding of rationality and its complement. *The Academy of Management Review* 3(4): pp.786-795.

Wall, S. (2008) Easier said than done: writing an autoethnography. *International Journal of Qualitative Methods* 7(1): pp.38–53. doi: 10.1177/160940690800700103.

Wallcraft, J. (2013) Service User Led Research on Psychosis: Marginalisation and the struggle for progression. In: Coles, S., Keenan, S. and Diamond, B. (Eds.) *Madness Contested,* pp. 197-212. Monmouth: PCCS Books.

Waterman, A.S. (2013) The humanistic psychology-positive psychology divide: contrasts in philosophical foundations. *American Psychologist* 68: pp.124-133.

Weimand, B.M., Sällström, C., Hall-Lord, M.L. and Hedelin, B. (2013) Nurses' dilemmas concerning support of relatives in mental health care. *Nursing Ethics* 20(3): pp.285-299. doi: 10.1177/0969733012462053.

Wilkinson, S. and Kitzinger, C. (2007) Representing our own experience: issues in "insider" research. *Psychology of Women Quarterly 37*(2): pp.251-255.

Wilson, J.J. (2013) Let's all play 'Stigma'! Learning together using forum theatre in collaboration with mental health service users and nurse lecturers. *Working Papers in the Health Sciences* 1(4): pp.1-3.

Winship, G. (1995) The unconscious impact of caring for acutely disturbed patients: a perspective for supervision. *Journal of Psychiatric and*

Mental Health Nursing 2(4): pp.227-231. doi:10.1111/j.1365-2850.1995.tb00061.x

Winship, G. (2016) Positioning the New Recovery movement. *Journal of Psychiatric and Mental Health Nursing* 23(1): pp.66-73. doi:10.1111/jpm.12266

Winship, G., Hall, E. and MacDonald-Winship, L. (2014) Wisdom, oblivion & the wounded healer: a one-act play based on Wilfred Bion’s war memoirs. *International Health Humanities Conference: Trauma Textualities*. Nottingham University, 7th Sept 2014.

Wood, A.M., Linley, A.P., Maltby, J., Baliousis, M. and Joseph, S. (2008) The authentic personality: a theoretical and empirical conceptualization and the development of the authenticity scale. *Journal of Counseling Psychology* 55(3): pp.385-399. https://doi.org/10.1037/0022-0167.55.3.385

Woods, A. (2011) The limits of narrative: provocations for the medical humanities. *Medical Humanities* 37(2): pp.73-78.

Woods, A. (2012) Rethinking “patient testimony” in the medical humanities: the case of Schizophrenia Bulletin’s first person accounts. *Journal of Literature and Science*, 6(1): pp.38–54.

Woods, A., Jones, N., Alderson-Day, B., Callard, F. and Fernyhough, C. (2015) Experiences of hearing voices: analysis of a novel phenomenological survey. *The Lancet Psychiatry* 2(4): pp.323-331.

Woods, A., Hart, A. & Spandler, H. (2019) The recovery narrative: politics and possibilities of a genre. *Culture, Medicine, and Psychiatry*. https://doi.org/10.1007/s11013-019-09623-y

Wright, C. (2002) Centrifugal logics: Eagleton and Spivak on the place of 'place' in postcolonial theory. *Culture, Theory and Critique* 43(1): pp.67-82.

Wright, C. (2013) Against flourishing: wellbeing as biopolitics, and the psychoanalytic alternative. *Health, Culture and Society* 5(1): pp.20-35.

Wright, C. (2014) Happiness studies and wellbeing: a lacanian critique of contemporary conceptualisations of the cure. *Culture Unbound* 6: pp.791-813.

APPENDIX 1: RESEARCH OUTPUTS FROM THE THESIS

Published journal articles

Clarke, S.P., and Wright, C. (2019). Tactical authenticity and autoethnographic mad narratives. *Social Theory & Health*, https://doi.org/10.1057/s41285-019-00092-2

Clarke, S. P. (2018). 'Madhouse and the whole thing there'. *Qualitative Research in Psychology, 15*, 247-259, DOI: 10.1080/14780887.2018.1429989

Clarke, S.P., Clarke, J.M., Brown, R., and Middleton, H. (2016). Hurting and Healing in Therapeutic Environments: how can we understand the role of the relational context? *European Journal of Psychotherapy & Counselling, 18(4)*, 384-400. doi: 10.1080/13642537.2016.1260620.

Book chapters

Clarke, S.P. (2018). Re-presenting madness in the form of a quadrilogue. In B. Avieson, F. Giles and S. Joseph (Eds.). *The Literature of Remembering: Tracing the Limits of Memoir* (pp. 59-73). Abingdon: Routledge

Clarke, S., Winship, G., Clarke, J.M., & Manning, N. (2017). Therapeutic communities. In M. Chambers (Ed.) *Psychiatric and Mental Health Nursing (3rd Ed.) (pp. 631-640)*. London: Routledge

Invited keynote speaker

'Madhouse and the whole thing there': lived experience, authenticity and psychiatry. INPP 2020: 22nd Conference of the International Network for Philosophy and Psychiatry, Expertise by Experience: Challenges and Prospects for Mental Health Research Methodology, Manchester, February 2020

Conference symposium lead

*Hurting and healing in therapeutic environments: how can we understand the role of the relational context**?*** 6th Qualitative Research on Mental Health Conference, Chania, Greece, May 2016

Conference presentations

Disciplinary power and degradation ceremonies: the case of the ward round, Second UK Mental Disability Law Conference, University of Nottingham, June 2018.

Madhouse and the whole thing there, Nottingham MAD Carnival, Institute of Mental Health, Nottingham, October 2017

"He denied feeling depressed, rather he insistently used the word "despair": a dialogical approach to mad narratives, Association of Medical Humanities Annual Conference, Keele University, July 2017

Relational approaches to mad narratives, The Importance of Relationships within Mental Health Service Delivery: The Institute of Mental Health and The Retreat York Research Day, York, December 2016

The 'Quadrilogue': An autoethnographic account of madness and its social environment, 2nd Annual Conference of the Association for Psychosocial Studies, Bristol, June 2016

How can the voice of madness be represented authentically? Institute of Mental Health Research Day, University of Nottingham, May 2016

The 'Quadrilogue': An autoethnographic account of madness, 6th Qualitative Research on Mental Health Conference, Chania, Greece, May 2016

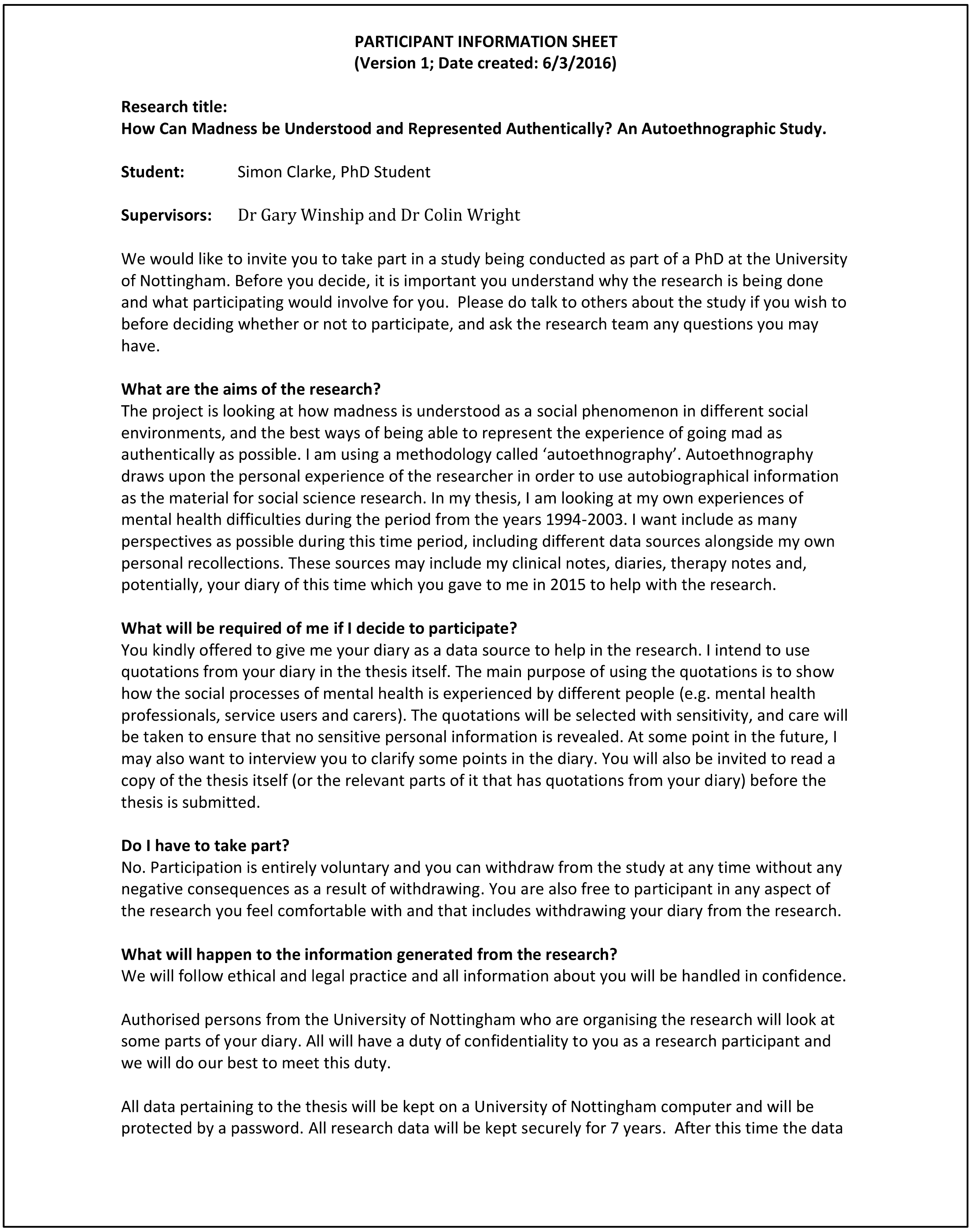
What can autoethnography tell us about the process of going mad and authentic recovery in a therapeutic community environment? The Consortium of Therapeutic Communities' (TCTC) Annual Conference, Windsor UK, October 2015

"If this is an answer, then what is the question?" Using autoethnography as a basis for a doctoral research project. Institute of Mental Health Research Day, University of Nottingham, May 2015

"Whose evidence is it anyway?" Using autoethnography and personal accounts as examples of therapeutic effectiveness. Community of Community Annual Forum, London, May 2014

"If this is an answer, then what is the question?" Using autoethnography as a basis for a doctoral research project. Mental Health Qualitative Research Network (MHQRN) meeting, Rethink Mental Illness, London, March 2014

APPENDIX 2: PARTICIPANT INFORMATION SHEET AND CONSENT FORM



PARTICIPANT INFORMATION SHEET
(Version 1; Date created: 6/3/2016)

Research title:
How Can Madness be Understood and Represented Authentically? An Autoethnographic Study.

Student: Simon Clarke, PhD Student

Supervisors: Dr Gary Winship and Dr Colin Wright

We would like to invite you to take part in a study being conducted as part of a PhD at the University of Nottingham. Before you decide, it is important you understand why the research is being done and what participating would involve for you. Please do talk to others about the study if you wish to before deciding whether or not to participate, and ask the research team any questions you may have.

What are the aims of the research?
The project is looking at how madness is understood as a social phenomenon in different social environments, and the best ways of being able to represent the experience of going mad as authentically as possible. I am using a methodology called 'autoethnography'. Autoethnography draws upon the personal experience of the researcher in order to use autobiographical information as the material for social science research. In my thesis, I am looking at my own experiences of mental health difficulties during the period from the years 1994-2003. I want include as many perspectives as possible during this time period, including different data sources alongside my own personal recollections. These sources may include my clinical notes, diaries, therapy notes and, potentially, your diary of this time which you gave to me in 2015 to help with the research.

What will be required of me if I decide to participate?
You kindly offered to give me your diary as a data source to help in the research. I intend to use quotations from your diary in the thesis itself. The main purpose of using the quotations is to show how the social processes of mental health is experienced by different people (e.g. mental health professionals, service users and carers). The quotations will be selected with sensitivity, and care will be taken to ensure that no sensitive personal information is revealed. At some point in the future, I may also want to interview you to clarify some points in the diary. You will also be invited to read a copy of the thesis itself (or the relevant parts of it that has quotations from your diary) before the thesis is submitted.

Do I have to take part?
No. Participation is entirely voluntary and you can withdraw from the study at any time without any negative consequences as a result of withdrawing. You are also free to participant in any aspect of the research you feel comfortable with and that includes withdrawing your diary from the research.

What will happen to the information generated from the research?
We will follow ethical and legal practice and all information about you will be handled in confidence.

Authorised persons from the University of Nottingham who are organising the research will look at some parts of your diary. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

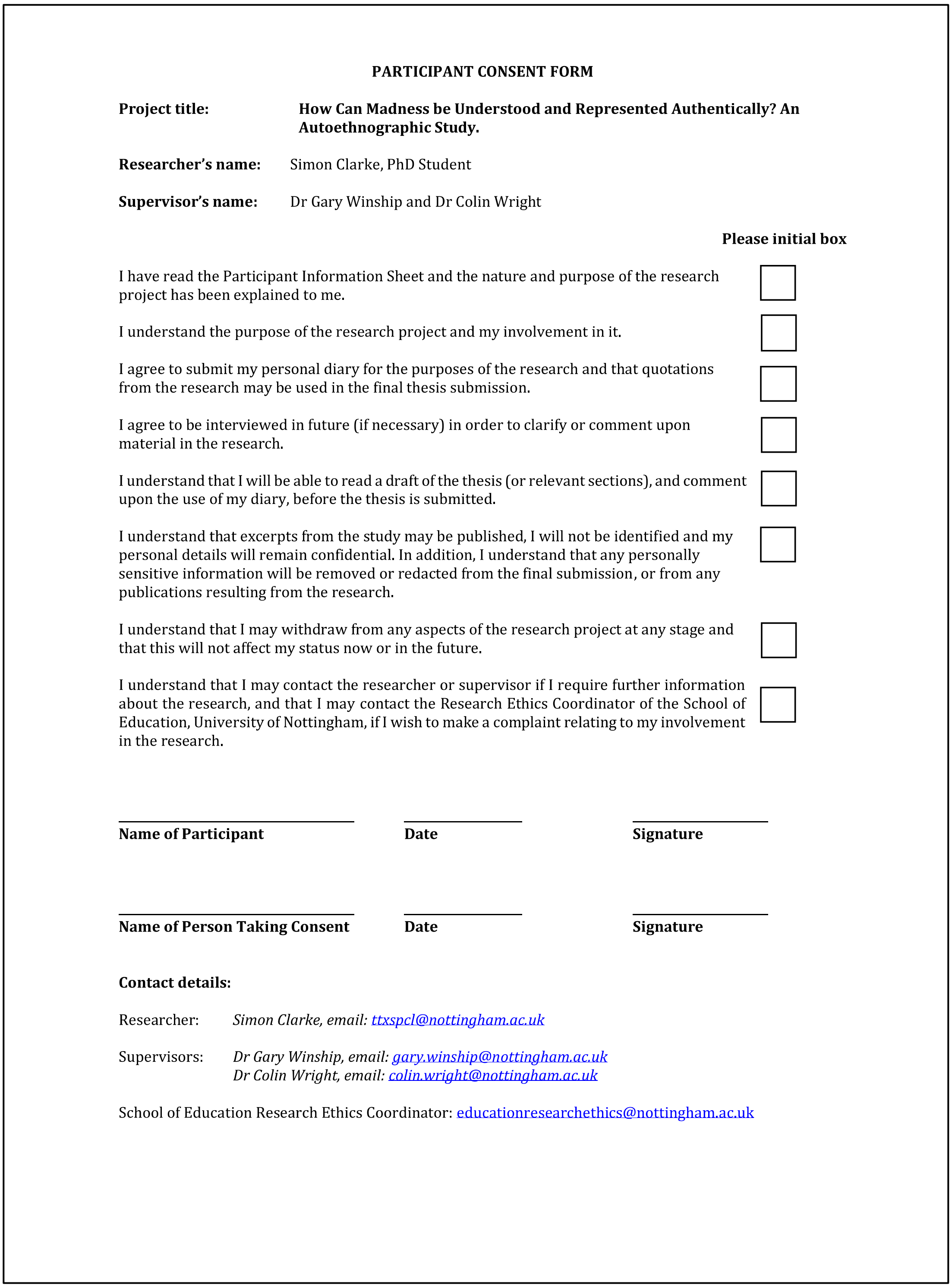
All data pertaining to the thesis will be kept on a University of Nottingham computer and will be protected by a password. All research data will be kept securely for 7 years. After this time the data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality and only members of the research team will have access to the data.

Are there any risks, harms or benefits to me by taking part in this research?
There are no direct risks to you taking part in the research, although you may be asked to talk about past events and experiences that you may have found stressful. There is no direct benefit to you by taking part in this research. However, we hope that the research will contribute to our understandings of mental health difficulties and how to understand, and best respond to, people when they are in distress.

Who can I contact if I need to make a complaint on ethical grounds?
You can contact the Research Ethics Coordinators at the School of Education, University of Nottingham if you wish to make a complaint about how the research has been conducted on ethical grounds. The School's Research Ethics Coordinators are: Dr Kay Fuller (Chair; 0115 951 4510), Professor Tony Bush (0115 951 4494), Dr Mary Oliver (0115 748 4791), Dr Mary Bailey (0115 951 4539) and Mary Biddulph (0115 951 4483).

Who can I contact if I need further information?
If you wish to discuss any of the research in more detail, please contact me or my supervisors Dr Gary Winship (email: gary.winship@nottingham.ac.uk and Dr Colin Wright (email: colin.wright@nottingham.ac.uk).

Thank you for taking the time to consider taking part in this research and reading this information sheet – it is much appreciated.



PARTICIPANT CONSENT FORM

Project title: **How Can Madness be Understood and Represented Authentically? An Autoethnographic Study.**

Researcher's name: Simon Clarke, PhD Student

Supervisor's name: Dr Gary Winship and Dr Colin Wright

Please initial box

I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. ☐

I understand the purpose of the research project and my involvement in it. ☐

I agree to submit my personal diary for the purposes of the research and that quotations from the research may be used in the final thesis submission. ☐

I agree to be interviewed in future (if necessary) in order to clarify or comment upon material in the research. ☐

I understand that I will be able to read a draft of the thesis (or relevant sections), and comment upon the use of my diary, before the thesis is submitted. ☐

I understand that excerpts from the study may be published, I will not be identified and my personal details will remain confidential. In addition, I understand that any personally sensitive information will be removed or redacted from the final submission, or from any publications resulting from the research. ☐

I understand that I may withdraw from any aspects of the research project at any stage and that this will not affect my status now or in the future. ☐

I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research Ethics Coordinator of the School of Education, University of Nottingham, if I wish to make a complaint relating to my involvement in the research. ☐

Name of Participant	**Date**	**Signature**
Name of Person Taking Consent	**Date**	**Signature**

Contact details:

Researcher: *Simon Clarke, email: ttxspcl@nottingham.ac.uk*

Supervisors: *Dr Gary Winship, email: gary.winship@nottingham.ac.uk*
Dr Colin Wright, email: colin.wright@nottingham.ac.uk

School of Education Research Ethics Coordinator: educationresearchethics@nottingham.ac.uk

APPENDIX 3: CODING FRAME

Part 1: Prelude

Account	Code/theme	Example from text
Simon	Sense of chaotic internal world	You pace back and forth, smoking one cigarette after another, the mad roulette of voices rolling around your head like an aural carousel.
Simon	Different voices signalling threat, guidance and mocking	*Meeting you at your parent's gate…* *Because I do not hope to turn…* *We will tell you what to do…*
Simon	Perception of family as being apart; cut-off; distanced; social isolation	You observe your family talking through the kitchen window below; they move in and out of focus like fish in an aquarium.
Simon	Perception of family as being anxious or talking about you	They cast anxious glances up at you when they pass the window, and then circle for another round, deep in conversation with each other.
Simon	Mother's concern about interaction with medical team	She asks you about your visit to the doctor.
Simon	Heightened sense of symbolism and significance	There is a sudden rustle of branches and a dull 'thunk!' as an apple falls from the tree and rolls down the patio to your feet.
Simon	Internal contradiction	
Mother	Inference about causality of illness / search for meaning	In Summer 93 we became aware that he had been taking drugs. Pot and L.SD He'd told his brother that he thought he was going mad. He told us later that week We never expressed any anger over the car. We were just so glad he was alive. Perhaps that made him worse?

Account	Code/theme	Example from text
Mother	Perception of help-seeking	He went to the drug rehabilitation centre at Wodenborough and spoke to a counsellor there. He seemed to be able to reassure him. He also saw Dr Carmen who advised him to go to a centre in Swapanley he felt guilty about "wasting the counsellor's time" as he felt people were worse than him I arranged for him to talk to a counsellor to talk through his problems. He didn't find it very helpful. He saw Dr Carmen who sent him to the day centre at Wodenborough. He didn't find it very helpful
Mother	Mistrust of son's help-seeking	We don't know if he went
Mother	Parent's interactions with medical team	Fear over betraying GP
Mother	Perception of son's identity	"he was very much his own person and could resent too much interference in his life"
Mother	The role of drugs inferred as a causal factor	He wanted to go to university, this had been quite important to him before he took drugs
Mother	Taking over agency	"…so we had got him into Portown College to get the necessary qualifications" "Difficult to get up in the morning" didn't really want to go back but I told him he must go through the motions of living, to plod on and we will come through this
Mother	Infantillisation	"Pocket money"
Mother	Description of life / life inventory	Work, education etc.
Mother	Son's social isolation / dissociation	Mainly he spent most of his time in his room Over those weeks he isolated himself more

Account	Code/theme	Example from text
Mother	Inference about the link between reading and illness	“He became fascinated by psychology & philosophy and that is mainly what he read. He was fascinated by Jim Morrison, Kafka, Jung Wittgensing” “I have the whole of philosophy on my shoulders”. The day he was admitted he threw all his books in the dustbin.
Mother	Son’s relationship with brothers / comparison with brothers / internal contradictions	“There was no competition between his brothers but I know he envied them” “They are both good looking my 18 yr old especially so, plenty of friends popular”
Mother	Attributions of value / son’s identity	“…all the attributes to be successful. They are both good looking my 18 yr old especially so, plenty of friends popular”
Mother	Inferences about sexuality and gender relationships – comparison with brothers	“It is a macho family of men” “…never tried to be like them…never dressed up to ‘get girls’…having a date once”
Mother	Retrospective searching for signs of potential incapacity / inference of causality – son dispositional factors / search for meaning	“My husband told me yesterday that when Simon was 3 yrs old his mother had said to him, that Malcolm & Alex will always manage and get by but Simon is different, he needs more looking after”
Mother	Judgements about normality / internal contradictions	I always felt he was a normal boy, sensitive, thoughtful, always talked a lot – had his own opinions, articulate”
Mother	Relationship with parents	He had a good relationship with his father. With me it was more volatile as we both tend to flare up quickly
Mother	Description of job / events leading to breakdown / internal contradiction	It was long hours – 10am – 10pm / 11pm a break during the day, he usually stayed there…it put no demands on him
Mother	Inference about illness – car accident	We were just so glad he was alive. Perhaps that made him worse?
Mother	The role of affect	Guilty about wasting people’s time Felt in a vacuum he was affectionate and was able to express his feelings for us worried he had schizophrenia He gradually became more agitated & withdrawn

Account	Code/theme	Example from text
		He was anxious but Alan said he thought he enjoyed himself
Mother	Diagnostic categories	worried he had schizophrenia
Mother	Risk	He told me he had suicidal thoughts
Mother	Inferences about illness - sleep	I don’t think he slept much recently.
Clinical	Agency taken away / power	I would be grateful if you would send this young man an appointment to come and see you. feel he is in need of your further assessment and advice regarding management
Clinical	Agency asserted by patient for treatment	He came to the Surgery this week saying that he felt he needed to see a Psycho-analysist.
Clinical	Problem framing	I asked him his problems and his main complaint is that he feels a lack of sensitivity and is emotionally flat.
Clinical	Taking on board other perspective	On questioning him more closely about these feelings
Clinical	The role of affect	he feels a lack of sensitivity and is emotionally flat he lacks any sense of creativity, he is not motivated, has no energy and no longer experiences pleasure or joy and admits to feeling depressed
Clinical	Normality	Atypically he feels better when he gets up and feels worse as the day goes on
Clinical	Institutional cross-referencing	He took ‘A’ levels at the local Technical College, getting a C grade in English and failing Social Studies. Currently he is working as a kitchen porter but only sees this as a ‘filling in’ job.

Account	Code/theme	Example from text
Clinical	Diagnostic transformation	probably has an underlying personality disorder but is definitely depressed
Clinical	Medication as answer	I have, therefore, prescribed him Prozac 20mg daily

Part 2: Assessment

Account	Code/theme	Example from text
Simon	Perception of lack of control / agency / passivity / power	You are ushered into the room The doctor asks you more questions: A short while later he concludes the interview
Simon	Perception of clinical staff / projections	Pale…insubstantial
Simon	Negative perception of other's perspective / heightened signification / non-verbal cues/ power / projection	You don't think she likes you very much. The nurse rolls her eyes behind the doctor. You assume that she is rolling her eyes at you. The Doctor looks up at you for the first time.
Simon	Implicit perception of power / structural power	The doctor sits behind his desk and the nurse stands behind him.
Simon	Sense of normal / diagnosis	The patterns do not fade away like they are supposed to.

Account	Code/theme	Example from text
		These images are known as afterimages and occur in persons with normal vision. These symptoms could be considered a symptom of early schizophrenia
Simon	Affect	I am in despair, you say
Simon	Diagnostic transformations	The doctor asks how long have you been depressed. How many times a day are you feeling despaired?
Simon	Resistance to diagnosis	You correct him. I am not depressed, you tell him. I am in despair.
Simon	Heightened sense of signification	The metaphysical significance of three then occurs to you immediately. *The unholy trinity*.
Simon	Institutional cross-referencing	When did you finish college? How are you finding your job?
Simon	Mistrust in process	What difference is this going to make? Scant offerings. Somehow it feels like something crucial is being missed.
Simon	Difficulties with cognition / dissociation	You are not holding things in very well anymore. There is too much in here already.
Simon	Medication as answer / power	The Doctor pushes a small plastic container across the desk towards you. You notice the container is laden with little red pills. The Doctor looks up at you for the first time. These are for you, he says. He smiles. These are for your…despair.
Clinical	Affect	Lacking lack of sensitivity, emotional flatness – i.e. lacks any sense of creativity, no motivation, no energy & no longer does not think he is depressed

Account	Code/theme	Example from text
		personally happy but about 3/12 ago have anxious ecstatic which was enjoyable. 2f in a frightening experience so he stopped it.
Clinical	Taking on board other perspective	Saw his G.P. & asked that he wants to see a psycho-analyst, (or psychotherapist as he told me now) does not think he is depressed
Clinical	Problem framing	Problem > Lacking lack of sensitivity, emotional flatness – i.e. lacks any sense of creativity, no motivation, no energy & no longer experiences pleasure or joy, feeling depressed
Clinical	Diagnostic transformations / implicit and explicit	gets better during the day but again despaired just before going to bed until he sleeps Inadequate P.D. with H/0 drug addiction Anxiety state & some social inadequacies
Clinical	Medication as answer	Med :- Prozac 10 mg pres. By G.P. 1/5 ~ ago but he has not take
Clinical	Inferred causality	It started from drugs:
Clinical	Risk	felt suicidal & needed urgent appt
Clinical	Internal contradictions	feeling depressed…does not think he is depressed… Doesn't look depressed
Clinical	Full life inventory (biopower?) / institutional cross-checking / Retrospective searching for signs of potential incapacity (search for meaning)	Lives with parents F49 √ [illegible] bus driver M50 √ (nurse in community. Closer. Bassington) Sib – 2b – Malesh 18 √ - Alex 15 √

Account	Code/theme	Example from text
		Maternal G. Father used to be physically violent to patient M & their sister otherwise no mental illness in family. Been working as a kitchen porter since July .94) → Effenwick Personal Born FBH, later birth (forceps delivery) Happy childhood. Had whooping cough for few months (4 yr old) School – left 18 3 GCSE 1 ‘A’ level good relation, no truancy. College – 1 yr English & sociology but left → C grade for English but failed sociology (doesn't do it again) 1st job the current one Thinking of going to night college to improve qualif [illegible] ?1st G.F. → Never had a G.F. “shy” Just social talking only Despair – 5-6 times/wk Smoking – 20 cig daily No without drugs for 1/12

Part 3: Ward Round

Account	Code/theme	Example from text
Simon	Heightened significance / paranoid interpretation	All you can think about is the significance of Dr Carver’s name and how this also fits together somehow. This is how it will happen, you think. Everything is building to this*. O golden child the world will kill and eat*.
Simon	Personal power	Throughout the week the other patients in the day hospital have told you stories about this Dr Cuthbert. They say he enjoys winding

Account	Code/theme	Example from text
		patients up. They tell you that the ward round is a ritual in humiliation
Simon	Structural / environmental power	The room is packed with people – at least seven or eight. You weren't expecting this many people. You open the door to the corridor and see the doctor running back to the ward round room. You don't know what to do. You are scared.
Simon	Time power	The meeting starts without delay and already you can barely keep it together.
Simon	Role power	Two officious-looking middle-aged men in suits at the head (doctors you assume) ask you questions. One of the doctors leads. What have been doing with yourself then, eh? How long since you finished college? When was that then? How did you do? I mean, what were your grades like? What's the plan for the future? The self-assurance in the doctor's blue-grey eyes seems to imply that the decision has already been made
Simon	Symbolic power	The doctor asks you whether you will consider being an inpatient. You can't keep your eyes away from the figure of the dark, hulking Victorian asylum with the barred windows that shimmer in the afternoon sun through the window opposite you. Will they drag you into the ward with straightjackets? Is that what happens here? The other man says nothing but swallows, then looks down. He seems to understand what this means.

Account	Code/theme	Example from text
Simon	Affect / fear	The fear is intense and overwhelming.
Simon	Uncertainty in response to power	You are barely keeping it together. The fear is intense and overwhelming. You cannot tell a coherent narrative. You keep contradicting yourself. You become so anxious you can barely talk.
Simon	Resistance to power / agency	You have had enough. You mutter something in a quiet, barely audible, mumble. You walk out. No, you tell the doctor, I don’t want to be an inpatient.
Simon	Double-bind	You are not sure why the doctor has left the room and whether you should wait for him to come back. What happens now?
Simon	Choice restriction / funnel effect	There is a brief moment of hesitation before you walk out of the hospital.
Mother	Affect - patient / Perception of patient affect / triggers / response or reaction to power	Simon came home from the day centre yesterday very disturbed and anxious.
Mother	Intimidation from service / power	He eventually told me that he had a meeting with the Drs and other people which made him feel intimidated.
Mother	Symbolic power	This obviously frightened him – he said he didn't want to be in a ward of mad people.

Account	Code/theme	Example from text
Mother	Cognitive difficulties / cut-off	The rest of the evening he spent drinking tea and chain smoking – very distracted – losing track of any conversation – unable to concentrate.
Mother	Resistance to power / Taking over agency / coercion	He refused to let me go back to the hospital with him the next day.
Mother	Backstage communication / going behind back / taking over agency	I had planned to go there anyway – but didn't want him to catch me there and go behind his back. I went to work and phoned the day centre – spoke to DM – she said she would arrange for Dr to see me elsewhere – – Simon still very anxious – refused to go to the day centre – so I went.
Mother	Distress / carer distress / impact	Unable to work I went home
Mother	Taking over agency	I told her Simon would be in late. Realised that he had to go in which at first he refused to do – eventually agreed.
Mother	Cross-source contradiction	They told when interviewed Simon was unable to concentrate and because of suicidal thoughts they felt he was unpredictable.
Mother	Pathologisation / diagnostic transformations	when interviewed Simon was unable to concentrate
Mother	Risk escalation	They told when interviewed Simon was unable to concentrate and because of suicidal thoughts they felt he was unpredictable.

Account	Code/theme	Example from text
		She did say that he had not planned how to do it which was a good sign.
Mother	Risk / self-harm	When I came home Simon had burnt his tee shirt and had scratches on his arm.
Clinical	Search for meaning / family dynamics / drugs	Need to look into family dynamics ? Started smoking marijuana after death of grandfather also note: maternal grandfather (the same) abused mother and her sisters
Clinical	Mistrust	Needs independent information
Clinical	Problem framing / diagnostic transformation / internal contradiction / coercion	? Do you see yourself as having a psychotic problem
Clinical	Institutional cross-checking	GCSE's English, Literature, History A-levels English and History but 2 fails "because of drugs and stuff" Left 6th form summer 1992 College Autumn 92 – summer 93 A-levels C for English and D for sociology Since then works in Effenwick as a kitchen porter
Clinical	Life inventory	Most of his friends unemployed "I just feel lonely"
Clinical	Patient resistance	walks out; when asked about the last ward round he said "Dr Cuthbert is too sleak"

Account	Code/theme	Example from text
Clinical	Institutional flexibility / coercion	Interviewed by Dr ---- “sad about being sad” Interviewed on his own = perplexed
Clinical	Diagnostic transformation / risk escalation	palinposia confirmed <u>Impressions</u>: probable early stage of schizophrenia, Simon’s presentation is quite worrying as he appears to be quite unpredictable
Clinical	Risk/self-harm / escalation / internal contradiction	thoughts about killing himself; but not current Risk of serious self harm
Clinical	Affect/cognition – negative	thoughts disappeared “mind goes blank” me and other Before this he would have strong opinions & would express them well now he is very passive.
Clinical	Medication as answer	- try on Trifluoperazine 10mg nocte concurrent with Procyclidine 5mg bd
Clinical	Coercive practice / backstage communication / risk escalation	- Simon’s parents need to be seen regardless of his refusal for further independent information and to share with them our worries 11:00 hrs Simon did not come to the day hospital but his mother came. Seen jointly with Dr Q.

Account	Code/theme	Example from text
		Admission offered.
Clinical	Coercive practice	- May be sectionable if not attends regularly at Day Hospital and refuses inpatient treatment Admission offered.
Clinical	Normality	Early waking is an unusual occurrence for him, always having difficulties in this area.
Clinical		Mother is very concerned about his unpredictability and lives in fear he might harm himself.
Clinical	Cut-off	He isolate himself from the rest of the family. Simon was still at home, looking in a world of his own, not acknowledging her when she spoke to him.
Clinical	Trust / faith in medicine	Mother would like to talk to a doctor.
Clinical	Risk / self-harm	Has agreed to come in voluntarily to hospital. Had burnt shirts & cigarettes? Scratches on limb.

Part 4: Admission

Account	Code/theme	Example from text
Simon	Dissociation / Passivity	They pack you into a car, on the way to the hospital. You are an observer to your experience. Passive.

Account	Code/theme	Example from text
Simon	Perception of medical staff – burn-out	You talk to the doctor. Bald, middle-aged, tired-looking. He asks you a series of questions. You say that there is nothing wrong with you and you are not sure why you are here. He throws you a baffled look. He does not look bothered. A nurse comes in, scolds the patients angrily, which they ignore, and then leaves.
Simon	Heightened sense of significance / symbolism / paranoia / projection	What's the matter? They say. We're not going to eat you. You freak out. Of course they are, you think, that is why you were sent here. As you lie on the bed looking up at the old Victorian ceiling and bay window, you have an overwhelming and crushing sense of déjà vu, that this will be the place that you will die and you have known this your whole life. At some point it occurs to you: they will steal all our money and frame us as paedophiles. Everything is significant. It all comes back to you. In the crowded lounge, it is overwhelming. Your parents walk in. The patient you are sitting next to turns to you and says, you didn't think he'd look up there, did you?

Account	Code/theme	Example from text
	Bullying / Power – patients / paranoia	They take turns freaking you out. One patient hands you a book called ‘The Lucky Loser’. Another time, you come into the lounge and four LPs have been taken out of their covers, the vinyl laid out on top of the record covers in a square. *The Four Zoas*. They can read your mind.
Simon	Sexuality	The women who is dancing falls between your legs and starts to try and unzip your trousers.
Simon	Affect	You go back to your room in terror
Simon	Self-harm	You take a knife from the kitchen. You have had enough. There is only one way out of this. You stab yourself several times in the head with it. The knife is blunt. It only makes shallow indentations in your skull. Your head hurts.
Mother	Internal contradiction / environment	The ward and felt comfortable about it even though it looks like a tip
Mother	Intrusive / medical gaze	Spoke to the admitting DR. who asked a lot of questions about him
Mother	Carer distress / reassurance seeking	Afterwards I asked for hope or indication he said the there is cause for concern
Mother	Loss of agency / double-bind	Leaving him in other peoples hands was awful
Mother	Carer distress	It was a shock to see him
Mother		The only positive thing he expressed was when I asked him if I could be present when DR Furbois sees him Monday and he said no. The DR at The Day Centre had said that he never wanted me present

Account	Code/theme	Example from text
Mother	Carer despair	Richard and I felt distraught when we left, we felt we had lost him and felt so down, the future looked bleak. It's like a bereavement, you've lost your son – he is there in body but [he'll or will] never be the same again
Mother	Carer despair / lack of agency	There seems to be nothing positive we can do but just be there
Mother	Iatrogenic impact of services – effect on carer	had slept a lot during the day. When we saw him, I nearly broke down – he looked so doped up
Clinical	Medical gaze	Remains on close observation.
Clinical	Coercion / diagnostic and medical transformation	Insight – doesn't know why he's here, thinking if he should go, but doesn't need much persuasion to stay.
Clinical	Institutional cross-checking	childhood but recently reported bullied & hated school Gradual decline in personality since 6th form (never had girlfriend)
Clinical	Diagnostic transformations	Imp 19 yr old m blunting of affect, loss of volition/self care. Despairing, increasing interest in psychology / philosophy, isolating self, day dreaming. Now mild thought disorder No persecutions or hallucinations ? Paranoid schizophrenia ? schizoid personality disorder ??
Clinical	Coercion / double-bind	Consider section 5(2) if wants to discharge self as set fire to self Friday & lacerations to foreman and has suicidal ideation
Clinical	Self-harm / risk	when he became very agitated. With the easy accessibility of knife on the ward, he got hold of a knife he was pacing up and down the kitchen, presumably pondering whether or not to harm himself

Part 5: Transfer

Account	Code/theme	Example from text
Simon	Bullying	winding up others with glee and then watching them unravel
Simon	Fear	You can’t take it anymore so you leave the ward, to go home.
Simon	Paranoia	Cars go by hissing insults
Simon	Faith/trust in medicine	Sorry, son, you need to be there. It’s killing us, but you need to go back. You need to be there
Simon	Coercion	If you’d like to come through here for a minute so we can have a chat? You feel he is being deliberately insincere, like he is playing a role, but you are not sure what to do.
Simon	Conformity	You say ‘jump’, he says ‘how high’ eh, Dave? He says with a laugh.
Simon	Paranoia	They are all witches. They have replaced the real staff.
Simon	Impact on staff / misrecognition	As the nurses lead you away to your room, you see the nurse taking her pendant off.
Clinical	Power – resistance / medical gaze	he will talk about general topics & when asked about his thoughts and feelings he refused to answer.
Clinical	Assumption	Explained to them that Simon was distressed when observing another patient’s disturbed behaviour.
Clinical	Medical gaze / diagnostic transformations	he’s clearly psychotically ill. Simon then left us. He – no insight ? partial: says he’s depressed with some peculiar experiences – delusions and hallucinations
Clinical	Coercion	The patient bed to be moved downstairs to Woodbrook I – a risk of absconding - Diagnosed psychotically ill by the consultant

Part 6: Intensive Care

Account	Code/theme	Example from text
Simon	Paranoia / misrecognition	Every person passing means something. Are you in trouble? Is this when they will transfer you to prison?
Simon	Chaos / lack of information and communication	Everything happens so fast. Activity, people rushing back and forth, police, ambulance, doctors, nurses. Comings and goings.
Simon	Misrecognition / fear	They tell you are going to be ‘sectioned’. You think that means you will be carved up into little pieces. You are holding onto this one book.
Simon	Despair	And then nothing happens for long periods of time and the ward feels almost empty. At these times, you wonder if you’ve been left alone and the world outside has gone post-Apocalyptic. And here you are, the last human being alive, wondering the corridors of a derelict psychiatric unit, until the end of time.
Simon	Internal contradiction / coercion / double-bind	Every piece of new information you give them throws you into a despair of panic. What did you do that for? How will they use that against you?
Simon	Misrecognition / Anxiety, Dread	Your eyes are being withdrawn into your skull like a winch which is being slowly wound by them, pulling the stalks into the sockets. You cannot see reality if they are pulled back just a fraction. You wonder if this is why you have always had problems.
Clinical	Care / gaze / double-bind / confession	I spent some time with Simon encouraging him to “talk”

Account	Code/theme	Example from text
		I spent here with Simon this morning explaining to him that he needs to tell staff about his experiences & also explained that the restrictions enforced were for his safety Simon did appear willing to talk but it was obvious he found it hard to trust me enough to talk of all his experience.
Clinical	Counter-conduct	He spoke a little about “going crazy” but would not elaborate On returning to ward he became extremely reluctant and placed his foot on the door and refused to come in.
Clinical	Carer distress / family dynamics	I spent more time with Simon and his mother together who appeared to need self support
Clinical	Agency / power (absence) / double-bind (for mother)	Apparently Simon was repeatedly asking his mother to take him home and she was becoming quite upset explained that the responsibility of deciding any leave or discharge has now been taken away from Simon and his mother and placed with the doctors here Given his previous suicidal attempt, informed Simon further escorted walks with nursing or his family will be suspended till reviewed on Sunday. Simon is still at risk
Clinical	Diagnostic transformation	Mrs Clarke requested that Simon has been reading a lot of psychological literature recently and had diagnosed himself as “schizoid
Clinical	Misrecognition	I asked him about the lacerating and burning he did on 23.9.94. He stated he felt “dead” and he was checking if this was true.

Account	Code/theme	Example from text
		Apparently he felt he was under surveillance last night by a group of doctors he found it difficult to accept this might not have happened.
Clinical	Affect – despair and dissociation	He said his emotions were flat he didn't feel himself hence the feelings hence the feelings of “deadness

Part 7: Leave

Account	Code/theme	Example from text
Simon	Normal / abnormal split – internalisation of institution / double-bind	The world is now ‘outside’ and ‘inside’ - the hospital, and everywhere else
Simon	Paranoia / misrecognition / anxiety	In the carpark, a woman takes a long lingering look at you, an expression of disgust on her face. On the way home in Dad’s minibus Chris Tarrant on Capital Radio is laughing about how you are being framed by being linked with the National Front. When you get home, two neighbours are talking and laughing together. As you and Dad walk into the home they stop talking and watch you. You presume they are laughing at you
Simon	Anxiety / dread / fear	What you been up to? *Running over the same old ground. What have we found?* I’ve been in mental hospital, you reply. Their smiles freeze in their faces. *The same old fear*. Then the smiles melt, like wax, with expressions of shock, horror, and concern mingling together. *Wish you were here*. Shit, says Stan eventually. Fuck, Si, says Lenny after that. They look at you with a mixture of fear and pity.
Simon	Misrecognition	You try and make small talk with each other but it’s no use. After a short while you excuse yourself and leave. We all thought you’d

Account	Code/theme	Example from text
		found a woman, Stan tells you much later. We thought that's why you'd disappeared.
Simon	Kindness – other patients /staff / recognition	At times, the small, homeless old man walks with you on these corridor circuits. Don't worry Simon, he says, might never happen. Walk with me, he says. Just keep walking. Stops me from getting lost, he says. The nurse at night, who brings you milk in bed even when you haven't asked for it, who sometimes gently taps you on the back before she leaves as if she's praying for you, doesn't quite fit your idea that everyone means you harm.
Simon	Power – counter-conduct /	You've been hanging around the door for days now, trying to make a go for it.
Simon	Misrecognition / lack of care	You rise quickly but sluggishly through the mist. Their faces are laughing at you through the narrow slit of a window. I just want my cigarettes; just give me my fucking cigarettes, you shout. Then the medication hits you with a head rush. You crumple slowly into the mattress.
Mother	Surveillance - panopticon	He has been on haliperidol 2 weeks. Last week he was very agitated. When Dr Furbois saw him, he presented himself quite well and I don't think the Haliperidol was changed – the depot injection was brought forward though .
Mother	Paranoia / misrecognition	This week he is not so agitated, more aware, but only of his paranoia Which seems to overwhelming him and he is unable to be distracted. 4 Simon Clarkes.

Account	Code/theme	Example from text
		Coming for me to-night. Patients think we are snobs. Staff “ “ “ “ Broken into bank account. Everyone knows of me and hates me. Patients/Staff read my mind – incriminate me.
Clinical	Iatrogenic effects	he says he only slept for 3-4 hours last night & the medication is sedating him heavily now He seemed concerned that someone had mentioned a depot injection to him – he says he’s worried about this and would prefer to take medication orally.
Clinical	Care / coercion / double-bind	Conversation was fluent and involved equal interaction from Simon and myself.
Clinical	Patient coercion / playing at being sane	He intends asking Dr Furbois for weekend / overnight leave. Says his thoughts improved tremendously. “I used to think evil spirits were after me”.
Clinical	Misrecognition	17.10.94 20.10 Nursing. Seen at the ward round appeared to cope well with the amount of people present and expressed himself well. He can have weekend leave and can go out for escorted walks.
Clinical	Loss of agency	He can have weekend leave and can go out for escorted walks. Although Dr Furbois is aware that Simon feels drowsy he feels it would be wise to review medication next week. Dr Furbois will see Simon’s mother on Wednesday. His mother feels that he should come back to Woodbrook 1 in the morning and stay here till Monday’s ward round. But would like this message to be given by [illegible] following assessment tomorrow.

Account	Code/theme	Example from text
		They feel that he should not go the 'Pink Floyd' as it would be too stimulating. I have asked Louise relay the message that we are quite prepared for Simon to return for further assessment if things are difficult at home, as previously relayed to Mrs Clarke.
Clinical	Surveillance / panopticon	N. report 21/10/94 Nursing 16.00 Message received from S/W Louise M. Simon mother rang Louise to reiterate that the Dad's unable to cope presently with Simon at home. He "is very suspicious about letters coming into the home". He has gone to his room, pulled the curtains and stayed in his room. He is according to his mother reluctant to take medication & mothers impression → poor compliance with oral medication on discharge
Clinical	Internal contradiction	Attended a football match when.
Clinical	Diagnostic transformation	he felt uncomfortable being in a crowd and the urge to walk about → ? anxious / akathisia
Clinical	Power – counter-conduct or resistance	Throughout "struggle" Simon was persistently resistant and it took a great deal of man-power and effort to restrain him; he looked incredible perplexed and seemed unable to comprehend why we are keeping him here – he did not seem particularly sensitive to restraint techniques and fought and fought incessantly.
Clinical	Bureaucratic transformation	Seclusion commenced at 18:25hrs, bleep-holder, doctor, and next of kin informed. Relevant documentation completed. Remains on close observation. BP – 130/90 mmlg, pulse 84.6 bpm

Account	Code/theme	Example from text
Clinical	Linguistic transformation / misrecognition	Simon returned from time out
Clinical	Misrecognition	He believes that that tonight the patients are going to kill him he wanted me to let him home so he had a quiet death rather than be “torn apart”. No words reassure him, he’s convinced it is going to happen.

Part 8: ECT

Account	Code/theme	Example from text
Simon	Misrecognition	Another piece of paper; something else to sign. ECT they tell you. We need your consent. Do you have a choice? I mean, really have a choice? This is part of the plan. The final act. They will cement your brain so you will never be able to access the spiritual world (their world) again.
Simon	Double-bind	What if you don't sign? Two seconds and a sigh. You sign. Crushing shame, despair. Terror. What if you didn't sign? Why did you sign?
Simon	Power – counter conduct	One small act of rebellion. You drink water the night before. Brief respite. Relief, however fleeing.
Simon	Care / coercion / double-bind	You are escorted, politely but firmly, by the nurse you know to the corridor at the back of the ward, which has always been closed. Now, it is open. You walk into the room. Three nurses you don’t know. One of them is very friendly.

Account	Code/theme	Example from text
Simon	Dissociation	Your escort chats with the other nurses and leaves with a quick nod to you. Good luck, she says with a smile.
Simon	Paranoia / misrecognition	That’s it they say. You can go now. But nothing happened, you say. They laugh. It’s over, finished. That’s all it is. You leave the room, bemused, rubbing your neck for some reason. Was this a charade? Some elaborate game? All part of the plan? Are they taking the piss again?
Simon	Iatrogenic effects	Something has gone. Was it valuable? After the scratch, you feel yourself descend in and out of consciousness, like a camera lens trying to focus. The hysterical beeping of the machine changing pitch and tempo with the camera lens. When does this stop? Things seem different. You are more aware and yet more foggy. Clarity has been gained at the price of something else, which you can't quite identify. This time there is a que for the ECT. You sit there in line with the old ladies, most of them quiet and immobile and wearing fixed expressions of horror, despair or confusion. After their course of ECT, they take the old ladies to the ward hairdresser to get their blue rinse done, as a treat. You wonder why they haven’t combined the ECT and the rinse together to save money.

Account	Code/theme	Example from text
Simon	Misrecognition	For the first time, you join in the conversation with other people, this time the cleaner and another patient. You are shocked to find they don't hate you. You ask them, but don't you hate me? O no, they say, you are far too nice. But what about the money? They laugh, that's your paranoia. Really? You get an inkling that you may have actually been wrong, or what it means to start playing at being sane.
Simon	Despair / dread	Barry, the elderly patient, hunched and grunting, beard and dreads now shaved, has put drawings up on the wall. This one catches your attention: a picture of a blue amorphous blob with the barely legible scrawl underneath, "you are that drop of rain that falls on good earth and is gone forever". That's you, that is. You cry.
Simon	Medical colonisation / transformation	Mum and Dad are happy. Mum tells me when she knew I was getting better when she saw me in my glasses; Dad says to me, that (place / treatment / doctor / ECT – *delete as appropriate*) sorted you out. This disturbs you, but you can't exactly say why.
Mother	Medical transformation / panopticon	15th Nov – Simon yesterday was asked by Dr Furbois if would have ECT treatment. Drugs change. Trimipramine 150ml Depixol 40 mg weeks. Chlorpromazine prn.
Mother	Misrecognition	Simon said he would not have it as he was not ill. He seemed very tense and I would not take him out for a walk due to his intensity and I was on my own.

Account	Code/theme	Example from text
		Said that the medication was useless, made him worse, and that he didn't need it. Other patients had come off it and were better. Said he wasn't going to spend rest of his life on medication.
Mother	Double-bind / loathing	Get me out of there' Stick up for me once in your life. Don't be passive. Someone in there tried to kill himself & he was out in a week. I'm not paranoid anymore (was yesterday/still is
Mother	Paranoia / misrecognition	Paranoia seems to obsess him and he was unable to think of anything else. Paranoia intense. 8) Patients had taken his back door key and got into information on our bank and we were ruined. This had happened on Woodbrook 2. 9) Whole world knows about him, through television. 10) People/patients read his thoughts. 11) Staff want to get rid of him because he's too much trouble. 12) "We're finished"? 13) His life is over. 14) Every time someone walks by he thinks they know him, says everyone in the hospital knows him. He went over the common today, there's still some paranoid, he said something funny is still going on. Some boys on the common pointed to him and laughed. I also told him that the week before he last he thought the house was bugged and he replied 'I think it is'.

Account	Code/theme	Example from text
Mother	Double-bind /	Richard took him out later but the visit was not so good, he wanted to get back to the ward quickly to feel safe.
Mother	misrecognition	He had been up to Woodbrook 2 to see Bobby and he saw Nathan who bothered him. We told Jenny later. She said it was because he was not happy on Woodbrook 2 & it brought back bad memories.
Mother	Bureaucratic transformation / care	17th Nov. Simon didn't have ECT as staff wanted Dr Furbois signature on form and he was not available. Although Simon had signed the form last night he was, they said, still undecided this morning.
Mother	Gaze	25.11.94 Simon had ECT Thursday (24th). When anne & I saw him later he see was wearing his glasses!! He was alert and seemed hyperactive.
Mother	Iatrogenic	We had to go back for some panadol for his headache. He said Wednesday morning that he felt like a senile old man
Mother	Medical transformation / misrecognition	He was disturbed to find that Dr Sheik had written on his v. Ray form "paranoid schizophrenia'. Penfold said he will look into it for him.
Mother	Coercion / panopticon / misrecognition	Picked him up to come home for the night. He was disappointed it was not 2. We had an argument in the car. He does not want us to crowd him, and will [illegible] be strict with him when he's home. He was angry that we had phoned and told staff how he was yesterday

Account	Code/theme	Example from text
		Found out later that he had two ‘puffs’ How disappointing that he has such a lack of control and insight into his condition. Especially after being told specifically by Penfold
Clinical	Anxiety / dread	14/11/94 Dr Furbois W/R 15.45 Patient is seen :- not too good, still worried about his safety, people want to harm him, made poor eye contact, restrict in his answers, with a flat mood, believes he will be sent to prison. Denies hallucinations. His brain is dead. Cannot read, delusions of reference from radio. Still suicidal risk wishes he could die, life is useless. Simon is apparently deteriorated.
Clinical	Bureaucratic transformations / misrecognition	16/11/94 Discussed with father and patient about ECT treatment. Patient agrees to have ECT. Consent √ ECT prescription √ 0900 BP 140/90. Temp 37. Pulse 76 24.11.94 Had 1st ECT good Bilateral contraction lasted 24 secs
Clinical	Contradiction	5 /12/94 nursing 1300. Simon had 4th ECT. 23 sec. fit, good recovery, returned to ward. Continues to feel he is “in big trouble” – worried about people getting his money. His mood appears brighter, mixing with fellow patients, went for short walk returned without any problems.

Account	Code/theme	Example from text
Clinical	Power – counter conduct	all he talks about is going home or going out for an hour or going out on his own. He doesn't listen when told it is not possible.
Clinical	Power – coercion / medical transformations / misrecognition	Keen to work out a discharge plan more appropriate, realistic.
Clinical	Medical transformations / iatrogenic	8/12/94 nursing 10.10. Simon had ECT this morning and a good fit. Was very confused when he woke up.

Part 9: Discharge

Account	Code/theme	Example from text
Simon	Misrecognition	Every day you pass the hard-looking man on the corridor, with just a nod of recognition both ways. This has been going on for two months. This time as you pass you ask him whether he was brought in from the local prison. No, he says baffled, I had a breakdown. I saw God he adds with conviction. Sorry, you say, ashamed. She was kind to you and you are being selfish. It’s your hell: you live in it! You ask him about it much later and he says he has no recollection of saying this. You realise he doesn't even remember who you are.
Simon	Double-bind / misrecognition	The way you think of it now is as an exchange: they don't want you here because they need the bed; you don't want to be here at all.

Account	Code/theme	Example from text
		But they need valid reasons to let you go, and those reasons are connected with your symptoms.
Simon	Double-bind / misrecognition / despair	You are going home a lot now. You keep your thoughts to yourself. It seems to work. You feel like going to bed and not getting out again.
Simon	Double-bind / anxiety	What if this is part of the previous game? Or were they just voices in your head? Or did you just misinterpret what you heard? What if there is no game?
Mother	Misrecognition - symptoms	Feels Worse in the mornings – hallucinates – but voices don't speak – it's like he hears things & thinks its about him.
Mother	Misrecognition of suffering	Says – hes now believes that he has a serious mental problem that may be permanent.
Mother	Despair / alienation	Doesn't think he will get any better. He went out with his friends. Feels very lonely – doesn't seem to have much in common any more with his friends.
Mother	Misrecognition / double-bind	14.1.95 These past few weeks Simon has been so happy. There has been no paranoia . When asked he says he still has it but that it is fading.

Account	Code/theme	Example from text
Mother	Internal contradiction – both in terms of account (reported paranoia earlier) and in contradiction with nurses' report	These past few weeks Simon has been so happy. There has been no paranoia .
Mother	Misrecognition – who's problem?	His main problem at the moment is getting up in the morning. Because he gets up so late he is unable to go to bed early – visious circle.
Clinical	Internal contradiction – reported being not too bad but lots of paranoia	19/12/94 1600 According to the mother's information Simon not too bad, he is quite and comfortable. She reported that Simon is still have lots paranoia e.g. That patients at Woodbrook I keep his keys with them. that everybody knows about his delusions because they talked about him in the TV She also stated that Simon became a bit depressed possible due to his realization that he is mentally ill
Clinical	Treatment	Mrs Clarke thinks that Simon needs someone to talk to about his feeling preferably on a weekly basis, and to focus on something, he doesn't need to come back into hospital now but to be given more freedom with some rehab programme
Clinical	Misrecognition	16.15 Simon feels generally alright, although still underneath some paranoid ideas but not to the extent of interfering with his usual routine.
Clinical	Misrecognition - suffering	Simon by Dr Furbois's opinion is much more better, healthier.