

Identity and Multiple Admissions to
Psychiatric Hospital: A biographic
narrative study of the experiences of
patients

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A Thesis submitted to the School of Health and Social Care in Partial
Fulfilment of the Requirements for the Degree of

Doctor of Philosophy

Bournemouth University, Dorset U.K.

September 2008

ABSTRACT

A small percentage of mentally ill patients, sometimes referred to as 'revolving door' patients, are frequently readmitted to psychiatric hospitals. This study explores how these patients construct meaning and reality and how this enacted reality provides a context for shaping their identities. The study draws on mental health policy, political ideologies and the history of deinstitutionalisation in order to illuminate this problematic phenomenon. The study is framed within the social sciences, but more specifically within the fields of mental health and social work practice.

The methodology is qualitative, placing emphasis on a hermeneutic phenomenological approach. The foundation of the study is underpinned by a social construction and social psychology framework. A unique minimalist interview technique based on the Biographic Narrative Interpretive Method is used for data collection and analysis.

Data from seven interviews with participants are presented followed by the researcher's reflections on the interviews and post-interview process. The life stories of four of the seven participants are analysed by using reflective teams. The *lived life*, or chronological chain of events as narrated, is analysed sequentially and separately. The *told story*, or thematic ordering of the narration, is then analysed using thematic field analysis; this involved reconstructing the participants' system of knowledge, their interpretations of their lives and their classification of experiences into thematic fields.

An integrated procedure of abductive and inductive analysis of the stories elicited from participants offered immense potential for constructing meaning. Perspectives

on 'revolving door' patients have often regarded them as having a one-dimensional life. This study revealed that these existential lives are complex and diverse and exist within a cultural matrix of social and psychological constructs. Interpretations of these patients' experiences illuminate the complexities arising from multiple admissions to psychiatric hospitals and highlight the problematic aspects which impact their socially constructed identities. These case studies of 'revolving door' patients' personally narrated lives extend the social psychological study of self/identity and contribute to the field of mental health research.

Keywords	Identity, self/identity, adults, patients, narrative, biographic, mental illness, schizophrenia, bipolar disorder, readmission, psychiatric hospital, community care, multiple admissions, revolving door phenomenon, social constructionism, post-modernism, social work, social psychology.
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ACKNOWLEDGEMENTS

First of all, sincere thanks to the seven individuals who willingly consented to participating in this study, giving unsparingly of their time and sharing their personal experiences. I trust that this research will accurately and sensitively reflect the strength of feeling that was communicated in the interviews with them.

I want to thank Michelle Jeyreratnam, Assistant Director, Hertfordshire Partnership Foundation NHS Trust, for giving me the opportunity to begin the research in the first instance, and the West Hertfordshire NHS Research Ethics Committee, which approved the study and gave permission to begin the research. It was an arduous task, but approval was ultimately gained.

I am deeply indebted to my supervisors Dr. Kip Jones, Prof. Kate Galvin and Dr. Carol Lewis, whose help, stimulating suggestions and encouragement helped me throughout the research and writing of this thesis. I would further like to thank Dr. Kip Jones, for whom I have the highest regard. It was his innovative research method that I adopted and that made this study possible.

In fact, the method was first developed here in the UK by Tom Wengraf, from the original method by Gabrielle Rosenthal in Germany. It was Tom and Prue Chamberlayne's teaching of the method that gave strength to this inventive approach to social science research. I owe them a great deal for imparting their knowledge and for their valuable comments on drafts of this thesis.

I owe a great deal also to the service users, community mental health team colleagues and the members of the public whose intuition, knowledge and perspectives enlivened the reflective team's interpretive process.

I am also grateful to Dr. Elizabeth Sullivan and Dr. Robert Johns who were my supervisors at De Montfort University before I transferred to Bournemouth University. It was their considerate guidance that helped lay the foundation on which I was able to become an independent thinker.

My parents, my brother (Devon) and two sisters (Icolyn and Shernette) have always supported me in so many ways, and I wish to thank them infinitely for everything. I

am particularly indebted to Gretel Bruce, my social work colleague, who showed interest in my study and gave me encouragement and advice along the way. I would also like to thank my long-standing friend Dian West, whose motivational words gave me the confidence to successfully complete this study. I would like to give special thanks to my partner Kecheng Yin, whose patient love enabled me to complete this work.

Finally and most importantly, I would like to thank God for giving me the physical and mental energy to accomplish this study.

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CHAPTER I

INTRODUCTION

A beginning is only the start of a journey to another beginning.

(Thinkexist.com 2008)

This chapter introduces the thesis *Identity and Multiple Admissions to Psychiatric Hospital: A biographic narrative study of the experiences of patients*, before presenting the study which will be examined in more detail in the scope of this thesis. The historical context of readmissions is described, including the Biographic Narrative Interpretive Method (BNIM) (Jones 2001; Wengraf 2001), which was adopted as the data collection and analysis tool for this study. This research project is a narrative study of the self/identity of patients who have had multiple admissions to psychiatric hospital, from a psychosocial perspective, as delineated by Erikson (1980). Key concepts such as identity (Erikson 1980; Ricoeur 1981, 1992; Breakwell 1983, 1986, 1988; McAdams 1993), mental illness (Porter 2002; Szasz 1973, 1974, 1987; Foucault 1967, 1973; Goffman 1961, 1970), social construction (Gergen 1982, 1994, 1995, 1999) and post-modernism (Heidegger 1927/1962; Lyotard 1984; Best & Keller 1991) are also introduced.

A variety of terms will be used in this thesis to denote mental health, including mental illness, mental distress, psychotic and mad. This is to reflect the diversity of interpretations of this phenomenon among those who are experiencing such problems and those hoping to help them. People identified as having a mental illness often identify themselves and are identified by the terms *patient*, *client*, *service user* or *customer*. In this thesis no one term is privileged over another because all are equally meaningful or meaningless, depending on the perceptions and experiences of individuals.

1. Background

Over the past five decades, Western psychiatry has witnessed the deinstitutionalisation of the mentally ill (Pilgrim & Rogers 1999). This period, however, has also seen an increase in the percentage of patients being readmitted to hospital (Goodwin 1997). Today, in accordance with the NHS and Community Care Act (Department of Health 1990), many of the services for people with severe and enduring mental illness are provided within the community. While most of these people manage to live in the community without major disruption to their lives, some are readmitted to psychiatric hospital. These individuals have come to be referred to as 'revolving door' patients (Haywood 1995).

Any crisis requiring admission to a psychiatric hospital (whether voluntary or involuntary) is, more often than not, followed by a period of stability of varying duration, discharge, exacerbation of the illness and then relapse, leading to readmission (Goodwin 1997). This cycle is illustrated in Figure 1.0 below.

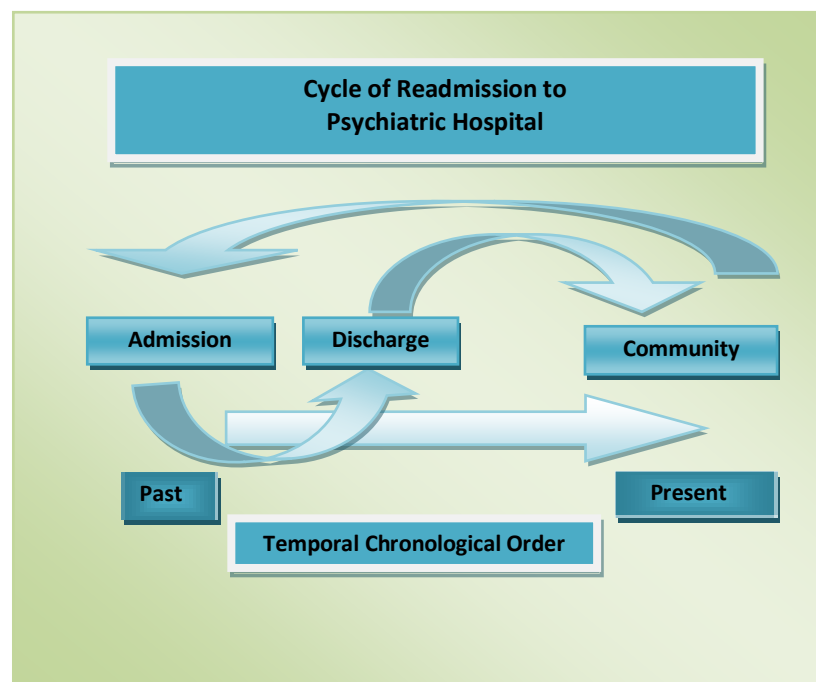


Figure 1.0 Cycle of Readmission to Psychiatric Hospital.

Not surprisingly, the revolving door phenomenon has raised many questions about the effectiveness of community care (Department of Health 1994) and particularly the

way that the mentally ill are regarded by society in general (Bartlett & Wright 1999; Perkins & Repper 1996). Certain high-profile cases (Department of Health 1994) have added to the debate on whether the closure of several large hospitals was indeed of any benefit to the patients themselves (Reith 1998), particularly since stigma remains a prominent problem of a patient's everyday life (Bean 1993). A study comparing the status of state mental hospitals in the United States between 1949 and 1988 found that admission rates in 1988 were nearly double those in 1949 (Stiles, Culhane & Hadley 1996). Similar trends have been reported in Denmark, Italy, Sweden and many other countries (Goodwin 1997 p. 91). In 1989, Britain reported a more than three-fold increase in the admission rates (Goodwin 1997). During this period hard-line plans to close psychiatric hospitals were implemented. The plans, based on policy measures of the 1970's, focused on moving funds from the National Health Service (NHS) to local government (Department of Health 1999). The key policy decisions during this period (1980's – 1990's) included the following:

- Large-scale institutional closures in the second half of the 1980's; Deinstitutionalisation became tacitly accepted as general policy.
- The NHS and Community Care Act 1990 – Care in the community was implemented.
- Major legislative reform aimed to close the social security funding and to impose on local authorities the responsibility for funding residential care.

By 2000, entire populations of the old asylums were discharged to the community, allowing the institutions to close. In England and Wales 100 of the 130 psychiatric hospitals disappeared and, with them, the most visible embodiment of stigma, the unmistakable architecture of the old asylums: remote, forbidding and with a palpable aura of incarceration (Leff 2005 p. 95). In 1999, the government published the National Service Framework to guide its investment of 700 million pounds to improve mental health services (Department of Health 1999). The National Service Framework capped a decade of activity, which successfully transferred long-stay patients to community settings, but has yet to resolve the problem of 'revolving door' patients.

According to Rogers and Pilgrim (2001), factors contributing to hospital closures and deinstitutionalisation can be summarised as follows:

- Introduction of new anti-psychotic drugs
- Economic and fiscal determinants
- A shift from chronic to acute problems
- A shift in psychiatric discourse

Another major factor which influenced deinstitutionalisation was a general shift in the disability paradigm, that traditional models of disability tend to start with the basic premise that mental illness is located within the individual (Conrad 1981 pp. 103 - 109; During 1992b pp. 40 - 41; Torrey & Hafner 1983 cited in Davidson 2003 p. 5). A contemporary approach, however, tends to move away from a purely medical model. Mental illness under this model is seen as a social construction (Conrad 1981; Gergen 1995 pp. 23 - 26; Ingleby 1981).

At the same time, different definitions have been used to describe the 'revolving door' phenomenon, varying in the number of readmissions and the period in which they occur. Kaustup (1987) defines 'revolving door' patients as those having three to four admissions within a follow-up period of five to ten years. In this study, I regard 'revolving door' patients as those having more than two admissions to psychiatric hospital within three years of the first admission.

2. Methodology

This study takes a qualitative and exploratory approach to the topic, focusing on psychiatric patients' stories as part of collective case studies. I decided to use open-ended biographic narrative interviews based on the protocol of the Biographic Narrative Interpretive Method (Wengraf 2001) for data collection and analysis. From this point onwards BNIM will be referred to as the Method for simplification. Roberts (2002) defines biographical research as:

Research undertaken on individual lives employing autobiographical documents, interviews, or other sources and presenting accounts in various forms, for example, in terms of editing, written, visual or oral presentation, and degree of researcher's narration and reflexivity (2002 p. 176).

The Method is traditionally used in social sciences research that has focused on life-story research (Hollway & Jefferson 2000). It was constructed from interactionist and phenomenological research by Rosenthal (1993) and Fischer-Rosenthal (2000) in Germany, who developed a narrative interviewing technique based on Overmann's 1979, 1980 hermeneutical case construction, and Schütze's 1983 method of story and text analysis (cited in Wengraf 2001 p. 112). The Method hinges on the fact that it uses a single, initial narrative-inducing open question to generate an extensive, uninterrupted narration, thereby maintaining the gestalt of the participants' story (Wengraf 2001). This enables participants to set their own agenda and pace and, therefore, to have greater control in the interview situation (Rosenthal 1993).

Engaging in open dialogue, the Method offers each participant the potential to speak in his or her own voice, to tell their stories in their own voices without recourse to structured questioning (Mishler 1986). Interestingly, *voice* has become a term used to denote a collaborative relationship between researcher and the researched. In this relationship, dominant voices take a lower place to the voice of people more used to being oppressed and silenced (Hadfield & Haw 2001 p. 487). Britzman, cited in Hadfield and Haw (2001), says:

Voice is meaning that resides in the individual and enables that individual to participate in a community ... The struggle for voice begins when a person attempts to communicate meaning to someone else. Finding the word, speaking for oneself and feeling heard by others is all part of this process... Voice suggests relationships: the individual's relationship to the meaning of her/his experience and hence, to language and the individual's relationship to the other, since understanding is a social process (2001 p. 487).

Riessman (1993) states, 'We cannot give "voice", but we do hear voices that we record and interpret'. An important point to note, is that 'voice' or 'voices' in this study does not refer to auditory hallucinations, as in the case of someone who is thought to be mentally unwell. Instead - unless otherwise stated - it refers to the situation where a person's views are not listened to because of some overriding opinion of the listener.

In order for me to elucidate participants' life stories, particular attention was given to the critical events and challenges they have faced and the way in which these events

have influenced their personal sense of identity. These life story accounts were authentic because they were given by the 'real' voices of those who had the experiences.

Generally, data analysis and interpretation follow the interview stage; however, the process can also be regarded intersubjectively as being present from very early on in the study (Hollway & Jefferson 2000 pp. 65 - 67). Since a reflexive relationship existed between me and the participant, I also analysed the dynamics of the interview and how this has affected my contributions to the construction of meaning throughout the research process.

Furthermore, I used an inductive approach to analysis, based on 'objective hermeneutics' and which is within the protocols of the Method (Wengraf 2001 p. 2). This, in essence, allows research findings to emerge from the frequent, dominant themes inherent in raw data, without the restraints imposed by structured methodologies (Thomas 2003). My aim was to understand the subjective understandings that patients have of their lived experiences and how these understandings inform personal constructs used for making sense of themselves.

A unique and interesting element of the Method's analysis process is the use of the reflective team approach. Using a reflective team approach to data analysis facilitates the introduction of multiple voices and opens up the possibilities in interpretation, rather than relying solely on the principal researchers' interpretation of the interview (Jones 2003). A prerequisite for the participants of the reflective team is openness and creativity/imagination, rather than knowledge of specific research methods (Jones 2003).

The Method is different from semi-structured or structured interviews that try to elicit facts particular to a researcher's own interests. The Method has relevance in this study because this research population has a tradition of not having its experience of living with severe and enduring mental illness explored in any meaningful way. Moreover, the choice of qualitative methodology is fundamentally linked to theoretical perspectives of phenomenology, social constructionism, symbolic interactionism and

ethnography. It provides, therefore, a framework for thinking about the phenomenon of 'revolving door' patients in the widest possible sense.

I first came across qualitative methodological techniques such as Smith's (1995, 1996) *Interpretative Phenomenological Analysis* and Crossley's (2000a, 2000b) *Narrative Analysis* at a conference at the University of Surrey, Guildford, in 2002. At that time, I had a keen interest in McAdams' (1993) autobiographical method as a potential method for my study.

In 2003, I attended further narrative training conducted by Dr. Corrine Squires at the Centre for Narrative Research, University of East London, where I was introduced to a wide range of skills for analysing short - and long - spoken narratives, lived narratives, and the impact of cultural narratives. In addition to this, I attended a conference in Swansea, Wales, in May 2003, where Dr. Kip Jones introduced me to the Biographic Narrative Interpretive Method. It was there that I realised the potential of this data collection and analysis tool for this particular research. Subsequently, I chose the Method to investigate patients' subjective experiences of multiple admissions. Since Swansea, I have attended further training in the Method at De Montfort University organised by Dr. Jones, who fortuitously became my first supervisor for this research project. I also attended a five-day intensive training in the Method in 2004, conducted by Prue Chamberlayne and Tom Wengraf.

3. Justifications for the Research

Because I see all people as being suspended in 'webs of meaning' based on their social and cultural context, I wanted to identify what factors were at play in shaping identity and a sense of self. I was particularly drawn to the study of people with severe and enduring mental illness through my employment as a mental health social worker.

In reviewing the literature on psychiatric patients' experience of multiple admission to hospital, it emerges that, while there are historical accounts of the changes in services and the treatment for mental illness, very little is recorded about the personal experience of the patients themselves (Beveridge 1998; Canvin, Bartlett &

Pinfold 2002). In fact, Cooper and McLees (2001 p. 500) state that 'readmitted patients have rarely been investigated in the UK'.

Medical researchers and pharmaceutical companies have written about the effects of medication and the illness itself, but not from the patient's viewpoint (see for example Conte, Ferrari, Guarneri, Calzeroni & Sacchetti 1996). These findings add to the view of Dahlberg, Drew & Nystrom (2001) that 'much of the insight of individuals with a severe and enduring mental illness remains relatively private and that, by excluding their stories, we are, in effect, omitting a large and essential body of information'. Pilgrim and Rogers (1999) also argue that clinical research in the area of mental health has tended to exclude the views of patients or to portray them as passive objects of study.

At the same time, a number of reasons have been given to explain this scarcity of representation of people with mental health problems within mental healthcare research, two of which are:

- The assumption that the views expressed by psychiatric patients will be irrational or unreliable because of the state of their minds (Dworkin 1992 pp. 59, 62, 69; Pilgrim & Rogers 1993 pp. 6 - 10).
- The assumption that research involving mental health users may cause distress by encouraging them to recall unhappy events or experiences that they may prefer to forget (McIver 1991).

Ironically, many patients have written extensively on their experience of mental illness, but independent of empirical research (Hornstein 2007). In spite of this, mental health professionals have often overlooked these accounts because the patients are considered to be too negative in their attitudes towards mental health services.

There is also the concern that some patients may not have a story to tell (Muller 2000b). In 1972 Peter Sifneos introduced to psychiatry the term '*alexithymia*' (cf. Muller 2000 p. 1). This is a construct for characterising patients who seem not to understand the feelings they experience and who seem to lack the words to describe these feelings to others.

Muller (2000 p. 1) argues that not having a story to tell almost certainly implies an impaired identity. This argument, according to Muller, is based on the understanding that who we know ourselves to be depends heavily on the story we tell ourselves about who we are.

Mclver (1991) identifies the vulnerability of these patients and the difficulties in achieving a representative sample, and the importance of asking the right questions in an appropriate manner. However, Mclver also believes that researchers can overcome these problems. She states that, 'by using qualitative research methods, such as unstructured interviews, research can establish the service user's agenda of importance. In fact, the use of interviews gives voice to service users who are not able to read or write, or who feel unhappy about questionnaires' (Mclver 1991 p. 12).

As a mental health social work practitioner, I was already aware of some of the stories told by the many patients with whom I have had the privilege of working with. Despite this awareness however, I was always conscious of a gap in my knowledge about what these patients tell us about multiple admissions to psychiatric hospital.

A literature review revealed the relatively little empirical social psychological research on patients' perceptions of multiple admissions to hospital. I began my metaphorical journey in many ways like a true explorer with apprehension and anxieties, simultaneously excited and daunted, not knowing what lay before me in terms of possible discoveries. I was however, motivated largely by a desire to understand more about the processes that make individuals and society in general work. More to the point, I was inspired to make the world more intelligible by adding something to the field of knowledge.

In many ways I began this research study from a position of ignorance; Borrowing a quote from Socrates, "thinking that I know something, but knowing little or nothing" (Reeve 1989 p. 11). It was precisely a lack of knowledge and real understanding of the experiences of these patients that inspired me to embark on this particular research topic. My ignorance was set against a background of ten years' post qualifying as a mental health social worker and having additional qualification as an Approved Social Worker. Yet, despite these achievements, I still did not have all the answers to the many questions in my head.

For example, I was interested in the following questions:

- What does it mean for a patient to revolve in and out of hospital / the mental healthcare system?
- What is the relationship between the patient and society?
- How can the relationship be explained through a psychological point of view?
- What role does socially constructed identity play in how a patient manages integration / reintegration into the social environment having had these experiences?

Much inspiration for this study came from these provocative questions. My theoretical interest in socially constructed identity was influenced by Gergen (1991) '*The Saturated Self*', and Breakwell's (1986; 1988) '*Identity Process Theory (IPT)*'. IPT proposes that the structure of identity is a dynamic social product of the interaction between societal structures and processes which constitute the social context.

In addition to the above, it was the key figure of Socrates and his insight that the beginning of wisdom lies in recognition of ignorance (Stone 1988 p. 39) that started me on my journey of discovery. By asking questions and through dialogue, Socrates taught that one can reach an understanding of how experiences can be a guide for understanding actions (Stone 1988). Socratic questioning, therefore, was at the heart my critical thinking. I used this thinking process to access and reflect on the assumptions underlying others' and my own ideas and actions. It is a simple yet effective method of exploring ideas or statements in depth.

In the fifth century B.C., when Socrates was declaring his ignorance and asking questions, he was probably standing in the middle of Athens in the marketplace. It was where people came to buy and to sell, but it was also where people met and exchanged ideas (Stone 1988 pp. 120 - 121, 207 - 208).

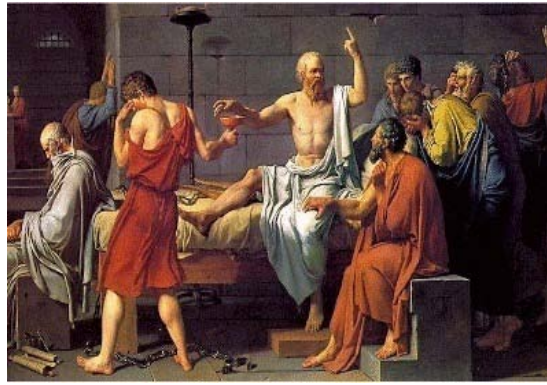


Figure 2.0 'The Death of Socrates', 4th Century BC

In spite of Socrates' arguably self-inflicted demise, he succeeded in providing methods and procedures for philosophical inquiry which have been in use right up to the present time. Figure 2.0 above conveys the sense of the loss experienced by Socrates' students and admirers. The face-to-face interaction of that time and the exchange of ideas through dialogue must have been a stimulating occasion. Imagining what that must have been like to experience also caused me to think about ways of disseminating the findings of this study.

Today the concept of a place where ideas are exchanged can now be thought of in terms of the medium of communication belonging to our present time. This variety of communication is especially important, as it offers possibilities for wider dissemination of qualitative research. Indeed, interest in the area of performative social science, pioneered by Dr. Kip Jones over the last few years, has been lively.

Finding himself dissatisfied with the limitations in publication and presentation of his own biographic narrative data, Jones (2006) looked to the arts and humanities for possible tools which might be transposed in order to better disseminate his narrative interview material (p. 67). What he discovered through *Performative Social Science* was a dynamic and essentially aesthetic method for disseminating research in the social sciences.

4. Summary

In this introductory chapter, I have demonstrated the fact that the experience of having multiple admissions to psychiatric hospital has not been addressed in depth and in a meaningful way within medical and sociological research spheres. Quantitative and positivistic approaches have been criticised, and I have tried to highlight the need for qualitative methodological approaches to help us understand the experiences of a disparate group of people such as those suffering from mental illness and experiences of multiple admissions to psychiatric hospital.

I have also shown that the Biographic Narrative Interpretive Method belongs to a growing branch of qualitative methods that focus on the story, its composition and its telling, and that it is a useful data collection and analysis tool for understanding the psychology/subjectivity of the individual. While there are some barriers to interviewing this particular research group – such as the possible difficulties of narrating a coherent story in times of crises, when personal identity is necessarily in a state of confusion and flux – I argue that the Method is a means by which people can relate experiences from everyday life and in this way provide opportunities for us to come to a modicum of understanding of what those experiences mean. I will now go on to summarise the thesis and remaining chapters.

5. About the Thesis

This section presents the overall scope and contributions of this thesis and summarises its structure.

6. Problem Statement and Scope

The study is framed within the social sciences, but more specifically within social work practice. Powell (1997) suggests that:

Social workers in their day-to-day practice are concerned with the different ways in which people construe their social worlds...The importance that the practitioner attaches to the significance of meaning, to a person's lived experience, and to the social

processes through which these are constructed, suggests the need for a research approach within the interpretative tradition (1997 p. 143).

This section makes connections with the ideas discussed above and reflects on what has essentially been for me a research agenda driven generally by an interest in mental illness but more specifically to do with individuals and their experience of multiple admissions to psychiatric hospital. I am particularly interested in how these individuals generate new meanings and identities for their lives.

In addition, the section unearths and illuminates some of the major themes directly relevant to the issues being studied. I approach this study from my perspective as a male social work practitioner from working-class Jamaican parentage. I regard my involvement to be intrinsically embodied within the process and, as such, acknowledge how my own experiences can inform the process of inquiry. Indeed, Powell (1997 p. 139) emphasises the importance and relevance of the researcher's biography to the research process and the centrality of critical reflection in the practice of both social work and social research. I shall now introduce myself as part of the research process.

Having arrived in England in 1964, aged eight, I can widen this perspective to encompass four decades of British society and culture. This perspective is also shaped by my fundamental Christian beliefs and personal values, as well as values underpinning my social work practice. More significantly, my own life experiences contribute to a conscious effort to maintain an ongoing evaluation of the decisions I have made concerning the clients I see in the course of my work.

Despite this effort, I feel that at times in my life I have taken nebulous paths which have left me disoriented and overwhelmed with changes. Not surprisingly, these changes carried with them the potential for me to reconstruct my identity and to gain a better sense of who I am. I believe this process of introspection has helped me establish ethical principles that have been important for informing decisions in my personal and professional life.

In essence, it is my belief that living one's life by making decisions based on a set of core ethical principles can be personally and professionally rewarding. As such, I

approach this study from a position consistent with the view of Miles and Huberman (1994) on openness, integrity, respect and trust. These principles are fundamentally important with regards to minimising power differences between me, the researcher, and the participants. The need for these principles is emphasised by O'Conner (2002), who argues that the power exercised by those who initiate a particular research project can be immense if they conceptualise a project in ways that affirm their position as those in charge. In this study, I drew on the work of Michel Foucault to bring to light concepts of power and empowerment and the ways in which this has impacted the patient. The concerns relate not only to the situations in the interview but also the general discourses to which the participants refer.

As a final point, an important element of the Method, both in the process of data collection and analysis, is that it offers ways of removing some of the power inequalities that can exist in research situations. It is, therefore, in keeping within the aim of participatory research, which is to move away from research on people to research with people.

7. Contributions of This Thesis

This thesis focuses on multiple admissions to psychiatric hospital and the social construction of identities. It explores these concepts by using the Method to access the unique stories of patients who have experienced multiple admissions to psychiatric hospital. As such, it has contributed to a systematic way of understanding these experiences and how the meanings patients attach to them are either discarded or incorporated into their senses of identity.

In this study, emphasis is placed on hermeneutic inquiry, or expressed differently, the process of interpretation and the understanding (*verstehen*) of the significance or meaning that is attributed to the stories being interpreted. In biographical work, this approach can help researchers gain special insight into the unique experience of each individual (Cooper 1990). The storied life is of particular relevance, as the ideas that people construct of themselves – their image of who they are and where they fit – are, according to (Bruner 1990), understood as the framing of memory.

Plummer (2001) supports this view regarding the storied life as memories gathered from years of personal experience.

The first part of the thesis consists of a literature review of important background knowledge for understanding deinstitutionalisation and multiple admissions to psychiatric hospital.

The second part of the thesis concerns itself with data collection and analysis of the stories told by participants in this study. The interpretation of these stories, through a phenomenological approach, offers a great way to learn about the ‘revolving-door’ phenomenon and mental illness. Furthermore, the use of an interpretative qualitative method contributes to a better understanding of the vast and complex history, culture and society of the mentally ill by adding to a knowledge base. I believe that the life stories of these patients would otherwise have been silenced by other traditional research methods.

8. Organisation of this Thesis

Chapter One	Chapter One is an introduction to the topic of the thesis and related subjects. The historical context of readmissions is described, including key concepts such as socially constructed identity. Post-modernism, phenomenology, and hermeneutics are also introduced. Finally, the remainder of the thesis is summarised.
Chapter Two	Chapter Two is a literature review. This review of the research literature of patients’ experience of the ‘revolving door’ phenomenon is designed to inform the study in this area and add to a knowledge base. The literature review revealed that over the last fifty years a substantial amount of research has been conducted in the field of mental health; however, these studies have tended to focus on the clinical and demographical characteristics of people admitted as voluntary or involuntary patients. Research has, to some extent, examined readmission

	<p>rates (Kaustrop 1987); Goodwin (1997). There have been a few studies that examined the psychological effects of such admissions: (Beveridge 1998); (Wright, Gronfein & Owens, (2000). A lack of studies that focus on the subjective experience of patients themselves was highlighted. In this chapter, some of the major themes directly relevant to the issues being studied are unearthed and illuminated. The substantive problem is discussed, which translates into multiple admissions to psychiatric hospital, and the various perspectives, through which this phenomenon is understood, are examined within the field of mental health.</p>
Chapter Three	<p>In Chapter Three the methodology elements are discussed and the rationale for using the biographical narrative method as a data collection and analysis tool. The sample size, ethical issues, selection process are also discussed and alternative narrative approaches reviewed. Their limitations are discussed and compared to the unique approach introduced in this thesis.</p>
Chapter Four	<p>In Chapter Four data and researcher's reflective work are presented. The data, which can be examined from the perspectives of mental health professionals, sociologists, psychologists, historians and anyone with an interest in this field is analysed from my perspective as a mental health social work practitioner.</p>
Chapter Five	<p>In Chapter Five reflective teams' analysis of data is presented.</p>
Chapter Six	<p>Chapter Six concludes this thesis; contributions are summarized and then areas for further work highlighted.</p>

9. Definitions

Deinstitutionalisation	In a broad sense, the transition from institution based care to care based in the community.
Institutional	A sense that the patient's behaviour is normalised to the routine of the institution.
Narrative inquiry	The process of gathering information for the purpose of research through listening to spoken stories.
Life history	A series of substantive events arranged in chronological order.
Life story	The account given by an individual, only with emphasis upon the ordering into themes or topics that the individual chooses to adopt or omit as s/he tells the story.

10. Delimitations

The number of patients interviewed was limited to seven. This was due to the size of the research population, the willingness of patients to take part and the time available for the study.

A further limitation was the fact that in order to be selected for interviewing, patients were required to be stable in their mental states before taking part. This requirement further narrowed the number of patients who could be interviewed.

The demographical characteristics of the participants were set to include only those who had more than two admissions to psychiatric hospital within three years of the first admission. They were also those who had been given diagnoses of either schizophrenia or bipolar disorder.

In spite of these limitations and even with just seven participants, there was a diversity of actors and a range of experiences to be discovered.

11. References

Previously published written works used in this thesis are listed in the reference section.

12. Appendices

The Appendices provides documentation to support the work presented in this paper.

CHAPTER II

LITERATURE REVIEW

The formulation of a problem is often more essential than its solution...To raise new questions, new possibilities, to regard old problems from a new angle, requires creative imagination and marks real advance in science.

Albert Einstein (cited in Simonton 1994 p. 92)

A. INTRODUCTION

This chapter consists of a literature review of the published material pertaining to the topic of 'Self/Identity and Multiple Admissions to Psychiatric Hospital'. The aim is to summarise the literature on a range of topics relevant to the current study. Each topic is discussed with emphasis on self/identity and multiple admissions to psychiatric hospital.

The review is divided into three parts. In part one, I provide an overview of mental illness. I trace the conceptual history of mental illness, deinstitutionalisation and readmission, reviewing the main social and political developments. The political ideology of deinstitutionalisation is also considered. I discuss the literature review strategy used for this study and provide reviews of empirical research on multiple admissions to psychiatric hospital. In part two, I introduce the concept of the self and narrative identity, as well as the importance of context in social construction of self/identity, and the role of memory in narrative identity. Discoveries from the literature review, and implications for 'revolving door' patients, social work and mental health research are then discussed. In part three, I reflect on my motivation for conducting the study. The review ends with a concluding section, summarising the main observations and findings drawn from the literature.

B. PART ONE

1. In Search of a Definition of Mental Illness

This section consists of an overview of the history and nature of readmission within the field of mental health. It will specifically examine different sociological perspectives on deinstitutionalisation and community care. It will also explain the pre-eminence of the medical profession and asylums at the centre of care of the mentally ill.

Before embarking upon this overview, it is worth spending some time exploring what is meant by mental illness. Mental illness has received much attention over the years. Porter (2002 p. 3) says that 'mental illness must be understood not as a natural fact, but as a cultural construct, sustained by a grid of administrative and medico-psychiatric practices'. Kaplan (1964 p. vii) defines mental illness as 'a radical alteration in the character of the subjective experience of the person'. Others who have sought to offer a definition do so by locating the problem in the brain. For example, the Oxford Modern English Dictionary (1994 p. 666) simply defines mental illness as 'a disorder of the mind'. Interestingly, the Mental Health Act 1983 does not offer a definition for it:

Mental illness, the category of mental disorder which is the diagnosis identified in the overwhelming majority of formal admissions under the Act, is not defined (Jones, R. 2001 p. 13).

Clay (1999 p. 31) asks some provocative questions about the nature of mental illness in her attempt to understand what it means to 'recover' from it. For example, she asks, 'If mental illness is a disease of the mind, what is the nature of the mind?' Is recovery for a mental patient something different from the wellness of any other person? These are very interesting questions that have puzzled many, but so far, have yielded few answers. There have also been critics of the concept of mental illness, who I will come to next.

Given the ambiguity surrounding a definition for mental illness, perhaps the question that should be asked is this: does mental illness exist? Historically, the notion of

whether mental illness exists or not has come under much criticism from the movement called anti-psychiatry. This term was introduced perhaps misguidedly by Cooper (1967), cited in Jones (1993), and loosely applied to several critical views of psychiatry. I believe an error in Cooper's judgement resulted from his indiscriminate grouping of psychiatric critics such as Thomas Szasz, R.D. Laing and Michel Foucault as 'anti-psychiatrists'. Apart from their hostility to most of the fundamental assumptions and practices of psychiatry, they had very little in common. Many of the concepts that anti-psychiatry uses are taken from the work of Thomas Szasz, regarded by many as a libertarian. He certainly did not think mental illness existed. In fact, Szasz (1974 p. 1) states that, 'there is no such thing as mental illness'. He regards it as a myth. Challenging the traditional framework of medicine, he asserts that 'the concept of mental illness only serves to obscure the everyday fact that life for most people is a continuous struggle' (p. 22). In this context, the notion of mental illness is used to identify or describe some feature of an individual's so-called personality (p. 14). As such, the concept is unnecessary and misleading (Szasz 1973 p. 14). Szasz (1973 p. 21) calls for mental illness to be looked at afresh. He suggests that it should be removed from the category of illnesses and that it should be regarded as expressions of man's struggle with *the problem of how he should live* (his emphasis).

Another libertarian whose works have also been influential in creating the anti-psychiatry tone of radical literature in the 1970s is Laing. In fact, Laing and Esterson (1964) took a less radical approach to Szasz, but nonetheless argued that reactions identified as mental illness relate to interpersonal behaviour, particularly within the family. This was also the viewpoint of Foucault (1972). Foucault emphasised the broader societal factors involved in presentations of mental illness. He (1973) emphasised the social construction of medical knowledge over time in *Birth of the Clinic*. In *Madness and Civilisation* (1967) he asked, 'What does it mean to be mad'? He provided a fascinating historical analysis on the development of madness as a social construct, as well as the development of psychiatric care. For Foucault (1967), madness was essentially a construct promulgated by power as a tool to control behaviour that is deemed deviant.

Goffman (1961 pp. 24, 154) adds another important dimension to the understanding of mental illness. He argues that the 'mental patient', once identified as such, embarks on a 'moral career' which affects the very core of his or her self/identity. Nevertheless, because the question of whether mental illness exists or not is such a controversial one, no attempt will be made to provide a definition in this thesis. What I believe is important is the recognition that different ideas have been suggested in an attempt to describe and categorise conditions of the human mind, which undoubtedly affect people in different ways.

Furthermore, despite the anti-psychiatric movement, most people hold a tacit understanding of mental illness that defines their views on whether it does or does not exist. Indeed, the genesis of madness has been the following, chronologically: the devil, the liver, bad genes, the brain, the mother, the family and, once again, genes and the brain (Loewenstein 2004 p. 119). Undoubtedly there exists a rich diversity of beliefs relating to the cause and aetiology of mental illness. Operating within this diversity of beliefs are a number of fundamental frameworks which endeavour to explain mental illness within Western society. Two of these frameworks are the medical and social models as described below. The medical or positivist model seeks to assimilate the human sciences as closely as possible to the natural sciences. The social or interpretative model views the subject matter and, therefore, the methodology of the human sciences, as constituting a class of its own. These two fundamentally opposed frameworks correspond to what Kuhn (1962 p. viii) terms 'paradigms'. In fact, Kuhn (1962 p. viii) argues that negotiation between holders of different paradigms is difficult not only because each paradigm uses a different conceptual system, but also because each represents different interests.

According to Busfield (1986, cited in Ussher 1991 p. 142), 'positivist science rescued eighteenth century physicians from the mire and has continued to be the lynchpin of psychiatric practice'. The psychiatric community's adherence to positivism, with its assumption of a fixed objective and universal reality, has, therefore, aided in perpetuating the assumption that behaviour can be classified and categorised in the same way scientists have classified and categorised atoms and particles. This has led to the legitimisation of the classification of mental disorders and the taxonomic approach to 'madness' (Ussher 1991 p. 144). Here pathology is identifiable through set, definable and universally recognisable symptoms that indicate the presence of

some underlying disease. The most frequently used diagnostic protocol is 'The Index and Glossary of Mental Disorders of the Tenth Revision of the International Classification of Diseases' (ICD-10), devised by the World Health Organisation (1992). Another is the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorder (DSM 1V) (1994), which is used to define an illness (Warner 1985 p. 4).

The belief at the beginning of the nineteenth century was that madness could be cured through moral treatment in asylums (Barham 1992 p. 66). The term 'moral treatment' referred to the belief of superintendents at the time that the minds and behaviours of the insane could be shaped through personal and humane psychological care. The asylum-building spree of the nineteenth century received its initial impetus from this belief. What was needed was bigger and better asylums (Shorter 1997 pp. 36 - 68). In spite of two quite separate moral movements, Tuke in Britain and Pinel in France, the belief in the need for a psychological approach was later completely lost from view in asylum life (Shorter 1997 p. 22). Released from the obligations of moral treatment, patients were recruited back into an ideology of prognostic pessimism (Porter 1999 p. 20) so that by the mid-1850s almost all American asylum superintendents had come to believe in the incurability of insanity (Cockerham 2003 p. 21). Ultimately, readmission soon became evident at hospitals where moral treatment was practised (Warner 1985). Moral treatment in the nineteenth century not only offered opportunities to learn from the past in relation to the development of mental health care, but it also conveyed a sense of the intensity of the social and political issues surrounding the asylums at that time. The thinking was that there was a need for a structured environment in which individuals who could not cope with life could be isolated from the world. This view contrasts with current mental health policy where the emphasis is on care in the community.

2. Historical Context of Readmission to Psychiatric Hospital

The phenomenon of frequent and repeated admission to psychiatric hospital is not new. For a history of madness, the asylums and readmission, see Jones (1993),

Mora (1980), Porter (1999), and Shorter (1997); more specifically, for a critical discussion of how discharge from psychiatric hospital has invariably been followed by readmission, see Foucault's (1967) *Madness and Civilisation*. Goffman's (1961) seminal work, *Asylums*, has also shaped modern understanding of both institutions and the people in them.

Readmission in the nineteenth century is, therefore, an indication, first, of the ineffectiveness of treatment (Warner 1985) and second, of the incurability of insanity. Readmission was also seen as a larger pattern of transcarceration, moving patients among families, private and public asylums, and institutions for the indigent poor (Scull 1981 p. 208 - 213). A ploy was to move 'incurables' out of asylums and into almshouses; if a patient had not improved enough to live with his or her own family, it was thought that perhaps he or she could get along in the almshouses (Hamilton 1940 p. 88). During the nineteenth century, asylums, therefore, lost their curative function and became a convenient apparatus allowing for the collection of 'dead souls' in a network of cemeteries for the still breathing (Scull 1991 p. 161).

Today, readmission to psychiatric hospital is not only argued to have enormous social and economic implications (Marshall, Crowther, Almaraz-Serrano Creed, Sledge, Kluiter, Robers, Hill, Wiersma, Bond, Huxley & Tyrer 2001 p. 2), but also to be distressing for the individuals concerned (Vogel & Huguelet 1997 p. 244), impacting every aspect of their everyday life and seriously disadvantaging them (Crisp 2001 pp. 197 - 199; 2005 pp. xi - xviii). This was also a viewpoint of Newton (1988 p. 15), who asserts that 'social implications of florid psychotic symptoms are such that few people with an acute illness will survive outside a treatment setting'. Advertently, the conception by many is that admission followed by readmission to psychiatric hospital creates stigma. This is an attribute that is deeply discrediting (Goffman 1970) and often leads people to be labelled as incapable of making decisions about their lives and thus requiring intervention from the state.

3. Towards the Political and Ideological Quagmire of Deinstitutionalisation and Beyond

The twentieth century saw a shift in the way mental health services were being organised in Britain. This transformation was characterised by a shift from

institutional to community care (Pilgrim & Rogers 1999 pp. 155 - 156). The 1930 Mental Treatment Act encouraged local authorities to make arrangements for the provision of outpatient services and aftercare facilities for people suffering from a mental illness (Jones 1993 p. 135). Busfield (1986 p. 330) noted a fairly small growth in provision of services during that time. The mid-1950s saw another expulsion of patients from hospital to the community. At the same time, a 'pharmacological revolution' was taking place, which enabled patients to be treated with medication within the community (Pilgrim & Rogers 1999 pp. 176 - 177).

Mental illness and its treatment cannot be understood outside wider economic, political and ideological practice. Indeed, Banton, Clifford & Frosh (1985) argue that ideology is of paramount importance in understanding individual behaviour and experience as well as the political place of mental health practice (p. 13). Banton et al., (1985) state:

Although economic and political practice are essential to specifying the context and effects of mental health practice, and do themselves have significant effects on consciousness, it is ideological practice that is of most direct interest to the area of mental health, because it deals with the way the contradictions of the social world (economics and politics) are experienced by, and have a hand in constructing, individual consciousness (1985 p. 13).

Spicker (1995 pp. 71 - 72) adds to this with the view that ideologies are 'the inter-related sets of ideas and values which shape the way that problems are understood and acted on'. This links into the ideas of the anti-psychiatrists that psychiatry is a political issue and only exists to define capitalist interests (Ingleby 1981, cited in Shorter 1997 p. 48; Thomas & Bracken 2004 pp. 362 - 363).

The shift to community care in the mid-1950s, therefore, invites a multiplicity of interpretations. A social democratic perspective (Jones 1972, cited in Carpenter 2000 p. 59) saw this turning point as humanistic, viewing the mentally ill as needing help and support. From Jones's (1972) point of view, the state, social workers and other mental health professionals are essentially neutral and caring. In this respect, civil libertarianism is blamed for producing the late Victorian asylums and for excluding the mentally ill while trying to protect the liberties of the sane. According to civil libertarianism, society has a right to constrain individual freedom when it threatens to

do harm to others. A person considered to be mentally ill and thought to be a danger to him or herself or to others could therefore be admitted to the asylum against their will and forcibly treated. Therefore, by protecting the civil liberties of the sane, who were concerned about dangerousness of the insane, civil libertarianism was actually allowing the distinction to be drawn between the sane and the insane.

A different view of the shift from incarceration to community was offered by Marxist structuralism. This view saw the changes in the psychiatric system as primarily a reflection of external political and economic pressures (Carpenter 2001 p. 60). Scull (1979 p. 113) regarded asylums as purely a custodial institution for the containment of labour market casualties, while O'Connor, (1973) cited in Carpenter (2001 p. 60), saw the shift to the community as welfare capitalism's provision of social security benefits, which provides a cheap alternative to refurbishment of decaying hospitals in an era of 'fiscal crisis', or inability to meet expanding social demands through the tax system.

Other perspectives have suggested that patients may have been using the psychiatric hospitals for non-psychiatric reasons, for example, when financial or housing problems or other social stressors precipitate hospital admission. Whatever the perspective, it is clear that frequent and repeated admissions to psychiatric hospital remain a serious problem in society. Despite methodological concerns, researchers have attempted to study this problem in order to better understand its causes. These studies are the focus of the next section.

4. Literature Search Strategy

This section provides the results of a literature search for past studies related to this work. In this way, I am presenting the literary background to the rest of the study.

I conducted an extensive search of literature relevant to multiple admissions to psychiatric hospital in order to identify and review past studies in the area and to inform the study. I first sought to identify studies that met the inclusion criteria; the diagnostic groups of schizophrenia and bipolar disorders and the inclusive age range. In the review of literature, I considered what has been written on patients'

interpretations of their experience of repeated admission to psychiatric hospital from a range of sources (for example social work, psychology, sociology and psychiatry).

I searched many different types of literature on the 'revolving door' phenomenon and readmissions to psychiatric hospitals using PsycINFO, Social Care Online, NRR and Zetoc databases from 1980 to 2008. I also found some articles using Google by means of an *ad hoc* approach, using the following keywords in different combinations: admission, deinstitutionalisation, mental illness, multiple admissions, narratives, readmission, psychiatry, identity, self/identity, compulsory and 'revolving door' phenomenon. Table 1.0 shows the results obtained.

Search Description	PsycINF	Social Care Online	NRR Archive	Zetoc
Compulsory admissions	147	14	1486	21
Deinstitutionalisation Mental health	55	63	0	8
Frequent admissions	12	10	1821	59
Narratives and deinstitutionalisation	5	1	0	0
Narratives and mental illness	125	7	5546	11
Narratives and readmission	2	0	0	0
Narratives and readmission and psychiatry	0	0	0	0
Narratives and repeated admission	0	0	3017	0
Narratives and 'revolving door'	0	0	44	0
Readmission and psychiatry	614	12	16	24
'Revolving door' and psychiatry	56	3	19	13

'Revolving door' phenomenon	12	0	429	4
Mental health and readmission	429	35	13751	9
Identity and revolving door	0	0	44	0
Self/identity and multiple admissions	0	0	200	0

Table1.0 Database Searches

It is important to say that results obtained through NRR Archive, and to an extent PsycINFO, were mainly medical studies. The most striking feature of this search was the lack of literature on patients' subjective experience of mental health problems vis à vis repeated admission to psychiatric hospital. Of the many articles I found addressing multiple admissions, only a few were related directly and indirectly to both the topic and the methodological approach used in this study. Two of these were Davidson, Stayner, Lambert, Smith & Sledge's (1997) phenomenological study and Adame and Knudson's (2007) interpretive interactionism narrative inquiry.

5. Readmission: An Overview of Empirical Research

The importance of understanding readmission to psychiatric hospital was emphasised by the number of studies conducted on this topic. Indeed, this review showed that readmission to hospital is a global phenomenon and has come to be recognised as a problem in many countries (Goodwin 1997 p.117). In most of these countries I found that studies examining the 'revolving door' phenomenon have, for the most part, focused on rates and predictive factors associated with readmission from a quantitative positivist perspective. The ways in which researchers have gone about conducting these studies have generally fallen into the following categories: demographic factors, diagnosis and medication, length of previous admission, and quality of aftercare. A few studies reported included a combination of these factors. I will now report on each of these categories.

Demographic Factors

Studies that have focused on demographic factors as their predictive indicator to readmission include Bernardo and Forchuk's (2001) review of 200 patients (age 17 - 83). Objective data of the 200 patients was collected for three years from 1992. Differences between patients were compared using chi-square tests for nominal data and t-tests for continual data. They found that more of the readmitted patients were male, slightly younger, were divorced, unemployed and received social assistance. A history of aggression was also related to readmission. A retrospective panel was used to look at the data collected during the three-year period. The study does not give any background information about the composition of the panel; however, I assumed that the panel was made up of clinicians. As such, without background information it may be a limited representation of the issues related to 'revolving door' patients. In another study, Lyons, O'Mahoney, Miller, Neme, Kabat & Miller (1997) found no evidence to suggest that readmission to psychiatric hospital indicated a failure of the level of care provided during a previous admission. In a Canadian study, Madi, Zhao & Fang Li (2007) conducted a one-year survey of hospital admissions and found that 37% of patients with a mental illness diagnosis were readmitted within the year. This was in comparison to 27% of patients admitted with a non-mental diagnosis. The authors concluded that the probability of readmission was higher among older individuals and among individuals who had longer stays in hospital. An association between individuals with dual diagnosis (having a psychiatric and drug related problem) and readmission to hospital was thought to be greater for individuals who were diagnosed with schizophrenia. These studies were surveys and took no account of the subjectivity of patients and as such, they appear only to give the perspectives of those conducting the survey.

Mahendran, Mythily, Chong & Chan (2005), in their study in Singapore, examined the patterns of readmission using a cohort of first-admission patients (133 male and 101 females). The aim was to identify demographic and clinical factors that influence readmissions. They concluded that males who had a history of self-harm and a short duration of illness were at risk of becoming 'revolving door' patients. Statistical analysis of data derived from clinical records and a questionnaire designed to collect data from these case records provided the evidence in this retrospective study. The

study did not involve the patient at all, and there is no way of verifying what was recorded in the clinical records.

In London, Langdon, Yágüez, Brown & Hope (2001) found that 'revolving door' patients were more likely to be living alone, in hospitals or private accommodation, to have an earlier age of illness-onset and to have used psychiatric services for a long period. Data for this study were collected from three main sources: the hospital's computerised patient administration system, the patient's hospital file and a 'Reason for Admission' questionnaire. Again, this study covered a wide range of demographic factors, but omitted the patient's perspective on his or her admission by relying solely on information that was recorded about him or her or a pre-constructed, closed-question survey.

Studies in the United States by Arnold, Goldston, Ruggiero, Reboussin, Daniel & Hickman (2003), and Haywood, Kravitz, Grossman, Cavanaugh, Davis & Lewis (1995) also considered demographic variables in their attempt to understand the 'revolving door' phenomenon. Yamada, Korman & Hughes (2000) went as far as developing an assessment tool for assessing the risk factors associated with readmission. In spite of the mass of studies focusing on demographic factors (the majority of which are not reported here), the 'revolving door' phenomenon still remains a problem.

Quality of Care

Goodwin (1997 p. 117) states that a link between the lack of support in the community and the tendency of discharged mental patients to be readmitted is often made. Picking up on this observation, Nelson, Maruish & Axler (2000) examined whether 3,113 patients discharged from inpatient care in the United States would have lower rehospitalisation rates if they kept an outpatient follow-up appointment after discharge. They hypothesised that when continuation of care after discharge was ensured, patients would progress in treatment instead of decompensating and requiring rehospitalisation. Patients were educated about the importance of compliance with treatment and of keeping outpatient appointments. Of the 3,113

patients, Nelson, et al., (2000) state that 542 were readmitted to hospital within a year of discharge.

Data was analysed using one and two-tailed non-parametric t-test. The result indicated that hospitalised patients who did not comply with at least one outpatient appointment after discharge were twice as likely to be re-hospitalised than those who kept at least one appointment after discharge. This was a medicalised study of patients' compliance. It did not consider the patients' socio-demographic situation or psychological circumstances which may have contributed to the admission. Also, the study appears to only delineate the perception of aftercare from the perspectives of those conducting the study.

Thornicroft, Gooch & Dayson (1992) in their comparative study in London aimed to identify risk factors which increase the likelihood of readmission for long-stay psychiatric patients after discharge from hospital. The study identified younger males with manic depressive psychosis and with more previous admissions as being at significant risk of being readmitted. It also identified these individuals as living in non-staffed group homes. A conclusion identified staffed group homes as a way of preventing relapse. The patient was once again not included in the study and did not take an active role.

In their UK study, Cooper and McLees (2001) posed the question: 'Can readmission be prevented?' Semi-structured interviews using the Cardinal Needs Schedule were conducted, and case notes were examined to assess whether patients' social and psychological needs were being met in the community. What they found was a relatively high number of unmet needs (clinical and social) in the patients they interviewed. This led them to draw a link between relapse and readmission however, they were unable to say whether the presence of unmet needs predicted readmission.

Compliance with Medication

Turning to compliance with medication, Hunt, Bergen & Bashir (2002) found that patients who regularly took their medication but also abused substances were readmitted to hospital sooner. The interval between admissions is further reduced for

patients who are both substance abusers and noncompliant with medication resulting in a 'revolving door' situation of frequent hospital admissions.

De Graeve, Smet, Mehnert, Caleo, Miadi-Fargier, Mosqueda, Lecompte & Peukenset (2005) in their study, aimed to define the most cost-effective pharmacological treatment strategy for schizophrenic patients. The main hypothesis of the analysis is that increased compliance arising from the use of long-acting injectable formulation of an atypical antipsychotic agent could increase clinical benefit and modify the cost-effectiveness ratio. The hypothesis was supported in the results, which suggest that, long-acting antipsychotic formulations have the advantage of reducing poor compliance, which is the most significant factor associated with relapse and rehopsitalization.

What these studies had in common was not only that they were set up to test the efficacy of anti-psychotic medication on patients diagnosed as having schizophrenia, but also, to identify factors that may predict readmission rates.

In another study, Burgess, Bindman, Leese, Henderson & Szmukler (2006) considered whether community treatment orders (CTO) reduced readmission to hospital. They compared the hazard ratios of readmissions to hospital before the end of the study period (1992 - 2000) for 16,216 discharges subject to a CTO and 112,211 not subject to a CTO using Cox proportional hazards model. They found that CTOs used on discharge from a first admission were associated with a higher risk of readmission, but CTOs following subsequent admissions were associated with lower readmission risk. Although the study reported some benefits in terms of reduced admission rates for subsequent admissions, it failed to consider why admissions took place in the first place.

Previous Admission(s)

Further studies whose aims were to identify the variables that predict the 'revolving door' phenomenon included Gastala, Andreolib, Quintanab, Gameiroa, Leitea & McGrathc (2000). For Gastala et al., (2000) 'revolving door' patients were those who had had four or more admissions during the study period. In the study, 3,093 patients were followed up for five to twenty-four years after their first admissions. These

patients had all been given a diagnosis of schizophrenia. Of particular concern in the study was the interval between first and second admissions. The results revealed that patients aged 13 to 35 who had an interval between the first and second admission of 1 to 360 days, and a length of stay greater than 60 days in the first admission, had a high risk of being readmitted. Kaustup (1987), in a longitudinal study over ten years, followed up 5,881 male and 6,586 female first-time patients age 15 and over. His aim was also to identify those who became 'revolving door' patients. The study found that, young (single or divorced) men living in highly urbanised areas who had been diagnosed with schizophrenia and had substance abuse problems, were more likely to become 'revolving door' patients.

Combination of Factors

Moran, Doerfler, Scherz & Lish (2000) studied 370 patients over a 15-month period. Patients readmitted during this period were compared with patients who were not readmitted because of:

- a) Symptom improvement during hospitalisation.
- b) Psychosocial and clinical variables.
- c) Length of hospitalisation to determine the likelihood of readmission.

The study found that readmitted patients were more likely to be unemployed, participating in a day treatment program, and receiving social security disability insurance. These findings suggest that the readmitted patients had a history of long-standing social impairment. Indeed, clinical features that distinguished readmitted patients were; a higher reported occurrence of early life physical or sexual abuse and suicidal and aggressive behaviour. The study concluded readmission is a significant problem and that patients' self reported symptomatology is not a major determinant of readmission for inpatient treatment.

Daly, Doherty & Walsh (2007), in a precedent study of Irish mental health history, showed that demographical characteristics were important factors in determining readmission to psychiatric hospital. This study had three main aims: first, it attempted to identify frequent users of the inpatient services as a subgroup of all readmissions; second, it sought to identify factors which may predict readmissions to Irish

psychiatric units and hospitals and to identify the specific characteristics (demographic and clinical) of those who were readmitted; third, it looked at whether certain geographical areas of the country were associated with a greater proportion of readmissions and whether this in turn was associated with the availability (or lack) of community psychiatric services and staffing levels in community psychiatric services (p. 14).

The study found that the most significant predictors of readmission were age and diagnosis with those less than 20 years of age, with a diagnosis of schizophrenia and drug dependence, and resident in counties with larger urban centres. Females and those with a secondary diagnosis were also more likely to be readmitted. Length of stay was also a significant predictor of readmission with those who had a shorter length of stay at first admission less likely to be readmitted than those with a longer length of first admission. Staffing levels in community services plus the number of community residences and the number of places in such residences did not appear to be associated with the number of inpatient readmissions.

Webb, Yagüez & Langdon (2007), in a two-year study of variables associated with readmission to a psychiatric hospital, argued that there are difficulties in obtaining a consensus within psychiatry as to which variables reliably predict multiple readmissions (p. 648). They identified these difficulties as the problems associated with cross-sectional versus longitudinal methodology and the lack of a definition of a 'revolving door' patient. Sampling was also identified as a contributory factor. They stated that 'all the previous studies have taken place within different countries that have differing mental healthcare services which may employ differing diagnostic systems and other services to differing population groups of, for example, socio-economic status' (p. 648).

The conclusion from their study identified 'revolving door' patients as more likely to have enduring and chronic mental illnesses than their non 'revolving door' counterparts, were younger at first contact with services and were more likely to be living in council housing. The conclusion drawn from this study was interesting because there was no direct contact with the patients themselves. Data were obtained from a computerised patient administration system and clinical notes. In

their attempt to find a consensus view on the variables that predict multiple admissions and a definition for a 'revolving door' patient, they seem to overlook the idiosyncratic characteristics of each patient. Life experiences for each patient would have been different, and so too would be their reactions to these experiences.

There have been a few qualitative studies of hospital closure from the patients' perspective, for example, Perring (1993). These however, have been relatively few in comparison to the mass of quantitative studies. In any case, the author was more concerned with the policy of community care and the plans to close the large psychiatric hospitals. In her study, she compared patients' perspectives with the knowledge and assumptions of service providers. There was little emphasis on the emotional aspects of readmission and the impact this may have had on the patients' sense of identity. In his study, Kaplan (1964) provides a collection of first accounts of mental illness from patients hospitalised in the 1940s. These accounts were desperate attempts by patients to convey information about their condition, confinement and what many experienced as torment. Indeed, these personal accounts went a long way to conveying what mental illness and hospitalisation were like for those patients. These personal accounts or stories open up a vantage point for understanding identity. More recently, qualitative studies involving patients at the subjective level are beginning to emerge: for example, Davidson et al., (1997) and Adame and Knudson (2007). These studies highlight the recent advances in qualitative research. They identify patients' narratives as a useful way to better understand the patients' situation. The researchers' aim in this respect is to identify through the narrative account how patients themselves explain their experiences rather than draw on conclusions from clinical records or questionnaires.

C. PART TWO

1. Theorising the Self through Narrative Identity

The notion that our lives are embedded in a relational social context of everyday life is of particular relevance in this study. This is because it has been established that a

person cannot be studied outside his or her social context (Schutz 1970; Bruner 1986; Czarniawska 2004). A good example of this has been the groundbreaking work by Florian Znaniecki (1882-1958) *The Polish Peasant in Europe and America* Zaretsky (ed. 1996), completed with William I. Thomas. Znaniecki was one of the first researchers of knowledge as a cultural phenomenon constitutive of the social worlds. Indeed, it was the influence of the seminal works of these two sociologists who sought to explain social problems by examining the relation between individuals and their surrounding society that captured my imagination concerning the possibilities of social research. In the mental health field, these social contexts are often formed by social experiences, which are also described by others using social constructs (for example neurotic/stable, severe mental impairment/non-psychotic). These social constructs are explored in this study in relation to identity and multiple admissions to psychiatric hospital, particularly because, as Breakwell (1983 p. 4) suggests, 'identity is something that can be used to explain why other things occur'. In this study I show how narrative inquiry can provide a theoretical and practical framework for obtaining accounts of patients' life histories and, with it, their unfolding sense of self/identity and the preceding factors that contributed to identity transformations; for example, being diagnosed with a mental illness is likely to create stigma, discrimination and oppression, in the context of which self/identity becomes increasingly threatened (Breakwell 1983, 1986, 1988) and 'undermined' (Goffman 1966 p. 4). Indeed, one of the reasons behind undertaking an in-depth study of the patient's experience of the 'revolving door' phenomenon, and issues relating to social construction of identity, was recognising the profound effects admission to psychiatric hospital can have on a patient, and the stigma that that creates (Bean 1993). In her study, Somers (1994 p. 606) states, 'We come to be who we are (however ephemeral, multiple, and changing) by being located or locating ourselves - usually unconsciously - in social narratives rarely of our own making.'

My theoretical aim therefore, in this section, is to apply narrative theory to the study of self/identity in relation to multiple admissions to psychiatric hospital. A starting point is Rogers' (1961) understanding of human beings as a process of personal self-discovery and the notion that self-consciousness is an essential part of being human. Kierkegaard (1849/1980), cited in Zahavi, Grünbaum & Parnas (2004 p. 13), defines the self as 'a relation that relates itself to itself'. This relational self seems to be the

self that Bakhtin (1981 p. 79) and Gergen (2006 pp. 119 - 124) refer to as progressively redefined through dialogue and lived experience with others. Davidson (2003 p. 45) argues that 'the re-definition of one's self as a person of whom mental illness is simply one part is probably the most overarching aspect of recovery from the illness'. I therefore decided to explore this concept of self through narrative identity because I believe narratives are interconnected with social situations in a way that provides a useful means of understanding human behaviours. Before proceeding to discuss narrative in more detail, it is useful to explain the relational differences between self/identity and narrative identity, as this may help to articulate the ambiguity in the concept of 'narrative identity' that is likely to be encountered further on in this chapter. In this study I refer to narratives as a connected series of happenings that is recounted verbally and has a structure proposed by Labov and Waletzky (1997). I will develop the concept of narrative structure in the methodology chapter. In the section that follows, the suitability of narrative for understanding 'revolving door' patients is outlined by interweaving different narrative identity theories. Next, the importance of context in the social construction of identity is presented. After that, I discuss the relationship between the concepts of memory and self/identity.

2. Narrative Understandings

According to Denzin and Lincoln (1994), the 'narrative turn' at the end of the twentieth century provided some interesting opportunities to analyse the narratives found within the social sciences. They state:

Where only statistics, experimental designs, and survey research once stood, researchers have opened up to ethnography, unstructured interviewing, textual analysis, and historical studies. Where "doing science" was once the watchword, scholars are now experimenting with the boundaries of interpretation, linking research to social change, delving into characteristics of race, ethnicity, gender, age and culture to understand more fully the relationship of the researcher to the researched. In various disciplines in various guises, this implicit critique of the traditional worldview of science and quantitative methods is taking place. All of these trends have fallen under the rubric of "qualitative research" (1994 p. ix).

Bruner (1986) also distinguishes the narrative mode of understanding from the more abstract scientific mode, which he calls paradigmatic. The paradigmatic mode, according to Bruner, is best for making sense according to principles that abstract from the context. In contrast, narrative understanding carries the weight of context, which makes it an appropriate medium for relating human experience and the contradictions and ambiguities that that entails. Bruner (1990) argues that to represent complex patterns of human interaction, often there is a constitutional tendency for people to construct their experiences in narrative form, from which aspects of reality can be abstracted.

Narrative inquiry therefore, can be said to offer an alternative way of thinking about 'revolving door' patients. First, the analysis of the narratives of 'revolving door' patients will enable interdisciplinary dialogue between professionals within the field of health and social care. This can be achieved by considering the diversity of disciplinary viewpoints in the context of attempting to understand individual behaviours. This approach first claims to present a framework for understanding the past, present and future lives of individuals, but from different epistemological positions. Second, it provides a better understanding of how identity is socially constructed. In seeking to understand identity, McAdams (1993) believes that one must look to life stories.

If you want to know me, you must know my story, for my story defines who I am. And if I want to know myself, to gain insight into the meaning of my own life, then I, too must come to know my own story (1993 p. 11).

According to McAdams and Bruner's argument above, encapsulating experience in the form of a story enables it to make sense in the interpersonal sphere. Atkinson (1998 p. 7) states, 'Typically, a life story narrative includes the aspects of our life and experiences that we want to pass on about ourselves to others, the parts that we have come to understand and see as the essence of our whole experience'. He adds, 'When looking at identity through the lens of the life story narrative, the immediate problem that presents itself is this: What is meant by identity? Does it tell who the person really is? Is there a felt unity of experiences in the story told? How is it defined, and what identity statuses are expressed? Are these internally and

externally consistent, and how do they match with identity formation models (p. 12)?' To answer questions of identity, Kroger (2007 pp. 3 - 7) offers a broad definition that is applicable across the whole life span and based on the work of Erikson (1980). Indeed, other identity theorists such as Marcia (1966), Gergen (1971), Kroger (1993) and McAdams and De St. Aubin (1998) have, to varying degrees, presented ideas on identity and its development. For example, according to Kroger (2007), identity can be understood from a historical perspective (Baumeister 1987) as well as from the sociocultural perspective pioneered by Mead (1934), the psychosocial perspective elucidated by Erikson (1980), or the narrative perspective of Ricoeur (1976, 1988, 1991b), and further developed by McAdams (1993), Wengraf, (2001) and Jones, (2001).

Bruner (1986), *Life as Narrative*, links identity and narrative. He concludes that self and story are 'complementary, mutually constituting aspects of a single process of identity formation' (p. 100). At the same time, MacIntyre (1981) conceives narrative as the most typical form of reporting human life, providing a rich source of insight. MacIntyre (1981 p. 218 - 221) speaks of identity as not only logically dependent upon the concept of a narrative – having a narrative structure - but also working in a circular fashion, a teleology. This circular teleology is what MacIntyre calls a 'narrative quest' (MacIntyre 1981 p. 218 – 221). For MacIntyre (1981), a life is lived with a goal, but the most important aspect of the life is the formulation and reformulation of that goal. MacIntyre asks, 'How can a person live a good life?' Since our lives are so unpredictable, this might seem a difficult question to answer given that the term 'biographical disruption' (Bury 1982) is often spoken of in relation to people with chronic illnesses. Frank (1995) approaches the issue from a different perspective, viewing 'quest' as a pursuit for answers about the illness so that life can seem more ordered.

Ricoeur (1981) provides another approach to understanding narrative identity. Fundamentally, Ricoeur (1981) argues that the narrative self cannot be segregated from the social nexus of the real world in which it is situated. For Ricoeur (1992), this means that the self can only exist in the form of 'selfhood' constituted by intersubjectivity. Ricoeur (1988) explains that to possess a selfhood is to be *subject to* and the *subject of* dynamic experiences and instabilities. To be a person and to gain one's identity – in the sense of identity as a narrated selfhood – means to be a

being which does not possess a fixed identity. A narrative identity is, therefore, not a stable and seamless identity. Rather, it is a complex array of stories about one's self and one's other entwined in history, community and memories – new and forgotten (p. 248). Thus, for Ricoeur (1992), to determine the identity of an individual is to enter into dialogues with others, as one can only make sense of one's self in and through involvement with others.

This involvement with others is regarded by Ricoeur as an opportunity for stories to be told about action within the institutions in which people live. Ricoeur (1992 p. 194) defines institution as 'the structure of living together as this belongs to a historical community – people, nation, region and so forth – a structure irreducible to interpersonal relations and yet bound up with these in a remarkable sense'. Within these institutions every human action has a conceptual network of motives, intentions, consequences and goals. Ricoeur (1992) then argues that there is a meaningful cultural context for every action and that action takes place according to the dictates of these cultural norms and presupposes motives, intentions and goals.

Ricoeur (1992 p. 147 - 148) makes the further point that narrative and action together create the narrative unity of a person's life by constructing the identity of the character in the telling of the story. Ricoeur (1981 p. 52) emphasises that the pre-understanding of human action leads to the temporal and historical dimensions of human action, in which the past is always in relation to the present and the present is always in relation to what is hoped for in the future. Therefore, when someone tells the story of his or her life, a biography, he or she is in effect connecting seemingly separate events with all their particularities into a coherent whole, so that the significance of each event can be understood through its relation to that whole' (Elliot 2005 p. 3). Taylor (1989 pp. 3 - 24) agrees with the statements above, arguing that our lives are shaped by inescapable frameworks which are deeply rooted in instinct. He states that, 'the very way we walk, move, gesture, speak is shaped from the earliest moments by our awareness that we appear before others, that we stand in public space, and that this space is potentially one of respect or contempt, of pride or shame' (1989 p. 15). Frankl (1962) puts it succinctly when he argues that the ultimate meaning in life must be beyond the simple comprehension of man. 'Man does not simply exist' as in a machine; he 'always decides what his existence will be and what he will become in the next moment'. Roberts (2002 p. 119) adds, 'Individuals, while

using wider modes of thought and expression (for example myths, symbols, beliefs), construct their own narratives according to their interpretations of experience in socio-cultural contexts’.

3. The Importance of Context in the Social Construction of Self/Identity

Writing from a sociological and phenomenological perspective, Schutz (1970) and Czarniawska (2004) point out that it is impossible to understand human conduct while ignoring its intentions, and it is impossible to understand human intentions while ignoring the settings in which they make sense. Based on this understanding, the settings in this study reflect Western perspectives of mental illness, historical and present; the current mental health system in England and Wales; psychiatric hospital environments; and care in the community as underpinned by health and social care policy.

I believe a significant factor in determining self/identity is the social and cultural environment of the patient. This includes the mental health professionals with whom patients come in contact and the interactions between them. I found Bourdieu’s (1998) sociological work of social field, capital (economic, cultural and social) and *habitus* added to the intelligibility of the environment, enabling a better understanding of the performances and affective connections of these actors. Bourdieu uses the term *habitus* to represent people’s perception of how they should behave in certain situations. For example, patients might hold a certain view of the world that bestows power to psychiatrists and other mental health professionals. The underpinning reality of this view is that it classifies the world and the patient’s position within it. This view is especially significant as feelings of powerlessness may cause patients to believe they do not have a ‘voice’.

In relation to the views of the mental patient, Faulkner and Thomas (2002) argue that ‘the dominant paradigm in psychiatry renders the views of people with mental illness invalid and negates the person as an individual’ (2002 p. 2). The point that Faulkner and Thomas make is interesting because, from a sociological perspective, Bourdieu (1998) views the individual as possessing social capital. In other words, the individual is the one best placed to talk about his or her social situation. At the same time,

however, Foucault (1973) in *Birth of the Clinic* provides an eloquent illustration of how the powers of professionals hover over peoples' lives, often preventing them from having their voices heard (Hadfield & Haw 2001). Faulkner and Thomas's (2002) observation raises questions about how people are to be understood if their views are being regarded as invalid.

Arguing for integration of narrative theory and a sociological concept of self, Goffman (1961) describes the general process of constructing life stories, of which the mental inpatient's is a particular type. Goffman (1961) makes a point of highlighting the influence of society's 'basic values' on the construction of a story. He argues that patients' stories are sanctioned by hospital staff, indicating the role of power and politics in the construction of identity (Goffman 1961; Vatne & Homes 2006 p. 590). The result of this sanction is that inpatients' stories are limited in their capacity. Essentially, what this means is that patients are often denied the opportunity to speak about their experiences of the mental health system in meaningful ways, for example, they are often considered too vulnerable (McIver 1991 p. 31) or irrational (Dworkin 1992 pp. 59 - 62; Rogers et al., 1993 p. 7) to take part in research. Hornstein (2007) points out that mental health professionals have often overlooked these accounts because the patients are considered to be too negative in their attitudes towards mental health services.

I believe that this has led to an absence of patients' accounts of their experiences in research. Indeed, one of the reasons for conducting this study was the realisation of the limited research that took as its starting point the experiences of patients. Furthermore, as found in this review of literature and in Birchwood, Hallet & Preston's (1988) and Hirsch and Weinberger's (1995) observations, 'revolving door' patients have more often been studied in the context of medical ideology, which focuses on biological and environmental factors that account for the aetiology or maintenance of severe mental illness.

Despite the difficulties likely to be encountered in the mental health system, it is within these settings that individual identities are negotiated with others in a social context, in response to cultural values and structural forces. Corker (2001) recognises the power of narratives to convey meaning, which is mediated through language and situated in spaces and historical moments. These meanings are,

however, often hidden. Josselson (1993 p. 2) picks up on this when she argues that 'the implicit meaning of life is made explicit in the stories people choose to tell about their lives'. These explicit theories are often drawn from sociological or social-psychological research on identity. Others draw their theories of identity from Berger and Luckman's (1966) social constructionism and Heideggerian post-modernist perspectives. These perspectives provide the context for reflections and ideas, particularly as changes in a person's self/identity are explained by the diversity of events and experiences in that person's life and stories told by the person having those experiences (Dilthey 1969, 1989; Polkinghorne 1988).

In a similar way, White (1973) argues that expressions of lived experience are construed as actions that are constitutive of life: these experiences are what is 'going on'. An understanding of these expressions of subjective experience and the real effects of these expressions is arrived at through the consciousness of those engaged in the actions. Hence, it is the explorations of subjective experience that contribute to 'rich' or 'thick' description (Geertz 1973). In this study, consideration was given to how these subjectively construed narratives are influenced and constrained by experiences of frequent and repeated admissions to psychiatric hospital. In further support of this approach, Atkinson (1998) views the telling of life stories as a way of answering the question, 'Who am I?' Atkinson (1998) states that, 'for some, in telling a life story, both self-image and self-esteem can gain in clarity and strength' (Atkinson 1998 p. 12). Atkinson (1998) further argues that this can be one of the uses for the researcher, to determine what relation the story told has to the person telling it.

In this review of literature, I found another feature of linking narrative to identity is the centrality of what McAdams (1996 p. 301) calls 'narrative text', a construct that Flick (2004) says is increasingly being used to refer to scientific knowledge (p. 91). Ricoeur (1991b) views narrative constructs as the durable character of an individual, which can be called his or her narrative identity. McAdams (1988) suggests that language is a text out of which identities are constructed, justified and maintained. This subjective or existential moment in the formation process is very important, as it is what enlivens the text and makes it relevant to a particular social group.

Jones (2001; 2003), McAdams (1993), Rosenthal (1993) and Wengraf (2001) have all contributed to a knowledge base by offering ideas on self/identity. These ideas are in contrast to traditional, positivistic approaches of human inquiry, for example, Heideggerian phenomenology goes beyond traditional research to offer an inside view of the lives of the mentally ill. This approach involves openness to multiple voices and inclusiveness of marginalised groups, such as those suffering from mental illness. At the same time, however, I believe the existence of self/identity as a universal but largely implicit concept complicates matters and makes it difficult to isolate and understand. This is because along with Breakwell (1983 pp. 3 - 4, 12 - 14), I believe it to be a complex entity that is open to different interpretations, depending on the perspective from which it is being studied. Essentially, this is what makes it difficult to define.

4. Memory and Narrative Identity

Memory extends the study of narrative identity in a number of ways. According to Bruner (1990), the storied life is of particular relevance in the construction of identity because the ideas that people construct of themselves – their image of who they are and where they fit – are understood as the framing of memory. Plummer (2001) supports this view regarding the storied life as memories gathered from years of personal experience. According to Pillemer (1998), events or episodes in a person's life, that happen more than once and suggest a pattern or theme that runs through the person's life story, are the most instrumental in defining the self/identity. Pillemer refers to these defining moments as 'personal event memory'.

The concept of a 'personal event memory' is delineated by Pillemer as having five distinct features; the personal event memory must:

1. Be a specific event that took place at a particular time and place;
2. Contain a detailed account of the person's personal circumstances at the time of the event;
3. Evoke a feeling of re-experiencing or reliving the event;

4. Link its details and images to a particular moment or moments of phenomenal experience; and
5. Be believed to be a truthful representation of what actually transpired (1998 pp. 48 - 51).

Considered in this way, I wondered whether the experience of having multiple admissions to a psychiatric hospital would have any significance in defining a patient's self/identity. As a social work practitioner, I have observed how mental health professionals often label patients as, 'revolving door' patients because of the number of admissions they have had. Indeed, the term has become common place in many psychiatric hospitals and is often used to identify patients whom professionals regard as difficult to manage. Because mental health professionals have already defined patients by the number of times they are admitted, it would be interesting to find out if, after having these admissions, patients identified themselves as being different in any way from other people.

It could be that admissions become the dominant story for patients and their experience of the admissions is all they remember. If this were to be the case, then memories of these admissions could be considered as defining the patient's identity. If the patient were to tell a different story, he or she would need to overcome difficulties in his or her social environment and recover memories that are coherent and meaningful. This is because understanding relations between self and the environment is often regarded as key to creating meaning in one's life.

Roberts (2000 p. 432) asks, 'What place do stories have in an evidence-based world of psychiatry, especially when the case of an individual has been downgraded to the status of an "anecdote"?' To answer this question, I drew on a quote by Peter Huxley, Professor of Social Work, Kings College, London. He states:

Without social scientists to study and improve social interventions and the measurement of the impact of social care the health service will simply continue to rotate consumers through its hospitals and community teams. Re-admissions and social exclusion due to the failings of the social system will continue unless the role of the social care provision is taken more seriously and concrete steps are taken to create a better evidence based social science (Huxley 2001 p. 23).

With this message in mind, I have attempted to explore identity in relation to multiple admissions to psychiatric hospital by listening to the stories patients tell of their experiences. As stated above, the notion of listening to patients' stories is central to understanding how lived experiences can be used to give psychological meaning to their lives through interpretive research. Indeed, Dilthey (1968 p. 218, cited in Marotzki 2004), states that 'life history shows itself to be a construct produced by the subject and, as a unit, organises the wealth of experiences and events in the course of a life in some coherence'. The creation of this kind of coherence of experience is achieved through an act of meaning attribution. From the present, meaning is given to past events. The memories that a person can recall of his or her life are those that seem globally meaningful and through which that person structures his or her life. It is only when these meaning-coherences set up by the subject are available that development is possible.

In order to capture participants' perspectives accurately, I placed emphasis on questions such as the following: What assumptions do participants make about their lives? How do they define their identity and the people they have become or are in the process of becoming (Ruthellen 1996)? Essentially, what significance do they place on multiple admissions in the definition of who they are?

5. Discoveries from the Literature Review

One of the most prominent features of this research group as discussed in the literature has been the observation that the experiences of these individuals are not being adequately or accurately represented in the discourses of psychiatry and in social policy arenas in general (Harper 1994). I believe that these individuals live lives that have meaning and that what is needed is a method to better understand their lived experiences. Mishler (1986 p. 67) states that 'telling stories is one of the most significant ways individuals construct and express meaning'. In fact, did not Conrad (1990 p. 1259) suggest that in order to understand and describe the patient's world, an 'insider's view' is required to access the person's social and psychological experience? Indeed, in his attempt to understand chronic illness within a sociological position, Conrad identified the powerlessness of the patient's position and the dominance of the medical model as two contending issues. Other factors include how

personality (Bruner 1987), gender (Busfield 1996), attitudes and beliefs (Hinton and Levkoff 1999), and the illness itself (Kleinman 1988, cited in Casey, and Long (2003 p. 89)) affect the way in which individuals construct their identities, and how these identities are interpreted and accommodated by their social environment.

6. Implications for 'Revolving Door' Patients

The review of literature has shown that the subjective experience of 'revolving door' patients has generally not been regarded in mental health research. Indeed, what I have presented above seems to be symbolic of positivistic research. Supporting my observation, Birchwood, et al., (1988) and Hirsch and Weinberger (1995) argue that 'revolving door' patients have more often been studied in the context of medical ideology, which is focused on biological and environmental factors that account for the aetiology, or maintenance, of severe mental illness. They have also been studied as passive objects whose individual characteristics and feelings are mostly variables to be 'controlled out' in order to ensure valid results (Rogers, Pilgrim & Lacey, (1993 p. 6). In this respect, psychiatry may not be any different from other areas of medical research in which emphasis is placed upon scientific method and design (Rogers et al., 1993 p. 6). At the same time, there are a number of reasons that have been used to explain this scarcity of representation of people with mental health problems within mental healthcare research. These reasons include the following:

- The assumption that the views expressed by psychiatric patients will be irrational or unreliable because of the state of their minds (Rogers et al., 1993 p. 7).
- The assumption that the very fact that those receiving psychiatric treatment may have been given a diagnosis of 'mental illness' means that they will be incapable of expressing a rational opinion (Dworkin 1992 pp. 59 - 62).
- The assumption that research involving mental health users may cause distress by encouraging them to recall unhappy events or experiences that people may prefer to forget (McIver 1991 p. 31).

7. Implications for Social Work and Mental Health Research

Social work in Britain continues to be bound up in ideologies of practice based on all aspects of social life (Spicker 1995 pp. 71, 72). While listening to what people say has in recent years become a key feature of government policy (Henderson and Atkinson 2003), few opportunities exist for the ideas of service users to be heard or acted upon (Coote 1992 p. 109). Denney (1998) argues that ideas relating to social policy and social work continue to be generated by political parties, civil servants, government advisors, the various arms of the media and, to an ever lessening extent, practitioners and academics.

Current mental health policy is laid out in the form of The Mental Health Act 1983 (Jones, R. 2001) and the NHS and Community Care Act 1990 (Department of Health 1990), established as the legal framework for health and social care needs for adults. In addition, the Care Programme Approach (Department of Health 2002) ensures the coordination of health and social care for people with mental health problems.

The National Service Framework (Department of Health 1999) gives direction for the further development of mental health services, but already the proposed reform of the current Mental Health Act has attracted fierce response from support groups, arguing that the bill does nothing to protect the rights of the mentally ill (Watson 2003) and that it is likely to do more harm than good to the people it should protect (pp. 764 – 765).

Where does all this leave the role of the social work researcher? Powell (1997) suggests that social workers need to attach more importance to research with emphasis on qualitative methodologies. She argues for an interpretive approach to social work research, which she sees as an attempt to encourage closer links among research, theory and social work practice (p. 151). This view is congruent with my own beliefs about the need to develop a knowledge base to inform social work practice rather than to rely on other disciplines. Shaw and Shaw (1997 p. 847) also call for social workers to find new purpose through an empirical research-based practice. Corney and Murray (1989), cited in Ruston (1990 p. 380), argue for a full range of approaches to evaluate specific methods of social work intervention.

Knowledge of the effectiveness of social care is the major missing link in the community treatment of mentally ill people.

Reason (1988 p. 2) argues that social workers need to establish dialogue between researchers and the people with whom they work to discover and realise the practical and cultural needs of those people. In recognition of this, Mohr (1997) acknowledges the contribution Denzin (1989) has made in the development of social research. Denzin (1989) states:

The primary aim of interpretive interactionism is to elicit “thick description” from the study participants and to develop “thick interpretation”. Thick description has the quality of being dense and richly detailed. It tries to retrieve the meaning and to “capture” the interpretations that participants have brought to their experiences, thus laying the foundation for thick interpretation (1989 p. 275).

This approach is consistent with Lofland and Lofland’s (1995 p. 146) ideas of deciphering and depicting exactly what sort of situation the participants are facing and understanding the different strategies they construct to deal with the situation.

Historically, the opinions of the mentally ill, while regarded as central to many ethical debates, were often not considered. A literature review illustrates this problem by the limited information available on the personal experiences of such people.

D. PART THREE

1. Motivation and Reflection

In this section, I reflect on my motivation for this study. Following this, I conclude with a summary of the chapter.

Essentially, for me this study has been a research agenda driven by a general interest in mental illness. Indeed, my decision to study how patients (re)construct their identities in relation to readmissions was influenced by the interest provoked by my work as a mental health social work practitioner. I was particularly interested in hearing from patients themselves about their experiences.

Further interest in this topic came from the realisation that so few studies that focus on the subjective experiences of patients have been conducted.

Reflecting back to when I first became a mental health social work practitioner, my initial reaction was one of surprise. I was surprised by the power dynamics in the relationship between myself and the service user, and the complex set of social structures that existed in social work practice. Pollack (2004 p. 702) points out what, to me, now seems quite obvious: The encounters between the client and the worker, the worker and the agency, and the agency and the state are all shaped within the context of unequal power relations. See also Layder (1998) for a discussion on dualistic relations from a socio-political perspective.

On reflection, it was Foucault's work that held the greatest importance for me. In his writings I have found the clearest account of how power is situated within social practices and situations. Much of Foucault's work is concerned with demonstrating the constructed nature of our most established assumptions. For example, in *Madness and Civilisation*, Foucault (1967) argues that the emergence of positivist psychiatry itself has sought to convert the human sufferings of madness and alienation into technical problems which can be understood in standardised ways.

Indeed, the current use of the Index and Glossary of Mental Disorders of the Tenth Revision of the International Classification of Diseases and Related Health Problems within the acute sector of the NHS across England confirms this. Psychiatry uses this code of practice' for the diagnosis or reason for a patient episode of healthcare. Mace and Binyon (2005 p. 418) argue that it is expected to be a guide for treatment as well.

Another aspect of my interest in human inquiry has to do with my fundamental view on open-mindedness and respect for human individualism. Mill (1998 p. 400) says that 'each individual has a basic right to manage and create his or her own life'. Conversely, During (1992 p. 12) argues that the ability to create one's own lifestyle may never be realised. This is because laws embodied in the state define concepts of 'normality'. In this way, certain behaviours regarded as socially unacceptable require intervention, consequently restricting freedom to act.

I stated in the introductory chapter that even though I have been a social worker for over ten years, I still believe I lack knowledge about mental illness and admission to psychiatric hospital. This lack of knowledge has not necessarily been a bad thing. What it has offered me is an opportunity to explore the phenomena of multiple admissions to psychiatric hospital, using interpretative qualitative methods to better understand the vast and complex history, culture and society of the mentally ill. I believe that the life stories of these patients would otherwise have been silenced by traditional research methods.

Smart (1993 p. 12) holds the view that 'the post-modern mind is a way of reflecting upon the world and our place within it'. In the field of mental health, the post-modern mind is where the plausibility of widely-held views based on the philosophy of positivist psychiatry can be challenged. I firmly believe this. I also believe that mental disorders are aspects of life, and not necessarily temporary difficulties that need to be overcome by structured systems.

E. CONCLUSION

The purpose of this summary is to bring together the topics covered in this chapter. In framing the research context, I drew on literature about the history of 'madness' and have evidenced the works, amongst others, of Goffman (1961, 1970, 1961), Foucault (1967, 1973), Mora (1980), Jones (2002; 1972, 1993), Shorter (1997) and Porter (1999, 2002). These writers have commented on deinstitutionalisation, offering critical political and ideological viewpoints in the context in which the 'revolving door' phenomenon is situated. This study situates the patient within a social and historical context and recognises the importance of reflexivity in making sense of social reality. The focus was on illuminating details and aspects within experience that mental health professionals and patients may take for granted in relation to repeated admission to psychiatric hospital.

From the review of the published material it emerged that an investigative exploration of the psychological/subjective experiences of 'revolving door' patients has not yet been reported. The most striking feature of this review was the lack of literature on patients' subjective experience of repeated admission to psychiatric hospital. In fact,

the studies reported in this chapter largely focused on biomedical factors and not on idiographic approaches to research.

Since there were not many results that focused on the subjective/psychology of the patient, I concluded from the absence of such information that there was a definite gap in knowledge. As such, this study seeks to fill in part of this gap by contributing to knowledge and understanding concerning identity and multiple admissions to psychiatric hospital. Jones (1972 p. 346) says that 'there is an urgent need for research which will trace individual cases through the services, and indicate what the total pattern of treatment is. Crude statistics tell us very little about the real significance of the events recorded in either the life of the patient or of the hospital'. Thus, to understand patients better, I decided to rise to Einstein's challenge: to look for new ways to ask questions and exchange views in order to gain a better understanding of people. This challenge has been applied to the study of self/identity and readmission to psychiatric hospital. By regarding the 'revolving door' phenomenon from the perspective of the patient, I have already taken my first step towards the real advancement of science. Perhaps the creative imagination part will now follow. Indeed, the next chapter contains the methodological approach to be used to develop the research discussed in this chapter.

CHAPTER III

METHOD & METHODOLOGY

When the number of factors coming into play in a phenomenological complex is too large scientific method in most cases fails.

Albert Einstein (Thinkexist.com)

A. INTRODUCTION

In Chapter Two, I introduced the concept of the person as an existentially embodied individual. My concerns were, in the main, directed toward a social psychology approach (Lindesmith, Strauss & Denzin 1977) characterised by the notion of socially constructed identity (Denzin & Lincoln 1994; Gergen 1991, 1995). According to social construction theory, meanings evolve continually from interactions between people (Gergen 1994, 1995; Mead 1934). These meanings are part of a course of continually changing stories (Schwandt 2000). In these stories, human beings construct knowledge by inventing concept models or schemas that help them make sense of their experiences. These constructions are continually tested and modified in the light of new experiences encountered. Finally, interpretations of these experiences are constructed against a background of shared understanding, practices and language (Bakhtin 1981; Geertz 1973).

In this chapter, I present the case for applying a qualitative biographic narrative interpretive methodology in the narrative study of 'revolving door' patients' self/identity. The argument in this chapter is based on the belief that 'revolving door' patients are best positioned to describe and analyse their experiences and feelings in their own words. I suggest that from a social constructionist (Berger & Luckman 1966; Gergen 1994, 1999) and post-modernist perspective (Best & Kellner 1991) self/identity is socially constituted by the life stories that participants tell in their efforts to read meaning into their lives (Holstein & Gubrium 1995 p. 3; Widdershoven 1993). This view is based on ethnomethodological belief (Gubrium & Holstein 1997) that

developing a sense of self is an essential part of every individual becoming a person. Supporting this view, Widdershoven (1993 p. 6) states, 'Stories are important for our identity: They tell us who we are.' Thus, each person's self-conception can be regarded as a unique combination of many identities constructed on the basis of various experiences. As such, these constructions are open to a variety of interpretations. In these interpretations, the meaning of life is spelled out (Widdershoven 1993 p. 9). How these interpretations are conceptualised and analysed involves the application of a variety of theoretical perspectives. Some of the main perspectives were introduced in Chapter Two of this thesis.

1. Philosophical Underpinning and Post-modern Thought

Without a doubt, it could be argued that the nineteenth and twentieth century, referred to in philosophical terms as the post-modern period, are a response to modernist thinking which proposes that truth or certainty can be found through empirical study. Leading the way is Heidegger (1927/1962), who challenged the view of positivism, suggesting that we can only interpret the meaning of a phenomenon within the context of our background and that there is no definitive meaning in any experience. Lyotard (1984 p. 24) defined this post-modern condition as 'an incredulity towards meta-narratives'. He set the stage for debates about the various ways in which human society gives meaning to its experiences.

On this same issue, Hollway and Jefferson (2000) argue, 'If we wish to do justice to the complexity of our subjects an interpretative approach is unavoidable'. Hence, phenomenological hermeneutics, primarily that of Heidegger (1962), underpins this study. For Heidegger, the task of hermeneutics was to understand the mystery of 'being'. Phenomenology is seen as the primary focus on the structure of 'being' (Heidegger 1962 p. 29) and is concerned with describing and analysing human consciousness as it is perceived, independent of theories. In their attempt to simplify terms, Dahlberg, Drew & Nystrom (2002) speak of the 'lifeworld' instead of using the term 'being-in-the-world'. Both terms, however, relate to the belief that individuals and their living conditions can never be completely understood if they are not looked upon as living wholes (Dahlberg et al., 2002 p. 91). Polkinghorne (2000) argues in a

similar vein that the importance of hermeneutic phenomenology lies in the fact that we are not locked into our backgrounds. He believes that we have the ability to expand our understanding of ourselves, our world and others in order to address issues and accomplish goals. I am in agreement with Leonard, cited in Benner (1985 pp. 5 - 6), who states that 'the goal of a hermeneutic, or interpretive, account is to understand everyday skills, practices and experiences; to find commonalities in meaning, skills, practices and embodied experiences, and to find exemplars of everyday practices (...) in such a way that they are not destroyed, distorted, de-contextualised, trivialised or sentimentalised'. Phenomenology, therefore, could be understood as offering the possibility of understanding social and psychological phenomena from the perspectives of those involved.

In order, therefore, to explore patients' experiences of the 'revolving door' phenomenon, it is necessary to inquire into the meaning of the phenomenon for them. What I take from this view is that it is almost impossible to fully understand individuals by doing research in which the principles of the method regard individuals as objective entities. This type of research consists generally of random control trials, questionnaires or even structured and semi-structured interviews (Creswell 1994). Indeed, psychological research tools such as the 'Likert Scale' – 1, strongly agree; 2, agree; 3, neutral; 4, disagree; 5, strongly disagree – have been developed to measure psychological concepts such as quality of life; as in, for example, *Lancashire Quality of Life Profile* (Oliver, Huxley, Bridges & Mohamad 1996). This interview questionnaire covers nine entities of life: work, leisure, religion, finances, living situation, legal/safety, family relations, social relations and health. Each entity is addressed by a set of 'objective' indicators (yes/no/don't know) combined with a set of subjective ratings (couldn't be worse, displeased, mostly dissatisfied, mixed feelings, mostly satisfied, pleased, couldn't be better).

Unfortunately, this kind of research tool is limited in its capacity to illuminate the 'lifeworld' of the everyday person and places control of the interview firmly with the interviewer. This is one of the reasons why phenomenological hermeneutics is used in this study to explore patients' experiences of the 'revolving door' phenomenon. Through this combination comes a shared understanding of what is known. Kvale (1996 p. 14) terms this as a construction of knowledge inter the views of the

interviewer and interviewee. In other words, the outcome of this co-creative approach is the social construction of knowledge.

The aim is to examine how ‘revolving door’ patients construct understandings of their lives and how they both influence and are influenced by life events. The use of a narrative-based interview approach (Jones 2003; Wengraf 2001) is viewed as imperative to eliciting the depth of information required to make sense of these patients’ experiences and actions. The notion that one must understand one’s self through dialogue, as postulated by Bahktin (1981), is used as the basis of the inquiry.

Following on from the series of concurrent decisions which have led me to the philosophical framework, perspectives and methodological approaches, the remainder of this chapter is as follows: First, I state the research problem and clarify the research question. Next, I discuss the research design. After that, I describe the interview process. After the interview process section, I discuss ethical considerations. Finally, to end this chapter, I offer a conclusion.

B. THE RESEARCH PROBLEM

As stated in the preceding chapters, mental health issues are becoming ever more important to policymakers (NIMHE 2004), particularly in a climate of rapid changes within the National Health System (Palmer 2006). A literature review reveals that a major stumbling block in policy has been the lack of qualitative data relating to the views of individuals who are frequently and repeatedly admitted to psychiatric hospital and how these individuals are affected by their experiences. The implications of this lack of research suggest that the views of service users are not reflected in policy decisions. Policies, therefore, that are not based on what works best for service users are being introduced. Service users know there is only one genuine yardstick by which to judge – the best system of service delivery is the system that works. There already exists literature advocating the importance of user involvement when planning and delivering mental health services (Department of Health 2001; Tait & Lester 2005; Thornicroft, Bindman, Gournay & Huxley 2002). Nonetheless, the literature on readmissions to psychiatric hospital has not been developed sufficiently

to include the perspective of the patient (Coulter, Fitzpatrick & Jane-Davis 2002) as evidenced in my literature review. There is very little work, however, that actually sets out, as a research priority, to gather the views of the mentally ill (Coote 1992; Pilgrim & Rogers 1993). This lack of empirical research highlights the gap in knowledge concerning the problem of 'revolving door' patients.

Interestingly, the 'revolving door' phenomenon is well understood at the socio-political level (macro) as problematic. At the social level, it disrupts the lives of those for whom it is an issue (Bury 1982; Frank 1995). Politically, it is regarded as an issue that must be tackled at the highest level (House of Lords and House of Commons 2005), partly because of the enormous economic cost (Knapp 2003; Layard 2004 pp. 10, 17; Personal Social Service Research Unit 2001; Scottish Development Centre for Mental Health April 2003). What remains less fully understood at the individual level (micro) is how this phenomenon impacts the subjectivity of the patient. This notion of subjectivity is intriguing since there seems to be an objective dimension within a patient's subjectivity itself. The ordinary person, who is mentally well and is capable of autonomous thought, can, in effect, think both subjectively and objectively (Atkinson 1998 p. 10). The person who is thought to have a mental illness, however, has an increasing problem in doing either of these things because of the likely detachment from his or her experiences (Sifneos 1972). By implication, Sifneos means that some mentally ill individuals are unable to identify with or express subjective emotional feelings.

Paradoxically, mental health professionals, whose responsibilities include assessments of mental states, are able to gather information from and about these patients, albeit from highly structured interview schedules designed to obtain psychiatric diagnoses (Robins, Helzer, Croughan & Ratcliff 1981). For most professionals, however, the workday holds little opportunity for engaging in the development of a deeper and more complex understanding of issues such as the 'revolving door' phenomenon (see Shaw 2004 pp. 1032 - 1045). Yet these professionals often find themselves in a position of trying to re-tell the way in which patients understand and interpret their situations. Further, complexity in understanding this phenomenon exists because of individualised views of the world (Dahlberg et al., 2002). Within these individualised perspectives, there exists valuable information that could shed light on how the 'revolving door' phenomenon is

perceived from the patients' perspectives. In addition, such perspectives convey how the 'revolving door' phenomenon relates to other aspects of life, seen as relevant by the patient.

Because of these inherent complexities, misunderstandings in practice are not uncommon between patients and professionals. The following quote from (Kleinman 1998 p. 25) emphasises this problem:

I don't think he heard me. I wanted him to listen to me not for the diagnosis but for my story. I know I'm depressed. But I wanted him to hear what is wrong. Depression may be the disease, but it is not the problem. The problem is my life. The centre doesn't hold. Things fall apart. It's falling apart. My marriage. My relationship with my kids. My confidence in my research. My sense of purpose. My dreams. Is this the depression? Maybe it caused the depression. Maybe the depression makes it worse; or seem worse. But the problems also have their own legitimate reality. This is my life, no matter if I am depressed or not. And that is what I want to talk about, to complain about, to make sense of, to get help to put back together again. I want this depression treated all right. There is something more I want, however. I want to tell this story, my story. I want someone trained to hear me. I thought that was what psychiatrists do. Someone ought to do it., ought to help me tell what has happened. But all he seemed interested in was the diagnosis and my dad's death. I am sure that is part of it, but so much else is going on. I need to talk to someone about my whole world not just part of it (1998 p. 25).

What the statement above indicates most clearly is a need to allow patients to tell their stories. It was, therefore, necessary and appropriate to take an exploratory and qualitative approach to this study that would facilitate the telling of life stories. The approach begins to understand the 'revolving door' phenomenon in a manner that captures the essence of the problem and explains how it relates to the concept of socially constructed identity.

The methodology developed to accomplish the specific aims of the research study, therefore, meets the requirements (identified below) by employing a combination of tools and analytical procedures. The methodological approach of the study is qualitative, employing the Biographic Narrative Interpretive Method, (Wengraf 2001) as its data and analysis tool. The Method incorporates principles of case studies (Yin 1994) in its design. These principles are used to illuminate the central question

about the way that ‘revolving door’ patients construct meaning and reality and how these understandings are incorporated (or not) into their senses of identity. Before discussing the research method, the research question is presented.

1. Research Question

After formulation and re-formulation, the research question has evolved into the following:

- How does each ‘revolving door’ patient construct meaning and reality?
- How does that enacted reality provide a context for shaping his or her identity?

For the sake of clarity, I consider it necessary to specify what is meant by the research question. This is because the questions are made up of terms that derive from medical discourse and are sometimes ambiguous and not commonly understood. They are defined so as to convey the context in which the study was conducted. In my definitions below, I wanted to identify the most important dimensions of the research topic and explain how its meaning connects to the overall aim of the project.

Term	Meaning
Revolving door	Metaphor for referring to people who are treated in a psychiatric hospital, are discharged, become unwell, and return to hospital again, either voluntarily or involuntarily, in an ongoing cycle.
Psychiatric patient	A person considered by others to be suffering with mental health problems. It suggests that the person has a problem which, in accordance with medical perspectives, must be diagnosed and treated.
Meaning	The messages or interpretations about a particular event that are conveyed to the patient.
Reality	An ambiguous term that implies an attempt by someone at making sense of his or her situation.

Enacted reality	Individual performance in relation to perceived reality.
Context	The personal familiarity with cultural, demographic and socio-political settings in which the action is performed.
Shaping	The psychological implications of an event or experience.
Identity	Ideas a person has about himself or herself in relation to others, about his or her position in the world.

Table 2.0 Research terms

The research question is consistent with the qualitative paradigm which is based in an ontological approach to human inquiry. In addition to the meaning of terms above, I define the term ‘revolving door’ patient as someone who has had more than two admissions to a psychiatric hospital within three years of the first admission.

2. The Biographic Narrative Interpretive Method

My search for a method that enabled participants to remain close to the reconstruction of their experiences and enabled me to move freely across traditional disciplines and levels of understanding was finally rewarded in the Biographic Narrative Interpreter Method (Wengraf 2001).

This Method originated in social sciences research that has focused on life-story research (Hollway & Jefferson 2000). It is constructed from interactions and phenomenological research by Rosenthal and Fischer-Rosenthal in Germany (Wengraf 2001 p. 112). They developed a narrative interviewing technique based on Overmann’s 1979 hermeneutical case construction and Schütze’s 1983 method of story and text analysis (Wengraf 2001). The use of biographical method, with its minimalist interview technique, is fast becoming one of the principle means by which qualitative and subjective construction of data about people’s lives is collected, particularly in eliciting stories from disparate communities (Rickard 2002), cited in Jones (2004)). This is because narratives not only reveal past actions but also show how people understand actions and their meaning (Riessman 1993 p. 19).

Fundamentally, structured interview formats aim to capture 'precise data, of a codable nature in order to explain behaviour with pre-established categories'. The Method, however, is used in an attempt to understand the complex lives of members of society, without imposing any assumptions that may limit the field of inquiry (Wengraf 2001). Biographical interviews have the advantage of situating any prior conceptions held by the researcher in the background, while giving priority to the participants' own conceptions of their experiences (Wengraf 2001). Indeed, in the self-reflexive process, identification of prejudices and pre-understandings that are outcomes of the researcher's background must be identified and reflected upon by the researcher at the beginning of and throughout the research.

Another key feature of the technique used in the Method is that a single, initial narrative-inducing open question can be used, such as, 'I want you to tell me the story of your life', to generate an extensive, uninterrupted narration (Wengraf 2001 p. 119). Miller (2000) states, 'This apparently simple request has led to a revolution in social science practice. For it even to be seen as a legitimate query required a shift in paradigmatic viewpoints, about the nature of the social scientific enterprise' (Miller 2000 p. 1). Alternatively, and still within the Method, response can be more targeted by a single narrative question that is, instead, directed to a thematic or temporal area of the participant life story (Wengraf 2001 p.122), for example, 'Tell me the story of your life, when you were first admitted to a psychiatric hospital.' Both these approaches can be useful, as the storyteller determines what is told, what is important and what is unspoken (Rosenthal 1993 p. 89). At the same time, this is different from semi-structured or structured interviews that try to elicit facts based on the researcher's own interests.

The interview process is quite different from conventional interviews described by Gubrium and Holstein (2001 p. 3). Instead, it is based on an interview composed of three sub-sessions/phases (Wengraf 2001). In the first phase, the interviewer asks a single initial question designed to elicit the full narrative and indicates that there will be no interruptions (Wengraf 2001 p. 119). This second phase is normally done on the same day or, if the narration is very long, in a follow-up interview, as soon as possible. The interviewer asks for more stories about the topics that were raised in that initial narration, following strictly the order in which they were raised and using the words of the interviewee in respect of those topics (Wengraf 2001 p. 120). The

ordering of topics or themes presented in the initial interview is done to protect the *gestalt* of the whole story presented by the interviewee. *Gestalt* is central to the theoretical principles of the Method and has been defined by Hollway and Jefferson (2000) as 'a whole which is more than the sum of its parts, an order or hidden agenda informing each person's life' (Hollway & Jefferson 2000 p. 34).

After the second session, there can be a third phase interview. In this phase, further questions arising from preliminary analysis of Phase 1 and 2 are raised. Additional material from clinical records and documents can be utilised to build the case, including the possibility of a follow-up session with more focused probes. Strategically, this phase is completely structured by the interviewer's concerns, which give a strong directionality to the flow of the interview. Here any questions can be asked about 'topics not mentioned' previously (Wengraf 2001 p. 120).

3. Analysing the Data

Data from the interviews is transcribed verbatim, and then a microanalysis of the narrative of the constructed life is conducted. At this stage a distinction is drawn between the *lived life* and *told story*. The *lived life* refers to a series of substantive events arranged in chronological order. It is a passive reconstruction, it is hoped accurate and reasonably complete, of a core of actual events (Miller 2000). It is analysed sequentially and separately from the *told story*. Conversely, the *told story* refers to the account given by an individual, with emphasis upon the ordering into themes or topics that the individual chooses to talk about or not as he or she tells the story (Miller 2000 p. 19). 'It is an active reconstruction of the interviewee's view of their life' (2000 p. 139), which is analysed using thematic field analysis. This involves reconstructing the participants' system of knowledge, their interpretations of their lives and their classification of experiences into thematic fields (Rosenthal 1993 p. 61). 'The thematic field is defined as the sum of events or situations in which the theme stands out as the central focus' (Rosenthal 1993 p. 64). The told story and lived life always come together to form the case (Jones 2003 p. 61). It is important to note that there is no single 'best' or 'correct' construction of the life story. The content of a life story that a respondent will give in an interview will be dependent upon how

he or she sees his or her life at that particular moment and how he or she chooses to depict that life view to the person carrying out the interview (Miller 2000 p. 139).

The Method is based, in part, on grounded theory (Chamberlayne & Rustin 1999 p. 25). However, Jones (2001) traces it back to inductive reasoning in analysis. According to Glaser and Strauss (1967), grounded theory is a research method that uses a systematic set of procedures to develop inductively derived theory about a phenomenon. The purpose is to build a theory that is faithful to the data. Analytical induction, from which the grounded theory is derived, was first described by the sociologist Florian Znaniecki (cited in Ratcliff 2001 p.1). It is also the data analysis method used in the Biographic Narrative Interpretive Method. Analytical induction, however, contrasts with grounded theory in various ways. Analytical induction not only generates theory but also, all data available must be used to test the hypotheses. This is in contrast with constant comparison which requires that data only be used until categories become saturated (Ratcliff 2001 p. 2). Additionally, 'in interpretive research, unlike in grounded theory, the goal is to discover meaning and to achieve understanding' (Benner 1994 p. 10). Inductive data analysis, as an alternative to grounded theory's 'constant comparisons method' (Thomas cited in White, Chalip & Marshall 1998 p. 1), 'is typically qualitative; it makes use of comparisons (typically of cases); it often makes uses of techniques which share some affinity in phenomenology and hermeneutics' (White et al., 1998 p. 3). I decided, therefore, to use the analytical inductive approach to analysis as it is based on 'objective hermeneutics' and is still within the protocol of the Biographic Narrative Interpretive Method. In essence, it allows research findings to emerge from the frequent, dominant themes inherent in raw data without the restraints imposed by structured methodologies (Thomas 2003 p. 2). Essentially, the analysis is done before any general formulations.

My aim was to comprehend the subjective understandings that participants have of their lived experiences and how these understandings inform personal constructs used for making sense of themselves. From a hermeneutic perspective on analysis, the interpretive biographical approach involves interpreting data from an empathic perspective (Josselson 1995). According to in-depth hermeneutics, subjective expression is not only taken for granted, but it is also allowed in order to look for meanings and implications beyond the knowledge or intent of the acting, knowing or

speaking subject. Further, it conceives reality as contradictory and repressive and assumes that critical interpretations should always be an attempt to develop the underlying or repressed possible actions of the subject. From this follows a double attempt to deconstruct meanings and actions and to construct other possible meanings and actions (Schwandt 1997).

4. The Reflective Team

A unique and interesting element of the Method's analysis process is the use of what is called the 'reflective team' approach (Jones, K. 2001 pp. 16, 66 - 67; Wengraf 2001 pp. 258 - 264). In Wengraf's version, the reflective team is referred to as a 'panel'. This section presents the conceptual framework used in this approach for analysing data. Before I discuss the analysis process, it is worth pointing out that there are some additional principle changes that distinguish Wengraf's (2001) from Jones's (2001) approach to analysis in this method.

Jones (2001 p. 67) backgrounded Wengraf's (2001 pp. 239 - 243) text structure sequentialisation (TSS) and foregrounded microanalysis of selected text in order to create a space within the team analysis for more creative possibilities.

Another important observation in Jones' (2001) work was the disappointment shown by reflective team members when time ran out, preventing the analysis of the whole story in one sitting. By not following Wengraf's TSS, which is labour intensive, and by incorporating Jones' approach in this study, it was possible to analyse the whole story within the time frame that worked for the reflective teams. I regard these changes to have enhanced the Method; the basic principles of the Method, however, remain the same.

According to the Method, analysis is begun hermeneutically by the reading of the interviews several times to get a sense of the whole and to compare the participants' statements for emerging themes (Dahlberg et al., 2002; Rosenthal 1993). Once these themes have emerged, a tentative interpretation can be conducted to find some preliminary meanings within the themes (Dahlberg et al., 2002). At this stage interpretations can be supported by well-known theories, for example,

psychodynamic theories of identity, as mentioned above. Dahlberg et al., (2002) suggest that:

It is worthwhile to keep more than one theory in the interpretive process (and that) it is important that the theory is chosen on behalf of the data, and that the opposite possibility be excluded when it no longer serves the interpretation (p. 208).

Using a reflective team approach to data analysis is intended to add robustness to the research. This suggests to me that the reflective team can be a way for researchers to critically examine their methods and their use. This approach to data analysis facilitates the introduction of multiple voices and the opening up of interpretation possibilities, rather than relying solely on the principal researchers' interpretations of the interview. A prerequisite for the participants of the reflective team is openness and creativity/imagination rather than knowledge of specific research methods (Jones 2003 p. 60 - 71). Jones (2003) used reflective teams of academics from diverse backgrounds to analyse interviews using the individual's understanding of their own experiences as a basis.

Miller (2000 p. 150) sets out the following procedure for micro-analysing texts with a reflective team, which was followed closely. A small segment of transcript is presented to the reflective team. They are invited to brainstorm about all the possible reasonable interpretations (hypotheses) that can be drawn from microanalysis of that single segment of text. These interpretations include making sense the way the interviewee may be influenced by factors such as my being black, middle class and a social worker. The reflective team process works well, as it allows for more than one perspective on the experiences of participants.

The interpretations that the team comes up with are written down. Then the next segment of the transcript is presented. At this point the researcher looks to see whether some of the interpretations/hypotheses that arise from the first unit of the text can be ruled out by this second segment of transcript (abductive reasoning).

The next step is to look at the two-text unit together and ask the team to brainstorm to see whether an additional hypothesis can be proposed. After that, the researcher moves to the next text unit/segment and repeats the procedure. The procedure is

repeated until the end of the transcript, at which point the final lists of interpretations/hypotheses are considered.

5. Reflecting on the Method

The discovery of the Method was a pivotal part of my research journey: a journey of evolving understanding of the research process that led me to appreciate the life story interview as a powerful research method.

On reflection, I feel as though I have made many journeys in the process, but there has only been one, in reality. The Method presented here is by no means the only approach considered for this study. It is simply one that follows naturally from the discoveries made along the research journey. Indeed, the Method shares some characteristics of other research techniques such as oral history and interpretative interactionisms (Denzin & Lincoln 2003). At the same time, the number of narrative approaches used in studying self/identity has rapidly grown in recent years. Two approaches considered on the way to the Method included McAdams' (1993) autobiographical approach and Smith's (1996) Interpretative Phenomenological Analysis (IPA). My journey, however, began by first considering a mixed-method approach (Creswell 1994). This was because of initial difficulties encountered with the NHS Local Research Ethics Committee (LREC), which suggested I should be interviewing around 350 patients in order to achieve validity. I thought of sending out questionnaires to the 350 patients – if I could find so many patients who would be willing to participate – and from that number select a small sample for qualitative work. I was also drawn to McAdams' (1993) interview protocol. McAdams (1996 p. 256) proposes an interview protocol for collecting narratives and argues that semi-structured interviews can be used to explore personal narratives. He invites the interviewee to think about his or her life as if it were a book, dividing each part into a number of chapters. The life-chapters provide an organising narrative framework for the life story (McAdams 1993 p. 257). The interviewee is then asked to think of about eight key life events in order to elicit a narrative account of the life.

Smith's (1995, 1996) IPA also uses a semi-structured approach. Both these approaches attempt to gain access to people's lived experiential world, but they were found unsuitable for this study, as explained below. As I became more familiar with

the research terrain and more confident and skilled with negotiating the 'turns in the road', I was able to make more personal choices about which methods and perspectives should guide this study. I realised at this stage that what I was looking for was a qualitative method that would open up a space for participants to set their own agenda, in other words, to talk about anything they wanted to in order to tell their life stories. In the end, I was guided by Mishler (1986), who argues that data collected this way would be richer and more useful than data where a participant is asked questions about a particular topic area.

At this point, I decided not to use McAdams' or Smith's approach, even though their work has been successfully employed to interpret the process of change and transformation in individual lives. My decision not to use McAdams' interview protocol was based in part on the fact that semi-structured interviews utilise a schedule of pre-set questions. Unlike semi-structured interviews, the biographical interview is more empowering for interviewees. I felt that the Method was an appropriate method to use with mental health patients, because of its ethical and emancipatory underpinnings, in order to look at the whole life and not just aspects of it. Also, I wanted to move away from the question-and-answer type of interview that often takes place in clinical assessments, with which participants would be all too familiar and by which they would be restricted. Atkinson (1998 p. 3) strongly supports the life story interview, stating that it stands alone as a method for looking at life-as-a-whole and as a way of carrying out an in-depth study of individual lives. The Method was appropriate for this study in a number of other ways:

- 1) The interview format enabled the participants to set their own agenda and pace, offering greater control in the interview situation.
- 2) It offers ways of removing some of the power inequalities that can exist in research interview situations (Wengraf 2001 p. 18).
- 3) It is in keeping with the aim of emancipatory research, which is to move from research on people to research for and with people (Faulkner & Layzell 2000).

4) It is also in keeping with the Research Governance Framework For Health and Social Care (Department of Health 2005), which advocates involving service users in research.

5) It offers marginalised groups, in this case 'revolving door' patients, the opportunity for their true internal voices to be heard (Mishler 1986).

This method has been used, for example, by Miller (2000), Jones (2003) and Froggett, Chamberlayne, Buckner & Wengraf (2005), to provide the type of 'thick description' (information about the context of the action, the intentions and meanings that organise actions) 'experiential understanding' and 'multiple realities' which Stakes (1995 p. 43) claims are what researchers look for when they inquire into a particular phenomenon by using multiple cases. I also think it is important to note how the reflective team analysis allows the voices of the participants to be heard, despite the complexity of the analysis. In the introductory chapter I cited Hadfield and Haw (2001). They state that 'voice' has become a term used to denote a collaborative relationship between researcher and the researched. This view also applies to the work of the reflective team. In fact, Britzman's (1990) take on 'voice' also has relevance when applied to the concept of the reflective team. Britzman states:

Voice begins when a person attempts to communicate meaning to someone else. Finding the word, speaking for oneself and feeling heard by others is all part of this process... Voice suggests relationships: the individual's relationship to the meaning of her/his experience and hence, to language and the individual's relationship to the other, since understanding is a social process (1990 p. 487).

It is by working systematically with the data, considering what is said and not said in the interview, as well as the nuances of the story, that an appreciation of the person can unfold. In this way the work of the reflective team is promoted. Emphasis is on the dynamics and interaction of the team, where mutual respect for each other is considered a vital requirement. By this I mean each member of the team is encouraged to participate with the assurance that their perspectives will be considered. In this way the reflective process is productive and insightful.

In the last section I provided a detailed description of the Method, including the analysis and the reflective team process. In the next section justification for the methodology is offered.

6. Justification for the Methodology

In this section, I provide justification for choosing this methodology, which is qualitative and reflexive in design. The section covers aspects of both qualitative and quantitative methodologies, pointing out similarities and differences. Perhaps the first thing to say about these methodologies is that they address different research questions, employ different research methods and ensure rigor through different techniques (Creswell 1994).

The second thing to say is that my arguments for qualitative research provide rich and detailed information about events and behaviours that allow us to describe, define and better understand actions and processes in their social context. I believe that the meaning of an event is more likely to be revealed in qualitative research than in any quantitative study and is more directly linked to values, politics and other factors that may be an important part of the situation. This should not be seen as a total rejection of quantitative methods, rather, it should be considered principally as a way of identifying the gaps such methods have left and the gaps this study is expected to fill. I also expect to uncover opportunities within social science research to provide new means for thinking about and understanding the research topic.

Having said that, a quantitative research approach, with its principles embedded in positivism is often referred to as the scientific model. A widely known fact in the field of mental health is that the medical model and pharmaceutical companies set the research agenda (Scottish Development Centre for Mental Health 2003 p. 3, 10). The status of quantitative approaches to mental health research is also provided by the National Service Framework (Department of Health 2005). Consequently, decision makers and funding agencies prefer the quantitative approaches that yield numbers, charts and tables that seem more convincing than a descriptive, qualitative research approach. Thus, by choosing a qualitative approach to this study, I am, in effect, distancing myself from the hegemony of positivism as the dominant approach to

scientific inquiry. Gramsci (1971), cited in (Burke 2005), originally developed the hegemonic concept to refer to a form of ideological domination that is subtly taken for granted. According to Denzin and Lincoln (1994 pp. 2 - 6), the key to this rejection is incorporated in the idea that there are multiple ways of knowing something, all of which may be valid. At the same time, while pointing out differences between these methodologies, it is also important to acknowledge the similarities between them. First, they share an investigative approach that poses a question, then collects and analyses data and presents analysis. Second, scientific rigor and integrity of theoretical framework are critical to researchers from both approaches.

Viewing quantitative and qualitative approaches as being at opposite ends of the research methodological continuum, serving different research purposes, I argue that a quantitative approach producing numerical data would be difficult to analyse in a way that is thematic. A qualitative approach, on the other hand, that produces descriptive data from open-ended interviews offers analytical possibilities in the form of themes, metaphors and thick description. This approach is more concerned with interpretations and understanding (Ricoeur 1991a pp. 110 - 124) rather than reliability and validity as is the case in quantitative methods (Rubin & Rubin 2005 pp. 20 - 21). To ensure that interpretations arrive at some truth that begins to open up new insights and understandings of 'revolving door' patients, a qualitative methodology was preferred over a quantitative one.

I was drawn towards a qualitative methodology because my professional background is underpinned in part by a humanistic approach that offers its own particular conception of humanity. This is also a view that recognises people in all their ambiguities as experiencing, perceiving, feeling, thinking and acting individuals.

This view is in direct contrast to notions of rationality and the statistically constructed person. The objective was to find out how complex psychological issues relating to the 'revolving door' phenomenon are understood by research participants in order to advance what is known of participants' lived experiences within a broader context of the mental health system. A determinant factor in deciding to use a qualitative approach was based on the research question. Gubrium and Holstein (1997 p. 502) state that qualitative studies are useful for answering 'how?' questions. Shaw and Norton (2007 p. 37) also advocate that the method should be related to the question.

Therefore, it would have been inappropriate to use a quantitative approach in this study, since the research question is constructed as a 'how?' question.

Furthermore, a quantitative approach was not going to provide an insider view or capture the details of multiple perspectives that a qualitative approach would offer (Mishler 1986 p. xi). In this study the focus is on learning the perspectives of the participants in order to illuminate the dynamics of their situations. These dynamics are often invisible to the outsider (Conrad 1990 p. 1259; Dahlberg et al., 2002 p. 212). Thus, the most effective and realistic way to learn about the influence of the 'revolving door' phenomenon on shaping self/identity was by qualitative, open-ended, in-depth interviews. (Denzin & Lincoln 2000) state:

Qualitative implies an emphasis on entities that are not experientially examined in terms of quantity, amount, intensity or frequency. Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry (2002 p. 8).

This implies that there are meanings or processes involved in research that are not quantitative in nature and that trying to quantify these meanings or processes tends to distort the meanings they present in any given situation. The aim, therefore, in carrying out qualitative research is to search for scientific knowledge as opposed to everyday common-sense knowledge which is often far from coherent and consistent.

7. Rationale

Research methodology has often been presented as a unitary framework that is present at the start of a project, guiding choices, approaches to the project and progress throughout it. I found that this was not the case in this particular study.

There was no one method that could have been chosen at the outset, or even with hindsight. This was due to significant shifts in the subject matter and increase in knowledge as the project progressed. Ultimately, however, I adopted Wengraf's (2001) Biographic Narrative Interpretive Method as an appropriate data collection and analysis tool for my work.

This decision was strongly influenced by Jones (2001), who used this method in his PhD on *Identity and the Informal Care Role*. Jones became my First Supervisor at the halfway stage of my study. It was at this turning point in the research process that a clearer map of the study's potential began to emerge. In addition, my sociological background as well as my growing recognition of the weaknesses of other methods was contributory factors in my choice of method. Having read the *The Polish Peasant in Europe and America*, Zaretsky (ed. 1996), I was further convinced of the value of applying a biographical approach to this research topic. It was the influence of the seminal work of these two sociologists, who sought to explain social problems by examining the relation between individuals and their surrounding society, that captured my imagination concerning the possibilities of social research.

I came, therefore, to this research with a clear desire for knowledge, coupled with a wish to articulate this knowledge to a wide audience in an evocative way. Aristotle touched on this passion 2,500 years ago, when he wrote that 'all men by nature desire to know' (Callahan 2003). Bacon expanded this idea to encompass the power of science and its ability to improve the human condition (Callahan, 2003). Even though Bacon was probably referring to medical science, I believe it can be applied to social sciences with equal effect. At the same time, this research study was quite a challenge for me. The first challenge, of course, was the research project itself. Apart from finding the courage to take on the research, the real challenge was finding an appropriate methodology for work within this particular research group. Given that mental health practice and research is driven by the medical model (Double 2002), it is not surprising that the prevailing concept of medical and pharmaceutical research seems to be quantitative research characterised by random control trials (Department of Health 2004), where the only way to know something is from afar by relying exclusively on reason and facts, logic and data.

This process overlooks humanistic approaches to understanding the person as advocated by Plummer (2001). It portrays truth as something we can only achieve by disconnecting ourselves physically and emotionally from the thing we want to know. In contrast, qualitative research is all about looking at things at different levels, close up, far away, in detail and with the whole picture in mind (Rosenthal 1993).

Emphasising the tension between these two conflicting approaches, I found myself submerged in what Lincoln and Guba (2000 pp. 163 - 186) talked about as 'paradigmatic controversies and uncertainties'. Further challenges pursued. In the end, tension plays an important role in understanding the life story of another and indeed, in good inquires more generally.

The second challenge was developing the habit of mind that could see alternatives and participating in the process of exposing basic assumption to constructive peer criticism, and thereby challenging the 'status quo' of mental health research itself. I do not believe for a moment that my utopian view of how research within this field should be conducted will be accepted by all. On the contrary, what I do hope for is that readers of this thesis will see the value in a methodology that places great importance on creating a space for participants to tell the stories of their lives.

The third challenge I want to mention in this section is the idea that the subjective experiences of participants could be regarded as unauthentic because of possible delusional features of their illness. Put another way, because of their illness, the experiences participants said they had, might not be the experiences they actually had. Also, questions about whether an experience could be re-constructed to be just as 'real' as the one experienced, were very relevant to the study and were anticipated as likely to open up debates about the extent to which stories narrated by these individuals can be considered as authentic. To respond to these particular concerns, I have drawn on Salter (2005), who says, 'the need to build narratives in order to explain our world is powerful, and our stories do not need to be true in order to bring comfort. Once we feel as though we have an explanation for something, we feel safer, and the simpler the explanation the better' (p. 118). For Dewey (cited in Boisvert 1998), philosophical reflection must grow out of the muddled, ambiguous, lived present.

A final challenge has been the many different ways of implementing this approach to inquiry. Although I have stated quite clearly above my rejection of quantitative methods, there are some approaches within qualitative research itself which I have felt were unsuitable for this particular study. The dilemmas of society can usefully be divided into two broad categories: macro and micro (Layder 1994), but my argument is that only solutions capable of solving both sets of problems can in the long run

solve either set. As a consequence of this interrelatedness, attempts to solve macro or micro problems in isolation not only fail but frequently result in further complicating problems of the other type. For the rest of this chapter I will be concerned with the research process and its challenges.

C. RESEARCH DESIGN

It was important for me to choose a research design that allows exploration of the deeper structure of the 'revolving door' phenomenon. This section, therefore, is about the research approach used to examine identity and the 'revolving door' phenomenon in depth and detail. The design was developed in light of the research objectives and propositions above. It sought to achieve an in-depth, close-textured, qualitative understanding of the multiple priorities, values and socio-economic and political circumstances that influence a small sample of 'revolving door' patients in the way they manage their lives. The method I chose for this particular study is the Biographic Narrative Interpretive Method (Wengraf 2001), which is based on the case study approach of Yin (1994). In this study the case represents the psychiatric hospital and the mental health system in which the patient is subject, to a range of complex situations and circumstances in the form of health and social policy, mental health legislation, psychological disorders and psychiatric diagnosis, medication and treatment, professional theory and social and economic concerns. Yin (1994) says that the case study approach is appropriate when 'how' or 'why' questions are being posed and/or when the researcher has little or no control over events (p. 1).

I chose a biographical method with open-ended interviews over and above other research strategies in part because it allows for the combination of elements from phenomenology and hermeneutics. At the same time, an interview according to Dexter (1970), is the preferred tactic because it appears that it gets *better* data or *more* data (p. 11). Dexter (1970) argues that the ability to tap into the experience of others in their own natural language, while utilising their value and belief frameworks, is virtually impossible without face-to-face and verbal interaction with them.

In this study each participant is the subject of an individual case study, but the study as a whole covers seven patients and in this way uses a multiple-case design (Yin

1994 p. 46). Multiple-case studies allow the possibility of comparing and contrasting cases and, according to Flick (2002), because of its diversity, of using as many different cases as possible in order to present evidence of the distribution of ways of seeing or experiencing certain things (p. 70), thus obtaining saturation. No attempt, however, has been made to extrapolate the findings of this study to a wider population, because each individual in this study is regarded as unique and, therefore, no generalisation can be made about the wider research group. I believe this notion of 'deeper structure' is the essential insight that opens up new understandings and meanings which are not based on objective truths and which can only be discovered by going deeper into the subjective experience of the individual. According to Hollway and Jefferson (2000), research subjects' 'inner worlds cannot be understood without knowledge of their experiences in the world'. Surveys, for example, offer a limited degree of understanding, whereas deeper understanding can be obtained from patients' own accounts of their life experiences. Conversely, 'the experience of the world cannot be understood without knowledge of the way in which the inner worlds of subjects allow them to experience the outer world' (2000 p. 4). Further, a key element of the case study is the selection and organisation of material to account for the complexities and interactions of the events.

Recognising these complexities and frequently conflicting perspectives, I have placed importance on a research approach that connects to patients' subjectivity. At the same time, I regard mental health social work practice as being positioned between its responsibility for the vulnerability of the patient and the more impersonal, but benevolent, intention shaped by medical knowledge. I believe this knowledge is detached from the subjectivity of the patient and is reflected in research that is quantitative and positivistic.

In a similar way to Szasz (1973, 1987) and other anti-psychiatrists, for example, Laing (1967), I feel uncomfortable with the notion that mental illness is a biomedical construct. I feel equally uncomfortable with the perceived dominance of the medical model in setting the research agenda. I am further dissatisfied with the general lack of direction in the mental health social work profession and its failure to offer any significant contribution to recent changes within the public services, which have been directed by a medico-health paradigm.

1. Data Collection Procedure

In this section, the procedure for implementing the Biographic Narrative Interpretive Method in this study is provided. The research reported here was undertaken primarily by means of unstructured open-ended interviews. Interviews were conducted face to face and audio recorded using a tape recorder, and later transcribed verbatim. All the interviews took place in the homes of the participants except for two, which took place at a day centre at the request of the participant. All participants were given the opportunity to decide where they preferred to be interviewed. I met each participant at least once before the initial interview to go over their information leaflets and to answer any questions or concerns. This also helped with building rapport, which in turned helped to make the participants feel comfortable enough to talk openly about their experiences.

Two sets of data were collected and analysed: the first, related to the *lived life*, the biographic chronological data, of the participant (names, dates and so forth). The other related to his or her *told story*, the events and experiences as they are remembered, for example, information about personal events that took place within the participant's home, school or community. Biographical information relating to the lived life was obtained from information shared during the interviews and from clinical records of the participants. Each participant was interviewed by being asked the same single open-ended narrative-inducing question (Wengraf 2000 p. 10) to illicit an extensive uninterrupted narration. In the first phase of the interview I let participants control the flow of topics. In the second interview phase I encouraged narrations by probing for more information on what was mentioned in phase one and in the order it was mentioned. The aim of this procedure was to obtained stories that contained Labov and Waletzky's (1967) five principles of a narrative structure: orientation, complicating action, resolution, evaluation and coda. Please see Table 3.0 below:

Orientation	Who, when, what, where?
Complicating Action	Then what happened?
Resolution	What finally happened?
Evaluation	The point of a narrative, so what?
Coda	Signals that the story has ended.

Table 3.0 Labov and Waletzky's Narrative Structure.

As well as gathering stories that were narratively structured, other types of data were gathered from the information elicited from participants, such as the modes of reporting and describing events. These were all transcribed verbatim. Finally, the production of transcripts included both speech and non-lexical responses, such as coughs, uhms, ers and pauses.

2. Participants

The participants were patients who had been given a diagnosis of either schizophrenia or bipolar disorder and who had had more than two readmissions to psychiatric hospital within three years. At the time of their interview, they were living in the community with support from mental health services.

3. Sample Size

Glaser and Strauss (1967) say that the key to grounded theory is to generate enough in-depth data that can illuminate dimensions of the phenomena. Although I have not adopted grounded theory for this particular study, the principles in terms of selecting an appropriate sample size are the same for my methodological approach. This is because in qualitative, as opposed to quantitative research, the focus is toward gathering data that are rich and descriptive (Polkinghorne 2005 p. 139). Also, in qualitative research, the flexibility of a less structured interview helps to bring out the

direction and strength of a participant's responses as well as what is most important within the social context of his or her beliefs, feelings and behaviour (Sampson 1996 p. 331). This leads to theoretical saturation of the themes that can come from the data (Glaser & Strauss 1967). Strauss (1987) states that themes are theoretically saturated when they account for all the data that have been gathered and illustrate the complexity of the phenomenon of interest. Of course, total saturation can never be achieved because of the uniqueness of each participant's experiences, however, I believe additional data always add richness and complexity to the analysis.

Because the Method draws on lengthy interviews and analysis (Jones 2003), a small sample size was considered sufficient for the depth of inquiry into the behaviours which participants have constructed from their experiences. In total, seven participants were interviewed. Each participant had three interviews, including an introductory interview to explain the research and to answer any questions they might have had. Since the study did not set out to produce interpretations which are representative of all 'revolving door' patients, it was expected that with the small sample size the findings would not represent the views of a wider population or that generalisations could be made. That being said, variation in the sample was represented by three females and four males. The youngest of the sample was age 27 and the oldest age 50. All but one of the samples was from White-British backgrounds; the one exception came from a Black-Caribbean background. All had been given diagnoses of either schizophrenia or bipolar disorder. They all had more than two admissions to psychiatric hospital within a three year period and were well suited to an understanding of the research topic. Table 4.0 below illustrates the composition of the sample.

Furthermore, what may have been lost as a result of not using a method with the potential for larger numbers of participants, thus producing large data sets, was more than compensated for by the deep and meaningful case studies enabled through use of the Method (Jones 2001 p. 17).

Number	Sex	Age	Ethnic background
1	Male	50	White - British
1	Male	45	White - British
1	Male	32	White - British
1	Male	27	White - British
1	Female	40	Black-Caribbean
1	Female	32	White - British
1	Female	50	White – British
Diagnostic criteria:	ICD-10: F20 – F29 Schizophrenia and delusional disorders and F30 – F39 mood (affective) disorders.		

Table 4.0 Composition of Sample

In keeping with the U.K. Research Governance Framework (Department of Health 2005), this sample reflects the diversity of ethnicity, gender and age of the researched population and is not discriminative in its design, undertaking or reporting. This is a qualitative study, and the aim here is to understand the real life experiences of patients who have had frequent and repeated admissions to psychiatric hospital.

It was essential to the design of the study that those who might volunteer to participate meet certain criteria. The study was designed to include only those patients who, at minimum, had two formal or informal admissions to psychiatric hospital within a three-year period. The criteria also required that these patients meet ICD-10 diagnostic criteria F20 – F39 and no longer be inpatients at the time of their interviews. The intent was to ensure that participants were well enough to be interviewed. Research parameters were defined and limited by excluding the following patients:

- Patients with personality disorders, dementia and a learning disability because the nature of their disorders may result in their having insufficient insight to take part.
- Patients currently in hospital as the belief is that participating in the study during admission may add further distress to what is probably an already terrifying situation.
- Patients admitted via the police/judicial services as they may have different experiences.
- Patients who were considered by their clinicians as too unwell to participate.

The research was further limited by date. Research prior to 1980 was not followed up.

4. Demographic Parameters of Participants

Although the age range for the study was set to include participants aged 18 to 65, the participants that actually took part were aged between 29 and 50, which is a broad demographic range. The study was conducted within a Community Mental Health Team (CMHT) in the Hertfordshire Partnership NHS Trust. All the participants lived in Hertfordshire except for one who, at the time of his interview, was living in Derbyshire. This particular participant's name was put forward by a member of his family who works as a social worker within the CMHT where the study was conducted.

5. Recruitment Process

Participants invited for interview were recruited through CMHT colleagues. It was my intention initially to recruit participants from other CMHTs in the NHS Trust, but because my initial encounters with gatekeepers in those teams were not good, I was forced to look within my own team for service users to interview.

I started off by writing to the managers of three CMHTs in the geographical research sector, explaining my research and asking them to speak with patients they thought fit the criteria for taking part. I allowed two weeks for replies. Not having had any

replies after the two weeks, I wrote again to the managers, this time requesting a ten-minute slot in their weekly team meeting to talk to members of the Multi-Disciplinary Team (MDT) about the research. After a further two weeks of no reply, I followed up my letters with telephone calls. It was only then that it was explained to me that the teams were short staffed and that workers were very busy. Despite the explanation given, I encountered in these teams a general lack of interest in the study, which was discouraging. At this stage I began thinking that I needed to find another way to make contact with service users. I even considered going outside the Trust altogether, but that would have meant making a fresh application to another ethics committee; it had already taken ten months to obtain ethical approval from this particular trust. Fortunately, it did not become necessary to go outside Hertfordshire NHS Trust.

I spoke to my sector manager about the research and the problems I was having with gaining access. By pure good fortune, she was supportive of the study. She offered me the opportunity to attend a meeting with her, the Assistant Director of the NHS Trust and other CMHT managers to discuss the research and the problems I was having. I was confident that once I had gained the backing of the Assistant Director it would make it easier for me to get the cooperation of gatekeepers in the CMHTs.

The eventual outcome of the meeting was successful despite strong objection from one of the CMHT managers, who was very critical of my research method. I was given permission, however, to conduct the study in my own team, provided I did not interview any service user on my caseload.

Next, I approached my immediate colleagues and asked them to speak with any of their clients they felt fit the criteria for taking part. They came back with names of clients to whom I subsequently wrote (Appendix A). Potential participants were sent a Patient Information Leaflet (Appendix B). I then made arrangements to meet with them individually to discuss the study in more detail. The leaflet highlighted the purpose of the study and outlined how the information gathered would be used; they were given seven days in which to decide to take part. Further to that, two weeks were given to allow them time to discuss taking part with friends, family or their General Practitioners. All participants were asked to sign a Consent Form (Appendix C), before they were interviewed. In total, twelve service users were contacted, but only seven agreed to take part in the study and be interviewed.

D. THE INTERVIEW

Seven interviews were conducted in total. Each interview was strictly between the participant and me. Every effort was made so that the participant felt no pressure and felt free to withdraw at any point in the interview without their care being affected in any way. The interviews were all tape recorded. The taping of the interviews did not seem to intimidate any of the participants. In fact, one particular female participant took over the management of the recording, ensuring that the tape machine was running properly.

In terms of the participants' interviews, the number interviewed was limited by the size of the research population, the willingness of patients to take part and the time available for the study. Recruiting participants was very time consuming, however, even with seven participants, there was a diversity of actors and a range of experiences to be discovered. A further limitation was the fact that in order to be selected for interview, service users were required to be stable in their mental states before taking part.

This requirement further narrowed the number of patients I could interview. All patients interviewed had had episodes in hospital but had been discharged at the time of the interview and were living in the community with support from mental health services. Unlike other qualitative interview techniques such as semi-structured interviews, the Method takes steps to reduce the disparity between the interviewer and the interviewee. The participant decides when the interview will take place, where it will take place and how long it will last, putting them in control of the process.

Interviews were conducted at the participant's home or day centre. Every effort was made to ensure a relaxed environment where participants felt at ease. None of the seven service users who agreed to participate in the study changed his or her mind about taking part or dropped out because of their illness, and no one objected to the interviews being recorded. I regularly reviewed the fitness of participants to continue in the study by having discussions with their psychiatrists and care teams. Participants were given the opportunity to withdraw or suspend their involvement in the study.

1. First Phase of the Interview

I began all the interviews with the following probe: **I would like you to tell me the story of your life, all the events and experiences that were important to you up to now. Take as long as you want, start wherever you wish. I won't interrupt you; I'll just take some notes for after you have finished telling me about your experiences.'**

I had considered modifying the probe question to: 'Please tell me the story of your life from when you were admitted to hospital for the first time.' I decided against doing so because I wanted to hear the whole life story and did not want to limit what participants could talk about. Rosenthal (1993) and Jones (2001) support this decision, pointing out that, if the interviewer does not set a specific topic but asks the biographers in a general way to tell their life story, the biographers themselves will select those topics that are relevant. This method also has the advantage of allowing the researcher to learn how the biographers – if at all – are embedding the topic of research interest in the presentation of their life story. Wengraf (2001), drawing on Freud's ideas of free association, suggests that 'by adopting an interview strategy that minimises the interviewers concerns we, in effect, allow for the fullest possible expression of the concerns and significance of the life-world of the participant' (pp. 69 - 70).

During this initial narration I listened attentively and took notes. This was done in order to follow up on themes in their narrated order (Hollway and Jefferson 2000 p. 36). Initially, I had difficulty dealing with the non-interruption or passive interviewing technique. I wanted to give more feedback than just nodding and smiling that the Method demands (Wengraf 2001), but had to restrain myself. I felt what was going on in this situation was a struggle to regain a position of power in the interview. Because I had relinquished the power that would ordinarily exist in other interview situations, I was feeling disconcerted. The environment where the interviewee had power over the interviewer felt strange and uncomfortable. However, once I was able to see the benefits of not having control over this part of the interview, it became less of a problem for me. The practice of projecting on to the interviewee a near blank screen presence is likely to be questioned by others. Also, they might view a lack of interaction as a big demand on the interviewees. My response would be that having

done the interviews, none of the participants seemed to have had any problems with the concept of non-interruption. In fact, I felt that they responded rather well to the initial question. Of course, all this is done in the context that body language accounts for far more communication than verbal feedback.

2. Second Phase of the Interview

In keeping with the protocol of the Method, I furthered the investigation process by conducting a second-phase interview. For three interviews this phase was carried out after taking a twenty-minute break. Two other second phase interviews were conducted after two weeks. Another took place after a four-week gap. Rosenthal (1993) suggests that a long break between interviews can allow the researcher to get closer to the data and form more considered questions in the second phase of the interview. A problem that I encountered as a result of having variable intervals between phase one and two was that at certain times in phase two participants struggled to remember what they had actually talked about in phase one. Although this was a problem, it was in the interest of the participants that I worked within a timeframe that was comfortable for them.

This phase of the interview had the purpose of helping the participant generate more information (Wengraf 2001). My role as interviewer was to facilitate the interview process by encouraging more narrative. These narratively pointed questions were asked in the order in which they were mentioned in the first sub-session. My experience of this process was problematic, however, in the sense that there was tension between deciding what topics or themes to follow up and how much time to spend on each topic.

I was able to overcome this tension by considering the constraining factor of time and assessing whether the interviewee was tiring or not. Also, if I judged a particular topic or theme to be interesting or relevant to the research question, I would travel along the horizontal plane a little further (Wengraf 2001). If I judged the opposite to be the case, then I would move downwards, vertically, to the next topic.

The way I did this was dependent on the impression I received during the interview of what seemed important from the information uncovered. I used Newcomb's (1952) process of foregrounding and backgrounding information to select themes or topics to follow up (pp. 88 – 96). The idea was to follow my curiosity but at the same time be mindful not to destroy the *gestalt* of the story that was being told. *Gestalt* is defined by Hollway and Jefferson (2000 p. 34) as 'a whole which is more than the sum of its parts, an order or hidden agenda informing each person's life'. Muenzinger (1942) argues that we cannot see all there is to see because of the limits of our cognitive capacity. He gives the example of a blind man who regained his sight after 30 years: 'When I could see again, objects literally hurled themselves at me. One of the things a normal person knows from long habit is what *not* to look at. Things that don't matter, or that confuse, are simply shut out of their seeing minds. I had forgotten this, and tried to see everything at once; consequently, I saw almost nothing' (Muenzinger 1942). I realised that I couldn't follow up all the information I received, so I was only able to select certain themes or topics that seemed relevant to the research topic.

3. Third Phase of the Interview

Because of the flexibility of the Method, a third phase interview not subject to the same rules as the initial two interviews can be used to clarify information obtained in the previous interviews, for example, to clarify dates, relationships and so forth. I was able to use this phase of the interview to follow up specific topics not addressed in the first two sessions or for clarification of particular points.

This phase of the face-to-face interview was set up by contacting the participants by telephone to agree a date and time for the interview and then a letter was sent to confirm the appointment. During these interviews, questions were directed at uncovering specific information related to the research topic (Rosenthal 2003). In this phase of the interview, I asked another single question aimed at inducing narrative: '***Please, can you tell me more about your life, in particular, your understanding of how hospital admissions have impacted on your life.***' This was done in order to elicit more narratives, this time more closely related to the research topic.

I attempted to explore the field of study, as defined in the title of this thesis, and gather information on it. In order to do this, data was collected and analysed from open-ended interviews and patients' clinical case notes. The interviews comprised the subjective views of 'revolving door' patients on the days they were interviewed and, therefore, cannot be replicated by another researcher, as the dynamics might change. Furthermore, the aim is not to make any generalised claims but rather to present the unique stories of the participants to a wide audience. In the following section of this chapter, issues emerging from ethical considerations are discussed.

E. ETHICAL CONSIDERATIONS

Prior to commencing the recruitment process, ethical approval was sought and obtained from West Hertfordshire Partnership NHS Trust, Research Ethics Committee (REC) on 25 June 2003, reference number EC2002 - 61. The ethical requirements of the university were also adhered to.

Holmes, cited in Liamputtong (2007 p. 25), argues that people with mental illnesses are vulnerable research participants because they tend to be seen as incapable or less capable of making informed decisions about their participation in research studies. Counter to this is the view of Stanley B, Stanley M, Lautin, Kane & Schwartz (1981, cited in Liamputtong 2007 p. 25), that labelling the mentally ill as such may compromise the autonomy of the whole group and people with mental illness may, therefore, miss out on some important research projects that may improve their health and well-being.

I agree with Flaskerud and Winslow (1998), Beaver et al., (1999), Cutcliffe and Ramcharan (2002) and Hall and Kulig (2004, cited in Liamputtong 2007 p. 25), that the benefits of undertaking the research need to be measured against the risks of being involved in the research itself. It was essential, therefore, to the design of the study that those who might volunteer to participate meet certain criteria. The study was designed to include only those patients who, at minimum, had two formal or informal admissions to psychiatric hospital. The criteria also required that these patients meet ICD-10 diagnostic criteria F20 – F39 and no longer be inpatients at the time of their interviews. The intent was to ensure that participants were well enough

to be interviewed. I worked closely with the participants' clinical support teams to ensure that support was available during and after the interviews if the need arose. It was also critical that all participants in the study indicated their willingness to participate in the lengthy interview and a possible follow-up interview and that they were happy for the interview to be tape recorded and for their medical records to be disclosed to me.

Once potential participants had indicated that they were willing to take part in the study, arrangements were made to meet with them individually in order to discuss the study in detail. Those who were willing to take part were given ample time to review their decisions and were sent a Patient Information Leaflet to read. The leaflet highlighted the purpose of the study and outlined how the information gathered would be used. All potential participants were asked to sign a Consent Form before taking part in the study. Participants were reassured that they would not be recognisable in any publication by the information they shared about themselves. The fitness of participants to continue was regularly reviewed by discussions with their psychiatrists and care teams. Participants were given the opportunity to withdraw or suspend their involvement in the study in the event of any deterioration in their mental state.

The process for gaining ethical approval did not proceed as smoothly as anticipated. First, there were difficulties with the committee's accepting a qualitative methodology and small sample size. This may have been due to the fact that NHS committees often consist of traditional quantitative researchers who may not be so familiar with a qualitative approach to research.

Second, the paperwork for the ethical committee's consent was more suited to drug trials than to a qualitative investigation of people's experiences. Issues to do with gaining ethical approval also centred on confidentiality and duty of care: when can confidentiality be breached, and do researchers have a duty of care? Certainly, in the case of potential harm to others, social workers have a duty to act to protect others, and this will include breach of confidentiality. A list of circumstances where confidentiality could be breached was highlighted in the Patients' Information Leaflet. It was, therefore, important to explain in the Patients' Information Leaflet the limits of confidentiality. At the same time, bearing in mind that stories are usually personal,

unique and idiosyncratic, making them confidential is more than changing the name of the participant (Plummer 2001 pp. 217 - 218).

Because interviews can be intrusive and stir up distressing feelings by the very nature of their contents (King 1996), provision was made for support to be available to participants should this happen. This is particularly important, as narrative research is likely to expose the hidden, intimate and private world of the participant. As participants may not always be aware of the level of impact of disclosure, in this respect it was helpful to work closely with the care team to ensure participants were not put in situations that may have endangered their well-being.

F. CONCLUSION

This chapter began with an overview of socially constructed identity in the context of mental illness generally, but the 'revolving door' phenomenon more specifically. Qualitative approaches of investigation were introduced as a means to conduct psychological work in this context.

The 'revolving door' phenomenon and self/identity was identified as an important but complex area of investigation which, at present, cannot be advanced by quantitative and statistical methods. The Biographic Narrative Interpretive Method was introduced as the data collection and analysis method for this study. This Method consisted of the collection of audio-recorded in-depth interview data, which was then transcribed verbatim before analysis. The transcripts were analysed first by me and then by a panel or reflecting team, typically consisting of three to four people from diverse backgrounds and mental health professionals from different disciplines. A key feature of the Method, which is based in phenomenology and *gestalt* theory, is the comparison of the *lived life* and *told story*. It focuses on the discrepancies between how the patient understands himself or herself and the resulting action. It was envisaged that this study might provide a way of connecting experience with the development and formulation of self/identity.

Working from a narrative perspective that explores socially constructed identity, I was able to generate sufficient data to understand how patients regard the experience of

multiple admissions to hospital. In the following chapter the biographies of the seven participants who were interviewed is presented.

CHAPTER IV

PRESENTATION OF DATA AND RESEARCHER'S REFLECTIVE WORK

Understanding the details of this science data is a bit like an archaeological dig: a scientist starts with a bull-dozer, follows with a shovel, and then he finally uses dental picks and toothbrushes to clear the dust away from the treasure. We are passing out the toothbrushes now.

William Bencze, Stanford University
(BBC News 2007)

A. INTRODUCTION

In this chapter, I present the biographies of the seven participants who were interviewed. The biographies provided enable ideas to be formed of the setting in which the lives have been constructed.

The chapter is divided up into four parts. The first of which introduces this chapter. The second part introduces the notion of biographical narrative research by comparing it to an 'archaeological dig'. Part three, contains the chronological life events of the interviewees put together in the form of their biographies. I was not present at these events, but I put them together from what the interviewees could remember and what I got from other sources. For each biography, I offered reflection on the underlying factors found in the life stories and these are presented in the form of *first impressions* and *personal reflection*. The fourth and final part concludes the chapter.

B. THE ARCHAEOLOGICAL PROCESS

The process of analysing a narrative biography is compared here to an archaeological dig, as these share an investigative approach that poses a question, collects and analyses data (excavation) and presents analysis (assigning categories to artefacts). Both processes centre on discovering aspects of the past. Both involve reconstructing the discovered past piece by piece until some resemblance of the original is achieved. Both require a sensitive, careful, ethical and systematic process in uncovering the past.

In both a narrative biography and an archaeological dig, context is essential to the interpretative process or meaning of each discovery. Denzin and Lincoln (1994 p. 13) say that 'all research is interpretively guided by a set of beliefs and feelings about the world and how it should be understood and studied'. Archaeological discoveries, for example, convey very little meaning beyond their aesthetic qualities. Knowing, however, that the discovery was from a particular period in history and linked to certain individuals gives it enormous cultural meaning and the power to enlighten and inform.

Sociological attention is given to Foucault's archaeological concept in *The Archaeology of Knowledge* (1972). Attention is given to how particular representations reflect the key social organising principles of societies and institutions. Indeed, this and other works by Foucault, including *Madness and Civilisation* and *The Birth of the Clinic*, were all directed at showing how certain discursive practices shape individuals and, indirectly, the institutions in which lives are led (During 1992). In his writings, Foucault is able to challenge modernist understandings of natural order, fixed truths, knowledge and identity. It is not enough, however, to understand the processes without understanding the individuals whose lives are shaped by them.

Throughout history people have always tried to understand their lives; the Greeks sought guidance from oracles at sacred shrines (Knoche 2001). Today, amongst other things, we have the benefit of biographical research methods which enable people to tell stories of their lives, allowing us to better understand their actions.

While objects or artefacts tell stories of real lives, biographical narratives convey the meaning of lives through coherent representations of the past.

Since everyone has a past, everyone will have a story to tell; however, not all of a life can be remembered and only parts of it can be recalled, sometimes in vivid details and at other times only in vague recollection (see Eysenck 1977 p. 77). As our lives are stored in our subconscious, it is possible that memories can surface randomly and at will (Bremner & Marmar 1998). It is also possible that these memories surface (or remain hidden) because there is something in the past that is unresolved and still has a deep impact on our emotional being (see Billig 1999). Perhaps stories have been just too painful to tell or, perhaps, dominant discourses have prevented these stories from being heard (Tew, Gould, Abankwa, Barnes, Beresford, Carr, Copperman, Ramon, Rose, Sweeney & Woodward 2006). Whatever the reason for telling or not telling one's story, one thing, in any case, is certain: it is possible to analyse the importance of such a past life memory by analysing the social constitution of the emotions that accompany it (Greenwood 1994). Analysis, therefore, is not done without a degree of difficulty. In analysing the data from this study, there was the issue that as a social work practitioner/researcher I would have brought elements of myself to the interview situation, thereby influencing participants' responses to the research question. Miller (2000 p.131) refers to this as a 'double hermeneutic'. What being a black, male social work practitioner represents for the interviewees would have either limited or enhanced what the participants felt comfortable revealing.

What this points to is that in order to grasp the significance of how identities are socially constructed, it is necessary to engage in dialogue with the people themselves. Miller (2000 p. 129) states that 'the manner in which the respondent perceives his or her situation and activities in social structures and networks, is the very stuff of analysis'.

In constructionist terms, the construction of self/identity is a constantly evolving process. Indeed, Gergen (1992) views the self as unfinished. We are constantly and perpetually inventing and reinventing ourselves by interpreting and changing the meaning of our and other people's actions. This suggests to me that what happened in the past in the actions of individuals can be interpreted to give meaning to the

present action. Thus, the narrative encountered will be the unique result of how an individual interacts with his or her social environment, since everyone experiences life differently. The reconstruction of the past in human inquiry or narrative biography brings in view the experiences or events in the narrated life. It is through interpretations of these instances that a better understanding of the person's self/identity might be obtained.

In order, therefore, to make any interpretations of a person's life, knowledge of that life must first be attained. To set the context for each participant interviewed, a biography of the participant is provided (Hollway & Jefferson 2000 p. 70). The pen biography seeks to develop a picture of the participant's lived life, including, for example, information about the characters, places, events, background, schooling, family life while growing up, employment history, the participant's life now and so on. Each biography is presented in chronological order, providing an outline of the participant's life up to the present day and their most meaningful experiences as they see them up to the time they were interviewed.

This chapter provides an understanding of the participant's life and unfolding sense of self/identity. It focuses on psychosocial factors common to and associated with the 'revolving door' phenomenon. Here, the term *psychosocial* is used to emphasise the close connection between psychological aspects of experiences (thought, emotions and behaviour) and wider social experience (relationships, tradition and culture). It also provides a foundation for Chapter Five, in which subsequent analysis is presented of four participants' experiences as they stem from their life stories. This was done by means of a reflective team analysis of the participants' told stories and lived lives.

Each biography is followed by 'first impressions' (Hollway & Jefferson 2000 p. 46; Jones 2001 p. 16). Here my initial reactions to the interviewee and interview situation are reported. Debriefing notes were made directly after completing each interview to facilitate this reflective process. According to the protocol of the Method, this is likely to be the best time to recall what happened in the interview.

Drawing on ideas from Jones' (2001) work, I looked first for how participants announce what the story is going to be about by the use of certain phrases in the first few sentences of the interview. Jones (2001 p. 76) argues that a case could be

made that these motifs or themes represent the whole story. Indeed, motifs that indicated the projected outcome of the stories were found to exist implicitly and explicitly in all the stories analysed.

Again, drawing on Jones (2001) and in further analysis of the stories, I looked for sentences containing the word 'want'. Jones (2001 p. 76) explains 'I want' as a phenomenon that gives clues to possibilities to be uncovered later and in more detail in the analyses of the transcripts.

This was a useful and appropriate strategy for this study. It offered a framework from which the significance of well-defined psychological concepts as processed by each individual in their everyday experiences could be understood. These processes are linked to each individual's sense of identity. Broadly speaking, identity locates the self in the nexus of others and emphasises the biographical continuity of the individual from past phases of events and experience into the current period (Ricoeur 1981).

In addition to 'first impressions,' I provided 'personal reflections' on the management of the interview, the dynamics at play in the interaction between the participant and me. Personal reflections also highlight how power and interpersonal dynamics manifest themselves and impinge on the interview situation. I also reflected upon my feelings about how the participant dealt with the interview. All this was done in order to capture the interview context as fully as possible, including all the factors that could affect what was happening in any particular instance.

I stated in the introductory and methodology chapters that I would not be offering a definition of identity because it is an allusive concept in psychology. I now find myself compelled to define it, believing this will help with how I approach the analyses and how I understand what the participants were telling me about themselves and their experiences of multiple admissions to psychiatric hospital. The definition I draw on is that of Erikson (1980). He places identity in a psychosocial framework of self in society. Erikson believes identity 'connotes both a persistent sameness within oneself (selfsameness) and a persistent sharing of some kind of essential character with others' (1980 p. 109).

According to this definition, difficulties in constructing an identity are expected to be more common now in a postmodern world than when Erikson formed his theory.

Recognising the importance of listening to how participants construct their own identities, in terms of the stories they tell, I am reminded by Sarbin (1986) that identity is a construction that arises in dialogue with others and is context dependent. It is, therefore, in each individual story that identity is defined. Identity tends to be varied in complexity and to depend on biographical experiences from childhood through adolescence into phases of adulthood (Erikson 1980). In order, therefore, to come to any definition of identity, the composition of the lived life for each participant must be considered.

Composition of a lived life includes the chain of events, people and places that the participant either felt comfortable with sharing, could remember, wanted to emphasise or perhaps just felt was what I wanted to hear. Indeed, I wondered whether participants would shape their identities in the context of their assumptions of what was expected from them in the study. Clearly, much more had happened in the participants' lives than what is recorded here, but only the stories reported can be considered. Whatever the reason for sharing these particular stories, what was reflected was the complexities inherent in the dynamics of interchanges between the participant and me, which consequently affects which stories are told and how.

The life stories presented below are all based on the transcribed interviews of the seven participants in the study and information from clinical notes and other documents. Each interview is analysed as an individual case and, although a discussion will take place that compares the cases, no attempt is made to 'unearth' a single reality. Each of the seven interviews accurately and authentically represents the lives of the participants in non-authoritative, non-judgmental and non-exploitive ways. The life stories are presented in the order in which the interviews took place: first with Hannah, followed by Kenton, Mandy, Andrew, Colin, Michelle and Keith, all of which are pseudonyms. Place names and other revealing details are either purposely vague or changed to further protect the participant's anonymity.

1. Hannah Salmon

Hannah's biography

Hannah Salmon was born in 1972 in a large town in Hertfordshire. She has one sibling, a brother, who is a year younger. She grew up with her mother and father and was close to her paternal grandparents, who lived next door. Her mother suffered from panic attacks, and a paternal uncle suffered from schizophrenia. An aunt on her mother's side suffered from an unknown psychiatric illness.

Hannah appears to have had disturbed early teenage years. In July 1986, she suffered a psychotic breakdown while on holiday in South Africa with a friend and the friend's family; Hannah had to return to England early and alone. She began behaving strangely after her return, exhibiting behaviour such as biting and tearing her clothes. Her parents were concerned that she may have been raped or involved in black magic in South Africa. Several family meetings were held at an adolescent unit before Hannah was finally admitted. During these meetings Hannah's father expressed his concern that Hannah might be schizophrenic and that this might be related to two of his relatives' having been in psychiatric hospital for schizophrenia. In one meeting, Hannah's mother expressed her concern about her husband hitting Hannah.

After her admission in August 1986, further family meetings were held at the unit to try to learn how to best understand what was happening to her. There were some disagreements between the parents over what the best course of action was and what should be discussed in the meetings, however, at the end of August 1986 Hannah's parents jointly requested her discharge, and Hannah was discharged.

At the start of the school year in 1986, Hannah returned to school, having moved from a convent school to a mixed secondary school. She was stable for two years and did well at her examinations, obtaining nine GCSEs with four grade 'A's. She stayed on at school to do her 'A' levels. Unfortunately, during her first 'A' level year, Hannah started to become depressed. She was seen again by the family doctor, who prescribed an anti-depressant. This did not seem to help, as Hannah became increasingly unwell. She believed that people were talking about her, that she had had an abortion and that she was raped incestuously by her father.

In February 1989, Hannah was admitted again to the adolescent unit informally for two months. This time she was referred by the family doctor. For some weeks prior to the admission Hannah had taken to her bed and had become increasingly abusive to her mother, father and paternal grandparents.

In April 1989, Hannah was transferred from the adolescent unit to a clinic in London when her behaviour deteriorated further. Nursing staff reported her crawling on the floor and masturbating publicly. Hannah claimed at the time that she had been sexually abused by her father, grandfather and brother. She believed that her grandfather had pulled out her ovaries when she was fourteen years old. Hannah based this claim on the fact that she miscarried when she was fourteen years old. The following year Hannah had two separate admissions to psychiatric hospital. The first one was at her mother's request and lasted for two months. The second admission lasted for six months and was made by the family doctor.

Hannah spent the whole of 1991 in a mental health hospital for adults. She was admitted in January, when her behaviour became unmanageable at home. More admissions were to follow. The following years were just as eventful. At age twenty, Hannah was admitted to hospital for the first time under the Mental Health Act 1983 at the request of her parents. She was taken to hospital by her grandfather and had been incontinent of urine at night for several weeks prior to the admission. During this admission she was diagnosed as having schizophrenia.

A few years of stability ensued, during which Hannah received two years of individual art therapy. The intention was to work on her ego strength and capacity to separate anxiety and fantasy from reality. The hope was that this would result in Hannah's having a stronger and clearer sense of self. Art therapy ended in 1997.

In October 1999, Hannah, in a frightened state, contacted mental health services stating that she was hearing voices telling her to kill people while listening to a sad song and to blind herself as well as other people with an instrument. She was admitted for six months as a result of her behaviour. In 2000, Hannah moved into supported accommodation based on the philosophy of Rudolph Steiner (Anthroposophy). A relationship with a man ensued in June 2000, and in 2001 Hannah recommenced art therapy.

Life appeared to be getting better for Hannah, and there was a sense that this may have been a turning point for her. In 2002, she moved out of supported accommodation into independent Housing Association property. Since that time, Hannah has remained well with regular attendance at the psychiatric outpatient clinic. There are, however, complaints of visual and auditory hallucinations of a former boyfriend. These symptoms take place inside and outside her, but Hannah states they are not distressing or upsetting.

First impression

The first thing I noticed about Hannah was her keenness to take part in the research. Her keenness was first evident in her response to my introductory talk at the day centre.

The next thing I noticed was that she was rather a shy person, with a seemingly fragile sense of self and a perplexed look on her face. She did not smile once throughout our interaction. At first I wondered whether Hannah's perplexity was to do with not being sure about taking part in the research, but this was quickly dismissed because of her apparent keenness to do so. Perhaps it could have been that her perplexity came from the fact that she had unresolved issues from the past that were still troubling her. I felt that the latter was more likely.

Behind her persona, however, I somehow felt there was a highly motivated, creative and sensitive person. She spoke openly about her experiences, holding back only on issues to do with her father. It struck me that her decision to be interviewed was a brave one given the strong emotions that would have resulted from her 'revolving door' experiences and the trauma caused from alleged child sexual abuse within her family.

Interestingly, Hannah started her story from when she was fourteen years old, omitting the earlier part of her childhood but chronicling her simultaneous introduction to sexual abuse and mental illness. I wondered why she had done this. It was very interesting, as later on in the interview she referred to herself as not having much to say because all of her experiences had been in the mental health system. I sensed that for Hannah issues concerning her father were perhaps too sensitive to talk about. At the same time, I felt that she wanted to give a 'good' story, having

periodically looked for reassurance by asking, 'Am I doing okay' and 'Is this bitty?' I was able to reassure her that she was doing all right by saying, 'You're doing okay'.

The motif in Hannah's story was around sexuality. A salient feature common in her story was sexual violence. The term sexual violence is used to refer to rape and sexual abuse, which Hannah seemed to have been the victim of since age fourteen. In her story she was wary of men in her family, alleging to have been sexually abused by them. She had been aggressive towards her parents and shown no regard for people in authority. Her many hospital admissions resulted from her unmanageable behaviour at home as well as psychotic symptoms that precipitated each admission.

Some of the social consequences that Hannah may have experienced are likely to include rejection by family members, double social stigma of mental illness and sexual abuse (particularly if the abuse became public), and reduced chances of social mobility (Sartorius & Schulze 2005 pp. 2 - 12). Given her experience and vulnerability, Hannah showed an extraordinary ability to regain her trust in others by allowing herself to be interviewed by me, a man and mental health professional. Entering the mental health system, she may have perceived it as an extension of her abusive home life, where doctors tend to be predominately male and are often viewed as controlling (Busfield 1996).

Hannah's narrative-based account of her life would also suggest that an explanation for her mental disorder and subsequent admissions to psychiatric hospital might be related to issues concerning social control, whereby her sense of identity would be doubly affected. Hannah's search for meaning in her traumatic experiences and her redefinition of her identity revealed much about her strength of character and her attempt to gain mastery over the original abuse by breaking the 'revolving door' cycle.

My overall impression of Hannah was that she was a resourceful and determined person who was motivated towards taking control of her life. She demonstrated, amongst other things, her resourcefulness and determination to control her life by taking control of the interview. Her narrative weaves together the threads of a compelling story that seeks wholeness, amid chaos and fragmentation, in an attempt

to highlight the plots of the story and come to a better understanding of who she is as a person.

Personal reflections

Hannah was the first of the seven participants whom I interviewed. I was apprehensive at first about the interview, not knowing what to expect or what the outcome would be. As it turned out, the interview was one of the most rewarding, as it became a rich source of information on childhood sexual abuse and its association with adult mental health issues and the 'revolving door' phenomenon. To obtain a better understanding of childhood sexual abuse, I read Spataro and Mulen (2004). These authors argue that childhood sexual abuse can lead to mental and psychological damage in adult life. It would appear that Hannah suffered two misfortunes in her life: sexual abuse and becoming a 'revolving door' patient.

Hannah presented as a vulnerable young woman whose gender-specific vulnerability demanded an extremely sensitive approach. I was conscious of how sensitive her story could become, and for the most part of the interview this was in the forefront of my thoughts. I was aware that many behaviours and feelings such as distrust and being withdrawn serve as coping strategies. I had already informed Hannah's care team of her taking part in the study and, therefore, had emotional support available if the interview was upsetting for her.

I was confident that the initial question, 'Tell me the story of your life', would allow Hannah to respond in a manner appropriate to her comfort level. I felt, for example, that using my social work skills to create a good relationship with Hannah would enhance the information likely to be elicited. There was, however, the possibility that when she told her story, painful memories would surface. I was prepared for this eventuality but still felt uncomfortable with the thought. I went into the interview, therefore, not knowing quite what to expect from Hannah but feeling assured that she had a story to tell and in some ways may have wanted to tell her story for some considerable time.

Hannah had a preoccupation with time. She interrupted me before I could finish the initial question, 'Tell me the story of your life', by saying, after an outlet of breath, "Ah,

I've got to uhm... go about one hour, is that all right? and *"Does it matter if I don't take that ... long long long time?"* I agreed to this because I felt that an hour was more than enough time to collect the first set of data. Her question, *'Are we recording now, are we?'* at the beginning of the interview could be interpreted as her feeling nervous about being interviewed or a feeling of just wanting to get on with it.

At first I wondered whether the timing of the interview had gotten in the way of something Hannah had planned, which meant that her time was limited. Then another thought came to mind which suggested that her concern about time may have more to do with her strategy to avoid delving too deeply into her past and of avoiding painful memories. It could also have been that she was unable to concentrate for long periods and, in order to avoid physical exhaustion and inadvertent stress, made a point of limiting the interview to a more manageable time frame. It was clear, whatever the case, that Hannah had taken control of the interview, shifting the power balance in her favour.

My own anxieties about the interview were to do with getting the interview right, for example, asking the right probing questions, following up on important points and maintaining the *gestalt* of the story. I struggled with the notion of suspending my own assumptions and pre-judgments about Hannah. I believe this in itself is a difficult task to accomplish. Habermas states that 'we cannot jump out of our tradition into a pure, value free state of immaculate perception' (cited in Outhwaite 1994 p. 24). I also had anxieties about whether interviewing Hannah would trigger a relapse in her mental state, particularly as she had remained well for over two years.

About ten minutes into sub-session two, Hannah looked at her watch, reminding me, I suppose, that she was still in control. She had once again taken over the interview. I was now working to fit in with her schedule. I predicted that Hannah would probably end the interview around the twenty-minute mark, and she did.

The interview was ended after twenty minutes by her saying, *"That's all I can do today"*, and *"Can I take this bottle of water with me?"* I was disappointed that there was a rush at the end; however, I was not sure if Hannah was overwhelmed by recalling painful memories and just wanted to leave the room as quickly as she could or if she had another appointment to go to. It could also have been that she had not fully overcome her fear of men.

Sub-session two of the interview was arranged for the following week. In this interview, Hannah was presented with probing questions aimed at eliciting more stories about some of the issues that were raised in the first interview. This process was difficult, as I was always aware that I was making the same repetitive request for more stories. I was concerned by how Hannah might respond to this form of questioning but she did not seem to be troubled by the repetitions. One problem I encountered, however, was the gap of a week between interviews. This was because Hannah had difficulty at one stage remembering what she had said in the first interview and had to be reminded. I considered the optional third interview unnecessary, and therefore it was not conducted.

2. Kenton Sutherland

Kenton's biography

Kenton was born in New Zealand in 1945 but was raised in England, where he received his schooling. His mother worked in the film industry but died in February 2002. His father currently lives in France and is a retired insurance agent. He has cancer. Kenton's relationship with him is strained to breaking point due to the fact that Kenton is gay.

When Kenton was two years old, his parents immigrated to England with him and his younger brother on a boat. They were forced to immigrate after a business partner ran off with all the family's savings. His mother had to sell her jewellery and dresses to buy the boat tickets. Both parents were from working class backgrounds. His father worked as a television repair man and his mother as a shop assistant.

On their arrival in the U.K., his parents sent Kenton to Mansfield, Nottinghamshire, to live with his grandparents because of financial pressures. He lived there until he was seven years old. At this time he moved down to Hertfordshire to live once again with his parents and younger brother in a house they had bought. Kenton's parents had high aspirations for him and wanted him to go to private school, but they could not afford the fees, so he ended up going to a comprehensive state school instead. At school Kenton got involved with the wrong type of crowd. He started off smoking

cigarettes and then turned to drugs and alcohol. Consequently, his health deteriorated. At one stage he was taken to see the school psychiatrist because his behaviour had become very rebellious and unmanageable.

Kenton left school at the age of sixteen without taking any examinations and started working in a semi-skilled capacity. His mental health continued to deteriorate to the point where his mother had to give up her job to look after him. She had enough money to take him to see a private psychiatrist in Harley Street, where, at the age of nineteen, he was diagnosed as having schizophrenia. Sadly, Kenton's behaviour and drug habit brought him in contact with the law. He received a conditional discharge for possession of a controlled drug in August 1978, a fine for importuning in February 1981, a fine for gross indecency in December 1988, a caution for a similar offence in June of 1995, and a further caution in May 1988 for shoplifting.

The deterioration of his mental state was usually associated with the use of illicit drugs and stopping his medication. He drinks alcohol, but this does not seem to have been a major factor in his relapses. The following admissions to psychiatric hospital occurred during June 2000 under Section 2 of the Mental Health Act (MHA) 1983, July 2001 under Section 3 of the MHA 1983, October 2001 on a voluntary basis, and also in October 2001 as a formal patient. Kenton assaulted an ex-neighbour in the street and, at the time, he was psychotic. He believed the ex-neighbour had harassed him and may have entered his flat and put LSD in his food. The matter went to Court, but no evidence was presented, and, therefore, it was dismissed.

There was a further incident in January 2002, when he was arrested following an incident during which he knocked a woman off her bicycle. Other admissions followed from February to May 2002 under Section 3 of the MHA 1983, followed by Section 25 (Supervised Community Discharge).

In August 2002, he was admitted for one month on a voluntary basis, followed by another admission from November to December in 2002 under Section 3 of the MHA 1983. In January 2003, he suffered a relapse in his condition and was admitted to a rehabilitation secure unit after he tried to pour petrol through his neighbours' letterbox. He believed at the time that his neighbours had been putting black magic upon him, and he wanted to stop them by burning down their house. He was hospitalised for two years.

First impression

Kenton presented as an intelligent but complex person. This interview was vastly different from the other interviews conducted in this study, in that Kenton was emotionally unresponsive and seemed unmotivated to me. This led me to assess him as having negative symptoms of schizophrenia. I felt the negative symptoms accounted for deficiencies in his emotional responsiveness, spontaneous speech and volition. It was later confirmed by his care coordinator that he has persistent negative symptoms of his condition. At the same time she described him as being very well, the best he has been for a long time.

Kenton told the story of his life in three stages: his childhood, adolescence and adult years. His life was chaotic from a young age because of moving to a strange country and then being separated from his parents at a very important time in his life. I wondered what impact this might have had on him and how he coped (or not) during this time. His parents, coming from working class backgrounds, had high expectations of him, to which he failed to live up. Kenton's 'I want' phenomenon featured strongly in his adolescent years. This was a particularly troublesome time for him, as he so badly wanted to be 'normal'. It is likely that Kenton would also have been struggling with his sexual identity at that time when he discovered that he was attracted to men. Information about gay men was not available to him at that time. This may have compounded the problem and contributed to his having a poor sense of identity. His desire to be 'normal' could, therefore, be seen in the context of his wanting to be like the other boys. The consequence of this was his mixing with the wrong type of crowd and eventually taking drugs and misusing alcohol. From a psychosocial perspective, this cycle of self-destructive behaviour perpetuated by a poor sense of self could be argued as contributing to his many hospital admissions.

Kenton's poor sense of self/identity could also be interpreted by his feeling that he let his parents down by his illness. At the same time, his way of dealing with his perceived failure may have been to immerse himself in his mental health problems, resulting in his becoming a 'revolving door' patient. The most consistent theme in Kenton's story, which he announced as what his story was going to be about, was 'struggle and disappointment'. This was stated at the very beginning of his story,

highlighted by his parents' need to move from New Zealand to try to better their life in the U.K. but not really succeeding. Kenton's lack of educational achievement, involvement with drugs and the law, and finally becoming a 'revolving door' patient sets up the plot of his story.

Personal reflections

Interviewing Kenton was very difficult for two reasons. The first was technical. Kenton was a rather shy, soft-spoken, insular person who seemed lost in his thoughts. His speech was rambling and incoherent at times, which made the recording of it difficult. The data transcription process was equally difficult and frustrating. Second, it was difficult to establish rapport with him because of his insular personality. Small talk with Kenton was, therefore, limited to very basic interaction, such as asking him about the weather and how he was that day.

After Kenton's first interview, I was unsure whether I should be interviewing him again because of his initial presentation. Certainly, he was not unwell in the sense of having positive symptoms of schizophrenia, but I wondered whether his negative symptoms would get in the way of his telling a coherent story. After the first interview I asked Kenton how he felt and whether he was willing to be interviewed a second time. He said that he was fine and wanted to continue with the interview. Before going ahead, however, I consulted with his care coordinator about her views on whether he was fit to continue with the interview. She felt he was well enough, stating that 'this is how Kenton has been for the four years that I have been working with him; he is very well at the moment'. She did not feel Kenton's mental state would improve any more than it had. On her advice, I invited Kenton back for sub-session two of the interview.

Kenton's interview was completed over two sessions, both taking place at the day centre. Each interview lasted twenty minutes. Sub-session three of the interview schedule was not used.

3. Mandy Robinson

Mandy's biography

Mandy was born in 1971 in London and was brought up by her mother as a lone parent. She has an older brother, with whom she gets on well, and a younger sister whom she does not like because Mandy thinks she is too domineering. Both siblings currently live with their mother. Despite conflicts, the relationship between family members is very close. The family moved from London to Hertfordshire when Mandy was two years old. Due to her mother's having a nervous breakdown and having to go into hospital, Mandy and her siblings had to go into foster care twice for short periods because there was no one around to look after them. Because of tough times the family went without some luxuries; however, when Mandy was old enough, she got herself a part-time job so that she could buy things for herself.

Mandy had a tough time at school and was bullied a lot; she regrets not being stronger as a child and able to stand up for herself. At the time, she felt unable to tell people how she felt and so ended up putting up with whatever abuse were hurled at her. She does not feel the same way today.

Mandy's first admission was in 1997. Her GP diagnosed her as suffering from paranoid schizophrenia and admitted her to a psychiatric hospital. She had been living with her boyfriend and working as a retail manager in London when she felt she could not cope anymore. She was initially admitted informally, but after trying to leave the ward, she was placed on Section 2 of the Mental Health Act 1983.

A month after settling down on the ward, she was discharged from hospital. Over the following months Mandy was able to return to her flat. She managed her life with support from her mother and mental health services very well for almost a year after her discharge. Things began to go wrong again for her when she had a big row with her boyfriend. She had accidentally locked her car keys in the car. This led to her leaving him and going back to live with her mother.

Soon after returning to her mother's, she began complaining that her food was being poisoned. She was assessed under the Mental Health Act but admitted informally to a psychiatric hospital. This all happened in the autumn of 1998. The doctors felt at

the time that she was paranoid and was a risk to herself because she was refusing to eat and wanted to kill herself. During this time her mother and brother remained supportive and often visited her on the hospital ward. Similar to her last admission, this admission lasted just under a month. After her discharge she went to stay with her mother for a while before returning to her own flat.

Mandy's next major event was in January 2001, when she took an overdose of 100 anti-depressant tablets. She complained of hearing voices at the time and was admitted for a short while to a medical ward. She had also been having arguments with her neighbour. On the occasion when she was admitted to hospital, she had attempted to kick down the neighbour's door, and as a result, the police had to be called.

Following her short admission, she was discharged back to her flat, where the problem continued with her neighbour. In April 2001, she complained of hearing voices telling her to hurt the same neighbour with whom she had been in dispute. She also complained of hearing a female voice making derogatory comments about her. She was readmitted to hospital for the protection of others. This time she was in hospital for two months. After her discharge she settled down for a few months, but in December 2001 she took another overdose of anti-depressants and was readmitted to hospital for a week. A pattern of repeated admission was developing and continued with another admission in January 2002, when she wandered out of the house in her night clothes. She was paranoid and was concerned that she was the devil's child. She was taken to hospital but discharged herself after only one night.

Despite ongoing support from her mother, brother and sister, she still found it difficult to cope. In August 2002, she was admitted for two weeks after taking another overdose. Following her discharge, she was supported by the Assertive Outreach Team who paid her regular visits. What seemed to be a major turning point in her life happened when Mandy revealed she wanted to make something of her life. She was unable to manage full-time work but thought instead to start a college course. She was supported by the Assertive Outreach Team, who helped her enrol in an Access course at her local college, which started in September of 2002.

Her plans took a major setback just two months into the course, when she began having strange thoughts about her tutor. She believed he was the devil and that she

should kill him. The Assertive Outreach Team quickly arranged for her to be admitted to hospital when they became aware of this. Due to a long hospital spell, she was unable to return to college to complete her course.

The reason for her next admission, which happened in August 2003, was different from previous admissions. For the first time she started harming herself by cutting. She had taken a knife to her arms and legs, resulting in serious lacerations. She was admitted initially to a psychiatric ward under Section 3 of the Mental Health Act 1983 but transferred to a medical ward for treatment for the cuts. On discharge back into the community she stopped taking her medication and was readmitted informally in September 2003 after cutting again and illicit drug use. She was put on Section 3 of the Mental Health Act 1983 after attempts to leave the ward.

Her next admission at the end of December 2003 was to a general ward after an adverse reaction to prescribed medication she was taking to help stabilize her thinking. During this admission her mood worsened, and she was transferred to psychiatric hospital and compulsorily detained at the beginning of January 2004.

Although discharged at the end of January 2004, having apparently improved in mood, she was readmitted two days later with psychotic depressive symptoms and suicidal thoughts. Another admission occurred in February 2004 after she stated again that she wanted to kill herself. It came to the attention of her care team that she was responding to the voice of a friend who had recently died. She believed the friend was telling her to join her in death. Hospitalisation was considered to be the only option at the time. Consequently, she was admitted under Section 3 of the Mental Health Act for her own safety. Since this admission the Assertive Outreach Team has been working more intensely with her, and so far there have not been any further admissions.

First impressions

My immediate impression of Mandy was someone who does not cope very well in stressful situations and someone who is rather impulsive and dramatic in her actions. This impression was borne out in the central motif of her narrative - her determination to end her life by taking overdoses. *"I couldn't cope"* was found in several places in

her story and interpreted as signs of despair. Indeed, one of the main themes that emerged was Mandy's inability to maintain personal power as she faced her illness and subsequent difficulties with interpersonal relationships. I wondered whether this was because of her having a poor self-concept. As a reflection of her childhood, it is possible that Mandy failed to master Erikson's (1968) stages of development throughout the lifespan. According to Erikson's (1968) theory, Mandy's many admissions to psychiatric hospital could be evaluated psychosocially as precipitated by poor socialisation, which could have been due to poor quality of life during her childhood.

Mandy's sense of identity seemed, then, to have been constructed from these recurrent failures to deal with stress to the point where she inflicts harm on herself. The most striking impression was that Mandy's account of her life in the first interview made no reference to family members or significant relationships. Instead, Mandy chose to tell a story of mental illness authored by her psychiatrist and other mental health professionals. I wondered how much of this decision was to do with fear of being who she is.

Personal Reflections

Mandy came to the interview over-prepared with a bundle of psychiatric reports from which she gave a chronology of her admissions to psychiatric hospital. It was either that she did not grasp the concept of the 'tell me the story of your life' question very well or this was a defensive strategy to avoid talking about things she felt were too private or sensitive. Perhaps she just felt uncomfortable expressing her emotional thoughts and feelings.

Mandy's opening question in the following segment of transcript suggested to me that she may have felt that I was only interested in her experiences within the mental health system. I wondered whether she was looking for confirmation from me that it was acceptable just to talk about these mental health issues.

This is part of the transcript that followed my opening question:

I would like you to tell me the story of your life, all the events and experiences that were important to you up to now. Take as long as you want, start wherever you wish.

I won't interrupt you; I'll just take some notes for after you have finished telling me about your experiences.

Do you just want it about mental health issues?

Just your life story.

About mental health?

Just anything you want to tell me (3)¹. You can begin when you are ready.

Okay, I first came in contact with the mental health team back in 1997. Before then I was fine. I've always been quite (3) an unstable person. But, uhm, in 1997 it all came to a head when I suffered from depression and went to see my GP, cos' I couldn't cope.

Interpersonally, I felt closer to Mandy - who like me is black – than I did the other participants. This may have been because of our culturally similar backgrounds, as well as the fact that she had a warm, welcoming personality that made our interaction friendly. At the same time, I was aware of the danger of making the assumption that, because we belonged to the same ethnic group, our experiences would be similar. Of course, it does not necessarily follow because of the complexities of individual identities.

Being members of a marginalised group, I identified with Mandy insofar as the definition of racial identity is concerned. For black people in the U.K. marginality is typically life-long and greatly determines our lived experience. For example, commonalities in our experience of racism are manifested by invisibility, stereotyping, hostility and even abuse, culminating in limited access to education and social and economic resources. It is also the case that the mental health system does not allow black people to be themselves because it may perceive them as 'mad' (Fernando 1991 p. 39). I wondered how Mandy perceived herself as a black woman in a predominately white European society and community. A third interview was not conducted for Mandy.

¹ Represents pauses in seconds.

4. Andrew Simpson

Andrew's biography

Andrew Simpson was born in 1978 and is the youngest of three siblings, with an older brother of twenty-eight and a sister of twenty-six. Both parents are alive and well, although they separated when Andrew was only six years old. Both parents have remarried, and Andrew has a stepbrother on his father's side and two maternal half-brothers.

Following his parents' divorce, all three children remained with their father for a time. It appears that none of the three ever formed a good relationship with their stepmother, and in later years his older siblings moved back to live with their mother.

At the age of eleven, Andrew started smoking cannabis. Around this time, he experienced bullying which lasted until the age of fourteen and frequently became involved in fights with other boys at school. Because of his behavioural problems, Andrew was eventually excluded from school at the age of fifteen. He attended a Youth Training College and was offered a training position at a car dealership, where he worked for three years, but because of his increasingly paranoid thoughts that people at work were talking about him, he left. For the following three years, he remained unemployed, mainly staying at home or socialising with friends. At the age of nineteen he started to work as a trainee electrician with his father and older brother.

In November 2000, it was alleged that Andrew threatened to kill his father with a knife. Consequently, he was placed on Section 2 of the Mental Health Act 1983 and admitted to psychiatric hospital. This was his first admission. He was reassessed in hospital and placed on Section 3 of the MHA 1983. There were further admissions in August 2001 under Section 3 of the Act and in January 2002 also under Section 3 of the Act. He was discharged from this section in March 2002 but readmitted informally in October 2002. He had a three-week admission in March 2003 under Section 3 for bizarre behaviour, when his mental state deteriorated after he stopped taking his medication. He believed that the Microsoft success was because of him and that he had several million pounds. At the time, he talked about negative energy between himself and his stepmother. It was reported that he had been drinking heavily and

had smoked cannabis heavily – up to eleven joints a day. Another admission took place in August 2003 to October 2003. This was also under Section 3 of the Mental Health Act 1983. He had another admission in March 2005 and was discharged in June 2005. In December 2005, Andrew was again admitted to psychiatric hospital due to a relapse of his psychosis, which occurred because he stopped his medication. He was admitted informally, but during his stay on the ward he was detained under Section 3 of the Act. His mental state gradually improved, and he became compliant and regained reasonable understanding and insight into the nature of his condition.

First impression

My first impression of Andrew was that he is a very pleasant and likable young man with real potential to make a go of his life. At the same time, I was struck by Andrew's struggle to renegotiate the relationship between his frequent and repeated admissions to psychiatric hospital and the rest of his identity.

Andrews' array of 'wants' came towards the end of his first interview and was associated with the wish for 'normalcy' (see below). Andrew chose to tell his story through a mixture of first-person and second-person narrative. His language reflected that which professionals would use, and at times during the interview he seemed reluctant to say anything negative about his relationships with professionals, probably in fear that what he said might have an adverse impact on his future care.

Speaking in a mixture of pronouns, he said:

They want control over themselves.

If you can't control yourself the way you want to it takes a bit of your pride away.

You want full control over your mind and body.

Being specific about what he does not want to do, he said:

I don't really want to find out about it. I don't want to take the time to sit down and think and diagnose myself. That's not me.

I don't want to sit down and think is it me or is it my brain.

I'm like most people, just want to get along.

Being around people is not what I want.

I don't want to grow old and have nothing to show for my life.

Identifying things he would like to do, he said:

There is a part of me that does want these things.

I want to eat healthy.

I want to go to the gym.

I want my own flat.

I want to buy my own house.

I want to work.

Going on holiday at least once a year is definitely what I want.

I want to see different places.

Essentially, Andrew wanted his life to be back on track. His story conveyed the struggles which were characteristic of his traumatic life experiences as a 'revolving door' mental health patient. The many unanswered questions that plagued him about his mental illness featured strongly as themes that emerged from his story, for example, he experienced a turning point in his life that happened at age 19, signalling the start of multiple admissions to psychiatric hospital:

...everything was basically normal until I went into hospital. That's when schizophrenia changed my life...

Andrew states that, up to that point, '*everything was normal,*' but then schizophrenia changed his life. From that moment onwards his whole world seemed to have been turned upside down by repeated admissions to hospital:

It's just horrible, the worst feeling, going into hospital, and to happen nine times is obviously something going on in my mind and I'm too stubborn and I know it's part of the illness. I keep fighting the system. That's why I keep relapsing and I've relapsed nine times...

Ostensibly, Andrew's 'wants' include engaging in normalising behaviours that mirror established standards of his gender and peer groups. At the same time, a divided life seems to have prevented Andrew from realising his ultimate goals.

Andrew evaluates his identity by comparing his life before hospital to his experiences of frequent and repeated hospitalisations. His construction of narrative, therefore, helps to make sense out of the situation which he struggles to understand:

Uhm uhm, about the only problem I have at the moment I suppose is about my mental health and about what's happened with that, and I mean that's one of the strangest things that's happened to me in my life. With not being able to understand why I become ill or why why why it affects people in different ways and what what what it actually is.

Andrew's story demonstrates very clearly the 'revolving door' phenomenon and, therefore, makes it appropriate for inclusion in this study.

Personal reflection

I was particularly touched by Andrew's story and his ability to speak for the most part of thirty minutes from a position of not really knowing what to say. At times during the interview I was overwhelmed by the sad tone of his story and his unrealised hopes, marked by the disruptive nature of the 'revolving door' phenomenon. Hence, my relationship with Andrew was the most empathetic, as his struggles for answers to his life reminded me of my own early adult years. I recognised similarities between myself and Andrew, who was struggling with overcoming his personal constraints. As a black youth growing up in London in the mid 1970's, I had neither the skills nor enough self-control to overcome my own personal constraints. It was a difficult time for me to come to terms with many of the social issues of that time.

Not being able to think of anything more to say after thirty minutes, Andrew brought the interview to an end after a ten-second pause by saying, '*Can we stop there?*' Sub-session two took place two weeks later at Andrew's request. Sub-session three was not thought necessary. Sadly, I learnt that Andrew was readmitted to hospital

under Section 3 of the Mental Health Act 1983 due to his stopping his medication nine weeks after his initial interview with me.

5. Colin Andrews

Colin's biography

Colin Andrews was born in 1955, the eldest of three siblings. He was delivered at home, as was the practice in those days. He grew up in a middle class area of Hertfordshire to parents from different social class backgrounds. His mother was from a middle-class background in Surrey and his father from a working-class background in London. Colin was two years old when his mother gave birth to a second child, another boy. His parents had high hopes for Colin, and at age five he was introduced to private education. In 1960, the family moved from one middle class area of Hertfordshire to another. The move was to a larger house that Colin's father had built himself. It was soon after the move that Colin's second brother, Ashley, was born. Colin was eight years old at the time.

At age thirteen, Colin was sent to boarding school, where he remained until he was 18 years old. He disliked the school for the first few weeks but eventually settled down well. He did extremely well at school and, at the age of eighteen, he left with high expectations of going to Oxford. During his schooling Colin developed a flare for rowing. He was appointed a cox and was very successful at it, spending most weekends during the summer on the river. At age eighteen, rather expectedly, Colin was accepted at New College, Oxford and attended for three years. In 1963, Colin had his first sexual relationship. It was with a Corsican French girl whom he met on a school trip to Marseille. The relationship was short lived, however. Soon after, Colin became heavily involved with another French girl with whom he lived for nine months prior to Oxford. He was engaged to be married to her but called off the engagement two days before her finals at Oxford. Sadly, she failed all of her finals. Around this time Colin was made the captain of his rowing team. It was not long after this that Colin met an English girl who became his fiancée.

Colin's big day came in 1981, when he married her. She was three years younger than him. They bought a flat in Putney, London, where they lived for four years. They also had a cottage in Dorset, where they would spend their weekends. Colin worked for a large firm of surveyors during which time he gained his qualification as a chartered surveyor. In 1985, a prospect arose in Dorset to redevelop a football ground into a big supermarket. It was an opportunity not to be missed, so Colin and his wife moved down to Dorset full-time to take up the venture. Colin tried to manage the project on his own, but the job proved too much for one person.

After three years, things came to a head when the building application was turned down. The stress was too much for Colin, resulting in him having a psychotic breakdown. He was found walking down the road carrying his jack russell, talking to him in the belief that the dog was bugged. He was subsequently assessed under the Mental Health Act 1983 and admitted to hospital for three weeks. This signalled the start of a downward spiral. The next six months were just as bad. Things got worse mentally as well as financially for Colin. They were forced to sell their house in Dorset and move back to London. Back in London, Colin tried to make a go at finding a job and joined a house building firm based in Watford, however, he became unwell again and was admitted to hospital for two months. On this admission he was given a diagnosis of bipolar disorder (manic depression).

Recovering from this episode, he returned to work but was sacked on the spot. This did not deter him, however, and he soon was able to find another job with another house builder. He was open with his employer about having manic depression and they were sympathetic towards him. After a year Colin was made director of the company. Unfortunately, Colin lost his job in 1990 due to the housing slump at that time. Fortuitously, however, he got another job with a well known estate agency and worked for three years. Colleagues became aware of his problems, but not top management. Because of the nature of the illness, Colin had another manic episode and, as he had experienced in the past, was sacked on his return to work. Having had enough of working for other people, Colin decided to set up his own business, finding sites for house builders. The work was intermittent but good. At the same time his wife was building up her own career in the publishing field in London. She started off as a part-time assistant and within a short time became manager and then director.

In 1991, Mrs Andrews became pregnant, but the pregnancy was entopic. She refused surgery, and on Colin's birthday delivered their first child, a girl they named Debbie. Two years later they had another girl whom they named Rosemary. Throughout this period, Colin was subject to intense and rapid mood swings; periods of delusions in which he thought he was getting messages in codes, alternating with depression.

Predictably, a hospital admission followed these episodes. This time he was admitted to a private hospital in London. The hospital had a pleasant and tranquil environment which helped Colin recover quickly. Disappointingly, however, Colin's next admission was to an NHS hospital in Hertfordshire. He was admitted again to the same hospital in 2005 for five months. At the time of his interview for this study Colin had been discharged from hospital for three months.

First impression

Colin impressed me, first of all, as an articulate, pleasant and intelligent person who is resilient, determined and straightforward. I was particularly interested in finding out how he had acquired his motivation and ability to bounce back time after time, in spite of all he had suffered. Understanding Colin's subjective experiences and sense of self, therefore, first began by considering the prime motivational factors in his life. From a psychosocial perspective, Colin's middle-class background and high educational achievements, it could be argued, made the difference in his struggles. A central and reoccurring theme in his story was that of resilience. He demonstrated that he is not his illness experience and that recovery transcends his illness. Indeed, despite his many admissions, Colin was able to tell a success story of making the transition from hospital back to the community. In so doing, he shows people that he has a life, the most effective anecdote to stigma and discrimination.

Personal reflections

I liked Colin a lot. I particularly liked his professionalism and straightforwardness. He did not have any difficulty grasping the concept of the 'tell me the story of your life' question and went straight into providing a chronology of his life. He was interrupted

after an hour by the arrival of family members (his brother and two daughters). I switched off the tape recorder at that moment. The break lasted for 10 minutes. Resuming the interview, Colin continued in much the same way. Eventually Colin brought the interview to an end after a six-second pause by saying, 'That's about it'. As the interview was particularly lengthy and detailed, I wondered whether I needed to have a second interview. Not being totally sure, I explained to Colin that I may need to see him for a second interview. Colin did not have any objections to my returning at a later date to further interview him. I did return to conduct phase two of the interview which was just as productive as the first phase. A third phase interview was not conducted.

6. Michelle Walton

Michelle's biography

Michelle Walton comes from a very privileged background with wealthy parents. She was born in 1957 in the Midlands and is the youngest of five siblings. The family moved to Hertfordshire with her father's job in 1959, and Michelle grew up in a large Edwardian house with a swimming pool and a pony.

Michelle had a happy childhood. She fought a lot with her brothers and sisters and was very spoilt. When she was eleven years old, her pony was stolen from the fields near her home. Fortunately, her parents were able to buy her another one, which she loved even more than the first.

She loved her parents but felt her mother was neurotic and unable to cope with looking after the children. Her father was a 'high flying' business man and was always working away from home. There is a strong history of mental illness in the family. A maternal great uncle committed suicide due to depression, her paternal uncle suffered from Bipolar Affective Disorder and her sister suffers from mental illness and has required electro-convulsive therapy.

Michelle grew into a very attractive young woman. She did well at school and was happy until the time of her 'A' levels. During this time her parents went away to Canada to visit one of their other daughters who was living there. Michelle was left

alone with her other two sisters and two brothers when she took her 'A' levels. She successfully left school at the age of eighteen with ten 'O' levels and three 'A' levels.

Michelle wanted to study music and drama when she left school but felt she was pushed into art college, which she hated. She was asked to take a lead part in a play while taking grade one flute. At the same time, she was responsible for looking after her pony at home. She became depressed, and when things became too much for her to cope with, she tried to kill herself by taking an overdose. In 1977, at the age of nineteen, she attempted suicide by crashing her car following a nervous breakdown. She went missing, but eventually she was found and admitted to psychiatric hospital for the first time for four months. Michelle remembers this as a horrible experience, and it was during this admission that she alleges that she was raped by a male nurse. The alleged incident went unreported. She hated being in hospital and tried to kill herself many times by taking overdoses. She blamed her parents for putting her in hospital so that they could make another trip to Canada. She believed her parents felt she would be safe there. Following her discharge from hospital, Michelle worked with horses for a while, training to be an instructor. However, she stopped her medication and became unwell again. She quickly recovered, though, and worked for Butlins before going back to art college for a year to do a Diploma in Art. After this she worked as a youth worker, part-time driver/messenger and temporary welfare assistant.

In the summer of 1978 Michelle went on holiday with some friends. She became unwell during the holiday, thinking that she was Jesus and could walk across the water. Attempting to do just that, she removed all her clothes and jumped into a river. After almost drowning, she managed to swim across the river. When she reached the other side, she was picked up by the police and admitted to psychiatric hospital for the second time. She became seriously unwell again when she was twenty-two years old and was diagnosed as having a bipolar disorder and put on lithium. A period of stability followed during which time she met the man who would later become her husband. They had a long engagement and were very much in love. Michelle wanted children; she wanted to get married and to have a house.

In 1984, her dreams came true when, at the age of twenty-six, her parents bought her a house. She got married and became pregnant soon afterwards; however, she

had to have an abortion because she was on lithium at the time. It was considered by professionals that being on lithium would harm the baby. This was a devastating blow for Michelle because she desperately wanted to have a baby. After the abortion she was desperate to become pregnant again. With a strong determination, she made the decision to slowly come off lithium so that she could try for another baby. She ate all the right foods to help her conceive and even gave up smoking for awhile. It was an especially joyous occasion when eventually she became pregnant for the second time and in 1989 gave birth to a son, whom she named Barry. That whole year was a particularly happy time for Michelle. Her son had his christening when he was nine months old, on the same day as his father's birthday. Michelle's parents arranged a party to celebrate, which Michelle enjoyed, describing that time as the happiest of her life.

Life was to change again for Michelle because the next five years were to see more admissions and a major turning point in her life, in the form of her divorce. She experienced a manic episode in February 1997 and was admitted to hospital for two months. She was admitted again in March 1999 for three months and in October 1999 for two months. She did not have any more admissions until August 2000. This time she was in hospital for four months. Three weeks after being discharged, she was readmitted. This admission may have been partially due to the breakdown of her marriage and was the lengthiest experienced, from December 2000 through to November 2001. During this admission she separated from her husband. The marriage eventually ended in divorce in 2002. There had been a history of marital difficulties, partially due to her illness, and on a number of occasions these involved physical altercations.

Michelle's last admission (up to the time of her interview) was in March 2002, when she presented herself to the ward with concerns that she had multiple physical problems, including cancer, and that she was pregnant. Michelle now lives alone in a one-bedroom flat and smokes 30-40 cigarettes a day. Her son, who is seventeen years old, lives with her ex-husband and his new partner. He visits his mother occasionally.

First impression

Michelle's 'wants' were all related to the psychosocial needs of getting married, buying a house and having children. This was her dream, and I suppose it is the dream almost all young girls are socialised into having and most likely will continue to have in the future. I wondered whether this also had to do with Michelle needing to feel secure. Earlier in her story, she indicated that she does not cope very well on her own. She described her mother as '*neurotic and unable to look after the children*'. I wondered whether this was therefore learnt behaviour or Michelle's just being spoilt.

Personal reflections

I really liked Michelle. I had noticed her on the hospital ward and always stopped to have a brief chat with her whenever I could. From what I gathered from colleagues, she is also well liked by ward staff and patients, I think, amongst other things, because of her 'colourful' personality. I wondered whether my liking Michelle would affect the way I went about the actual interview or the analysis. I had already established a good professional relationship with her and had heard from her care team that she only agreed to take part in the study because she thought that I was a nice person. Because a good rapport existed between us, I felt that this helped create a space where Michelle felt safe talking about experiences that she might otherwise not have disclosed to someone else. Michelle gave me the impression that she wanted to give a good interview so as to mirror the kindness I had shown her in the past when I stopped to talk to her whenever I visited the hospital she was in. I believe this relationship helped produce information that otherwise may have been kept hidden. In terms of the analysis process, using a reflective team helped to generate an alternative understanding to my own, of what was happening in the story she told.

Michelle was in a very cheerful and jolly mood at the time of her interview, despite having a bad cough for which she apologised profusely. She was smartly dressed with a mixture of bright colours to match her well known warm and colourful personality. She is a chain smoker and asked permission to smoke during the interview. I felt I could not refuse her this request for two reasons. First, and the most important, it was her home, and I could not deny her the right to do whatever she

wanted in her own home. The second was that I was afraid that if I said no, she would decide not to take part in the study. I really wanted to hear her story, so I thought an hour or so of passive smoking was a small price to pay for the story of her life.

I came to the first interview not being sure of what to expect from Michelle. I knew I would get lots of laughter because that is what Michelle does. I was unsure about anything else. The interview began well enough, without Michelle being thrown by the invitation to tell me the story of her life. In fact, she took it in her stride and straight away began giving me a chronology of her life, starting from when and where she was born.

Everything was going rather well until Michelle mentioned in a matter of fact way, that she felt she was raped during one of her hospital admissions many years ago. Alarmed by what I had just heard, I was thrown into the dilemma of whether to maintain my passive stance or disrupt the *gestalt* of her story. I decided to remain passive, but it felt extremely uncomfortable. I wanted to stop the interview to offer my sympathy even though no emotional distress was acknowledged. I reminded myself that Michelle's revelation could be followed up in sub-session two of the interview. I made a note to do just that while Michelle continued telling the story of her life, unaware of the dilemma that had gone on in my head because of what she had just revealed to me.

After twenty minutes, Michelle brought the interview to an unexpected end by a coughing fit, probably due to her smoking. I think by this stage she may have naturally come to the end of what she had to say. We took a fifteen-minute break, which was agreed at the start of the interview. Michelle went to the bathroom, and I made notes and highlighted areas in my notes for further exploration after we returned from the break.

In sub-session two, I asked probing questions in relation to the research topic and followed up on Michelle's unexpected revelation of being raped as an inpatient. As an ethical issue, I felt that I needed to bring the matter to the attention of my team leader. She subsequently convened a meeting to discuss what action, if any, should be taken in light of this information. I also discussed what had happened with my university supervisory team. After reading and rereading Michelle's interview

transcript, I decided, three months later that I needed to see her again to get more information in relation to the research topic. Sub-session three served this purpose well.

7. Keith Edwards

Keith's biography

Keith was born in 1974 in the West Midlands and comes from a family of five. He is the only boy, the eldest of three siblings. His parents were both university lecturers when he was growing up. Keith had a particularly happy time growing up with his siblings, with whom he had a very close relationship.

Keith left school in 1992 with good 'A'-level results and a place at Queen's College to study maths. After spending six months in Calcutta teaching English in a mission school (during which time he became quite depressed), he decided that maths was not vocational enough for him. So, on his return to the U.K., he had another interview at Queen's College in order to change to a natural science degree. He began his studies in October 1993. He arrived at Oxford very hyperactive, having recovered from his depression in India, however, not feeling sure that he was studying the right subject, he left Oxford after only four weeks. After abandoning his degree at Oxford, he took a year out before starting a medicine degree in London. During the first year of medicine he became involved with Christianity, singing in a rock gospel choir and attending various Christian functions. Towards the end of the year he felt an urge to gain a better understanding of who Jesus was. After devoting an entire weekend to reading philosophy, religion and history, he began to feel that he was the Second Coming and that he had a special message for humanity.

He started giving away his belongings and generally behaving as though nothing was of any importance except spreading the 'message'. He stopped going to his medicine lectures and just spent his time talking to people about religion. At this time some of his friends took him to a psychiatric hospital. He was admitted in May 1995 for the first time. He absconded from hospital, however, during a visit by his mother and went on a hitch-hiking adventure around the country. Eventually his parents persuaded him to go back to hospital and take his medication. A combination of not

being prepared for his exams in August and the effects of his antipsychotic medication resulted in him not doing so well at his exams. He passed anatomy and physiology but failed biochemistry. Consequently, he had to re-sit the final term of the first year.

In February 1996, he went down to Essex, where he did voluntary work in a home for disabled people. He met and fell in love with a Polish girl named Magdalena. He thought that she would be an important part of his life because of the similarity of her name to Mary, mother of Jesus. In 1996, at Christmas, he travelled to Poland, where he proposed to her in her parents' house. They were seriously planning a life together when he finished his medicine degree, but in summer 1997 he fell in love with a fellow medical student called May. He called off the engagement with Magdalena, and this naturally caused a lot of upset.

In August 1997, just before the start of the clinical phase of his medicine degree, Keith experienced another strange state. He deliberately burnt his hands and refused to acknowledge anyone else's existence (a state that is referred to as solipsism). After May saw him doodling maths in the margin of his lecture notes, she suggested that he change to studying maths. He jumped at the opportunity and went straight into the second year of the four-year degree. For a while things ran smoothly. He did very well in the second year and was very happy. The following year, however, he went into psychiatric hospital twice, but his condition was not serious enough to disrupt his studies. The fourth year was a different story. He was hospitalised seven times that year, and his studies were so disrupted that there was no way in which he could sit the final exams. Once again, he had to re-sit an academic year. His relationship with May ended before the start of the re-sit year. During this final year, Keith went into hospital once at Easter. This manic episode was prompted by disappointment about being rejected for a teacher training course.

In 2001, Keith was rewarded for his determination with a first class degree. After completing this stage of his studies, he met a Scottish girl called Marion and lived with her for a year in Scotland, where he went on to do an MRes degree. He continued to be plagued by his illness and was manic for much of the year. During a choir tour to Holland in 2002, he took it into his head to abandon the choir and start walking to his birth place in Africa. After a day of walking, he returned to the hotel

having thrown his shoes and wallet into the river. On another occasion, he gave all of his prized possessions away.

Keith's final admission was in July 2002 and involved him going off in the middle of the night, and the belief that he could talk with animals. Around this time his relationship with Marion ended. In 2003, Keith started a PhD in statistics. The journey through the first two years was not without its difficulties, but he persevered and recently completed the degree.

First impression

I found Keith to be a dynamic person with a sharp mind and effervescent smile. In addition to that, he seemed to be someone who really enjoys being around people. One of the other things that struck me about him was that, in spite of enduring over fifteen admissions to psychiatric hospital, he not only survived but accomplished remarkable achievements in the process. I really admired that.

In a similar way to Colin, Keith demonstrated that it is possible to bounce back from adversity and go on to live a fulfilling life. He was determined not to let adversity define who he is. This was one of the things that made his story special. He transcended his troubles with mental illness by defining himself as someone who is academically capable and socially competent. Psychologically, Keith took responsibility for his life by externalising blame and internalising success. The toughest part of having an illness such as bipolar disorder and multiple admissions to psychiatric hospital is that it gets in the way of plans and is disruptive. I wondered whether these setbacks made Keith realise his vulnerability in any way. If this was the case, there would have been a need for him to understand himself enough to realise that as long as he got back to his plans, he would be fine.

On the other hand, the social consequence of Keith's multiple admissions to psychiatric hospital meant that he has now come to be known as a 'revolving door' patient. Notwithstanding the social stigma and terrible public perception that this carries, Keith was determined not to let his many hospital admissions prevent him from achieving his goals. His life story emphasises his strength of character,

Keith's multiple admissions to psychiatric hospital were almost entirely precipitated by manic episodes which, for him, were marked by religious themes and broken relationships. At the same time, the motifs that permeated his story consisted of academic achievement and the forming of relationships. These motifs, combined with a sense of purpose, provide the biographical background for exploring Keith's identity and motivational system in relation to the 'revolving door' phenomenon.

Personal reflections

I felt very comfortable interviewing Keith. The interview itself went extremely well. Indeed, Keith fully grasped the concept of the 'tell me the story of your life' question without any difficulties at all and went straight into narrating a well-thought-out, coherent and inspiring story. This interview was one of the most enjoyable and inspiring for me. Keith's story of his academic journey brought out my own personal experience of my own academic pursuit. My research journey has indeed presented many challenges along the way. These challenges, of course, were unique to me. At the same time I felt that I could identify with the story Keith told of his life and all the challenges he had to face.

Keith ended the initial interview by saying, *'I'm trying to think if there was anything else. Well, I think that's enough of the story. Really, I can't think of anything else that stands out'*. Keith had spoken substantively about his adult experiences. His personal history was notable for the absence of his childhood.

I wondered why he had decided to omit his childhood from his story. Was it because he felt that this part of his life was unimportant and not worth talking about, or was it that he just wanted me to hear about his illness narratives? It also occurred to me that he may have wanted to make the point that he succeeded in spite of his many admissions and disrupted life.

In sub-session two, which followed after a fifteen-minute break, I made a point of asking him about his family, as I wanted to get a more rounded view of him as a person. Even though I asked probing questions about his childhood and family life, he almost always returned to talking about his experiences in the mental health system as an adult. Perhaps this was part of his identity, as someone who is always looking forward to the future with a positive attitude. Indeed, Keith summed up his

story as a 'positive experience'. Keith is truly an amazing individual who I feel privileged to have interviewed. A third phase of the interview was not conducted.

C. CONCLUSION

Having co-constructed the remembered past of the seven participants presented in this study, what becomes apparent is the diversity and richness of each individual life across the lifespan. Chronicling the experiences of each *lived life* highlighted the descriptive importance of the historical context in understanding the 'revolving door' phenomena. These reconstructed chronological stories have indeed created the skeleton upon which the fleshier *told stories* will come to rest.

The inclusive nature of the research methodology recognises the reflective importance of the researcher as part of the research process. In doing so, a reflective perspective is provided of the underlying factors that come out of each of the stories, presented as *first impressions*. These *first impressions* consist of two reoccurring elements that have symbolic significance to the stories: the 'motifs' and the 'I want' phenomenon. In addition, *personal reflections* generate insight into the dynamics of the interview situation and understanding of the text.

In the following chapter, the stories of four of the participants outlined above will be analysed by the reflective team method as described in the Method chapter. Only extracts from the interview transcripts will be provided in the next chapter, however, as a way of illustrating how I have conducted the interviews, an example of one the transcripts can be found in Appendix D. Also, a sample of the reflective teams work can be found in Appendix E.

CHAPTER V

REFLECTIVE TEAMS' ANALYSES OF DATA

We are like dwarves standing on the shoulders of giants, so that we can see more than they, and things at a greater distance, not by virtue of any sharpness of sight on our part, or any physical distinction, but because we are carried high and raised up by their size.

Bernard of Chartres (cited in Morrison 2005 p. 73)

A. INTRODUCTION

In Chapter Four, the extraordinary *lived lives* of the seven participants who took part in the study were presented in order to get to know them personally and to set the context for analyses. In essence, what each *lived life* represented was a rich diversity of experience spread across equally diverse demographic backgrounds. Thus, having collected the data necessary to consider the whole life of each of the participants, I now move to the reflective teams' analyses of the *lived lives* and *told stories* of participants in the study.

In this chapter, the results of the data analyses of each of the *lived lives* and *told stories* of four participants selected for in-depth analyses by the separate teams are presented. This was done according to Spiegelberg (1982 p. 712) 'to elucidate meanings that are concealed in the stories'. I achieved this by making psychological insights into what is happening in the experience of the participants. I argue that the interview-generated narratives are representational forms that provide valuable information about individual identity in the context of mental illness and frequent and repeated admission to psychiatric hospital. Riessman (1993 p. 17) identifies the universality of narrative, but Abbott (2002 p. 16) simply suggests that 'narrative is the representation of an event or a series of events' consisting of story and narrative discourse. A story is an event or sequence of events (the action) and narrative discourse is those events as represented. It is by analysing this ordering of events that I attempt to discover the meaning that pervades each participant's life. Previous

chapters referenced the works of Mishler (1986), Sarbin (1986), Gergen (1988), Rosenthal (1993), Riessman (1993), Denzin, (1997), Jones (2001, 2004, 2006), Wengraf (2001) and others in an attempt to formulate a constitutive definition of how stories are constructed and interpreted. In this chapter, emphasis is on the structure of narratives, drawing on the framework of Labov and Waletzky (1997) in an attempt to draw meaning from the experiences of 'revolving door' patients, as told in the stories of their lives. Particular attention is given to the teller's evaluation of his or her action in the narrated event.

To illustrate the process of analysis, I drew up a table with two columns (see p. 148). The left hand column includes the narrative extract of the participants' story and the right hand column includes Labov and Waletzky's narrative framework. I also constructed a table to illustrate the particulars of the reflective teams that were involved in each participant's *lived life* and *told story* (Tables 5 – 8). Each table gives the name (pseudonyms), profession and description of the interests of each reflective team member.

The chapter is divided into three parts. These parts centre on what I consider to be important analytical issues. In part one, I introduce the concept of reflective teams. I also report on my observation of the teams, in particular, how individuals from different backgrounds worked together in undertaking the reflective task. I discuss Pierce's (1839/1914) abductive reasoning as a way of generating theory, which is then followed by a detailed discussion on how the teams approached the task of constructing meaning by this process.

A point worth noting is that the process of analysis in this study does not lend itself to any fixed hypotheses. Instead, hypotheses were generated during the data analysis stage based on the stories told by the interviewees. Having said that, I hypothesised at the beginning of the research that the study would provide insights into the characteristics of 'revolving door' patients, what the experience might mean for the participants interviewed, and the impact of 'revolving door' patients on the health service generally. At the same time, I anticipated that key insights would emerge during the course of the research that would steer the analysis in unforeseeable directions.

In part two, a presentation of the data just mentioned and microanalysis of the narratives produced by participants is provided. Finally, part three offers a conclusion to the chapter.

A. PART ONE

1. The Reflective Teams

As mentioned in the methodology chapter, a key feature of the Method is the use of the reflective team approach to the analysis of narrated text. The concept of a reflective team and its applicability to narrative analysis is based on the work of Jones (2001) and Wengraf (2001). This concept is distinctively different from other concepts of reflective teams such as those that can be traced back to Anderson, a Norwegian family therapist trained in medicine and psychiatry. Anderson's team acted as expert, neutral observers who discussed cases while watching from behind a one-way mirror. They issued interpretations via the therapist, who would leave the client briefly to consult with the observing team (Pare 1999 p. 3). This type of reflective team is suited to psychotherapy sessions and is not necessarily considered appropriate for the research context in this study.

Using the Method's reflective team as an analysis tool involves a process in which segments of the interview data are placed on a flipchart and the reflective team is invited to generate ideas about what they think might be happening in that particular passage of text. They do this by forming predictive hypotheses and microanalysing small segments of the text. Adopting Sarbin's (2004 pp. 5 - 20) approach, teams are encouraged to be as imaginative in their thinking as possible and to consider not just what was being said, but also what was not said in the participant's self-narrated biographies in order to develop hypotheses. By working in this way, an inductive approach is defined (Jones 2004 pp. 45 - 47). This non-linear process involves continual reference back to the data, with a focus on eliminating or confirming hypotheses while still focusing on the whole story. This dynamic movement of the analytical inquiry serves also to bring salient issues to the fore, uncovering that which

is hidden or forgotten; this is in some ways comparable to the work of Foucault's archaeologist.

Continuing with the simile, I now report on the 'archaeologists' that constituted the reflective team in this study. First, I wish to say that there were eight reflective teams. Six were made up of mental health professionals. This group represented all the professions within a typical community mental health service, including mental health social workers, psychiatrists, psychiatric community nurses (CPNs), professional assistants and psychologists. One of the teams was made up of service users in accordance with *The National Service Framework for Mental Health* (DOH 1999), which encourages the involvement of service users in research. I was also encouraged by other research that involved service users in their study such as Clark, Lester and Glasby's (2005) work. Clark et al., (2005 p. 77) identified certain benefits of involving mental health service users in research:

- Users are experts about their illness and need for care and will have viewpoints about issues grounded in personal experience.
- Users may have different but equally valid perspectives that challenge traditional assumptions.
- Having users involved in research, signals the importance of seeking a diverse range of views and life experiences.

All the service users lived in London and belonged to a different mental health trust outside the localised geographic area in which the study was conducted. The other team was made up of members of the public who I personally recruited from the West Midlands. Members of this team were all employed and lived in Birmingham. I deliberately chose Birmingham to eliminate the likelihood of any of these individuals knowing the participants.

I anticipated that each team member would bring to the analytical sessions their own life stories, social skills, knowledge and interests, which would inevitably influence how participants' stories were interpreted. Clark et al., (2005) found that this was a problem in their research, stating:

When conducting a narrative review, there is always a risk that we subconsciously pick themes and issues out of the literature that support our own preconceived ideas. By having a multidisciplinary research team (including service users), we were able to guard against these dangers as much as possible (2005 p. 80).

Because the Method encourages diversity of team members (Wengraf 2001; Jones 2001, 2004), each expression of diversity is an important aspect of a team's composition. It enlivens the dynamics of the analysis process and at the same time creates a space for broadening the range of interpretation. Wengraf (2001 p. 258) states, 'The more the diversity of those involved, the better and more interesting the work of analysis becomes'. As such, each person's background plays a part, whether they were professionals, members of the public or service users.

Teams in my study were further enhanced by a combination of personal experience, knowledge and intuition to support their interpretations. Of course, these interpretations would have also been influenced by cultural differences as well as underlying beliefs, values and assumptions. To counter any negative attitudes or the teams' being judgmental, team members had ethical obligations to treat each other respectfully, as well as the participants whose lives they had become indirectly a part of.

To emphasise this point, the teams operated with the philosophical underpinnings of social constructionism (see Gergen & Gergen 1988; Roberts 2002 pp. 7 - 8) as well as humanistic principles which emphasised careful attention to the interviewee's psychological experiences (Glover 2003). Humanism also means that personal autonomy, dignity, liberty and responsibility are considered positive values. According to Glover (2003), humanism in psychiatry has two central themes: Interpretation of people, and human values. These underpinnings further enhanced the analytical process, making it possible for the teams to work interactively and productively. This was achieved by constructive dialogue and being open to alternative viewpoints.

In a similar way to Jones (2001), I began each reflective team session by inviting members of the team to introduce themselves to the group. What I found was that each person, including the team consisting of members of the public, would give a basic description of themselves which included name and professional status, for

example, 'I'm Everton Bolton, and I am a mental health social worker, but I am also completing a PhD in mental health'.

This was an interesting observation. I expected mental health professionals to construct their identities in relation to their professional roles, but I was uncertain whether this would also apply to members of the public and service users. What I learnt was that professional status served as an important anchor for constructing a sense of identity for teams consisting of members of the public as well as service users.

After everyone had introduced themselves in this way, I went around again and ask each person to reintroduce himself or herself, this time stating something different that the group may be surprised to hear. This is an example of what was said: 'I'm Everton Bolton. In my early teens I was homeless for a year, during which time I slept rough on park benches'. It was this other self that I encouraged reflective team members to bring to the analysis. The reason for doing so was to broaden the imagination and not be restricted to a one-dimensional or professional viewpoint.

As the main facilitator, I was able to make direct comparisons across the teams and, in doing so, made some important observations about the operations of the teams and the individuals in it. While there were clear differences between the teams in terms of age, ethnicity, gender, professional discipline and social status, I noted that there were also clear similarities, the strongest of these being their unified commitment to the reflective task. Each team member willingly contributed to the analysis process by bringing their tacit knowledge and intuition to inform their interpretations of the research material. In many cases, using their knowledge of history, they were able to connect the life events of various participants to the wider social conditions of that time. Miller (2000 pp. 21 – 40) highlights the importance of considering any influential political social situation within the historical context. Likewise, Marx (1852) wrote:

Men make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under given circumstances directly encountered and inherited from the past (*The 18th Brumaire of Louis Bonaparte*).

I found this quote enlightening. Its sentiment seemed to inform the interpretations of many team members, for example, one member referred to the political and social situation in the early 1970s in making sense of Hannah's story of sexual abuse, while another, a nurse, drew on her personal knowledge of the practices of larger hospitals before deinstitutionalisation occurred, making sense of Michelle's story of her treatment on a mental health ward. Miller (2000) is in support of Marx's view when he adds, 'In this respect, historical events and social change at the societal level impinge upon the individual's own unique life history' (p. 9).

The teams were also comparable in terms of the respect that individuals showed to each other. I wondered whether this was because most of the team members knew one another. Would the same effect be achieved if they did not know one another? This was something I was interested in finding out by closely observing the other two teams. The result turned out to be the same. Unsurprisingly, they still had a high regard for each other. I concluded that this high level of respect was most probably due to the manner in which the session was conducted. Another thing the teams seemed to have in common was their thirst for the whole story. In several instances, when it was realised that the session time was about to expire, the team asked that I continue so they could hear the whole story (see Jones (2003) for an elaboration of this phenomenon).

2. The Reflective Teams - Similarities and Differences

Team of Service Users

Having said all that, each team had its own idiosyncrasies. The team of service users tended to personalise the information from the research material, for example, if someone in the story had suffered abuse, they would show their rage by shouting abuse back at that person in the story whom they considered the abuser. They also made connections with the diagnosis of the participant, saying for instance, 'I'm schizophrenic!' This identification with the characters in the story could have also been due to the fact that they too had similar experiences. If this was the case, generalisations could be made about this particular group, however tentative. In addition, what was conveyed most strongly was that service users seemed to have a

collective feeling of shared victimisation. This made me wonder whether they may have felt that the story was as much about them, as the person telling it.

At times, the service user session became chaotic, with members of the group wandering in and out of the room at will. Concentration for this particular team seemed difficult, and I wondered whether they were finding the session uninteresting or perhaps too distressing. One person kept asking me what this was all about. When this happened, I would stop the session to explain what I was doing and why. Another person began telling his own story in the middle of the session. I found it difficult to keep everyone focused on the task, but amidst this moving about and interruption, two members of the team remained focused on the task and really got involved in the session. Without them, the session would have probably ended prematurely. Fortunately, I was able to complete the analysis, but I did have to race through it while trying to keep the whole process as interesting as possible. This particular team looked at the *lived life* of Hannah Salmon. Involving service users as team members was an invaluable experience for me. It provided a dimension to the analysis process which, not only illustrated the inclusive nature of this research method, but also promoted its ability to create space, so that the 'voices' of this vulnerable group could be heard both as the analysed and as analysts. Despite the mental health difficulties they experienced, team members were able to reflect on their personal experience as service users and by channelling the combination of their unique perspective and awareness were able to bring insights and added value to the analysis. Not only that, their contribution provides stimuli for future research in this field.

The Team of Professionals

The idiosyncrasies of the team of service users contrasted greatly with that of the teams made up of professionals. Indeed, while these sessions ran smoothly, some psychologists and doctors appeared to have difficulty moving outside their bounded professional roles. One doctor, for example, was able very early on in the session to conclude that the person was suffering from bipolar disorder. I was not surprised by this, given his training, but did wonder whether he could see the person beyond the diagnostic label; a case of not being able to see 'the woods for the trees', perhaps?

The Team of Members of the Public

My experience with the team of professionals was different to that of the team comprising members of the public. They came to the reflective process unaware of what to expect but were able to meet the challenge with open minds. What was remarkable about this team was their excitement about being part of the study. I think this may have been because the notion of a reflective team was completely new to them. It could also be said they had an innate desire for stories, a natural inclination; they got fully involved in the session and would not stop until I had placed the last segment of text on the flipchart. The session lasted four and a half hours.

3. My View of the Teams

My reflective work with the teams was experienced as an enjoyable, dialogical process in which I was able to engage in the reconstruction and interpretation of self-narratives. Individuals were able to bring their prior experiences to the thinking process, which made the whole event interesting and pleasurable. An important advantage of using a reflective team was that these teams were able to come up with imaginative perspectives that I may not have had, working on my own. In retrospect this was one of the main benefits to come from using this method. Another point worth mentioning is that interpretations go beyond the work of the reflective teams and open up the stories for a modicum of interpretation by others to whom the study may be presented.

4. Feedback from Members of the Team

As soon as it was practical, I met with members of the teams individually after each session to ask them about their experience being in the team. Some of the responses I got are provided below:

I found it greatly useful to how I approach my work. It showed me the importance of seeing people in their whole context, and it helped me understand that their current situation has been shaped by numerous life events.

David, social worker

Following the life of someone with schizophrenia made me think about my own life and my experiences in the mental health system.

Brian, service user

It was invaluable from my point of view as a CPN in reflecting on the clients and families health promotion as a family unit and considering the varying reasons as to how the problems first arose. As a CPN, the reflective team work helped me remain more objective to the unravelling story, a very useful tool.

Rob, community psychiatric nurse (CPN)

I really enjoyed being part of the reflective team. Despite being a little apprehensive at first, it turned out to be a good experience for me.

Gee, member of the public

Having discussed the reflective team, I will now proceed to make connections with the process of empirical analysis. By doing so, I unveil the method of abduction and induction as tools in the analytical process necessary for meaning making.

5. Narrative Text and the Abductive-Inductive Process

Perhaps the first thing to say about the process of analysis in this study is that it starts from the critically important question: What is happening in the lives of the participants interviewed? Similar questions are often raised in the field of social psychology such as, 'What is going on inside human beings when they use discourse?' These questions arise from Heideggerian existential ontological phenomenology, which asks, 'What does it mean to be a person?' Starting from this philosophical position re-enforces the research question which, in turn, attempts to answer the question, 'How does each "revolving door" patient construct meaning and reality, and how does that enacted reality provide a context for shaping his or her self/identity?' Given this context, I positioned myself strategically in the complex mix of the participant's social and psychological world. Put another way, I attempted to understand each participant from his or her own evaluation of his or her life events and experiences. This meant getting as close as possible to their lived experiences. This is because understanding the relational and configurational context allows for a

more appropriate interpretation of the significance that things have for a person (Benner 1994 p. 51) . As such, I was drawn to make judgments about the pathology of their actions. Indeed, to answer the research question meant psychologising the dimensions of these individuals' personal lives. At the same time, this also meant setting them apart from each other in terms of the uniqueness of each of the lives explored because, subjectively, each person is regarded as living his or her life within his or her own personal ecology of meaning.

The notion of ecology offers a unit of analysis that emerges from the interaction between people and their environment. It is similar to Latour's (2005) network theory. Ostensibly, application of the ecology concept serves to form a perspective on the culture of mental healthcare in order to create an understanding of how the different actors (patients, doctors, social workers, nurses, psychologists and so forth) behave or interact with each other. Miller (2000 p. 13) emphasises the fluid nature of the individual's standpoint within this ecological environment. What this means in terms of socially constructed identity is that each participant's sense of self is shaped by social encounters within the environment.

Bevan Brittan (2008), for example, points out that 'The Mental Health Act 2007 seeks to offer a twenty first century solution to the perplexing question of how society treats the mentally ill. The Act seeks to balance many complex problems – for example the desire to treat patients in the community with the duty to protect the public from those perceived to be dangerous. All of this is set against the backdrop of a Health Service in a state of constant change which makes for a complex time for all'. In the midst of this complexity is the 'revolving door' patient whose self/identity is the subject of this study.

I deliberately began this chapter with a phrase attributed to Bernard of Chartres (cf. Morrison 2005 p. 73); this was to reflect the importance of the works of social scientists interested in generating ideas about the narrative study of lives. These authors have done considerable work that deals with giving voice to human feelings and experiences. Whitwell (2005) writes, 'Attempts to describe and explain human experience are not limited to science. If reductive scientific accounts are felt to be lacking in some way, then there are narrative ways of describing the human condition' (p. 50).

The field of analysis within qualitative social research is understood to be broad-based with no definitive methodology (Baumgartner 2000 p. 425). In other words, there is no gold standard approach to the analysis of narrative text data. Acknowledging this point, I became increasingly aware of the importance of giving full consideration to how real-life data was to be analysed and understood. This is because it is often found in qualitative research that analysis is limited to thematic coding of what is said, resulting in quantifiable data without regard for the context and other dimensions of the action, as in the case of content analysis. I was influenced by a social constructionist perspective (Gergen 1991) that views self/identity as defined by the contexts of a person's life. This view was supported by post-modern beliefs about the nature of reality. Because of this positioning, I sought to find a methodology that resonated with complex and multi-dimensional lived realities. Without doubt, this has been one of the more challenging aspects of this study.

Notwithstanding this challenge, I was not surprised to find that within the complexity of the post-modern world, where the necessity for understanding cultures, attitudes and sensibilities other than our own has never been greater, a need had arisen for a new approach to data analysis. I believe this need has come about from the desire of certain qualitative researchers not to generalise findings but to understand people better. Jones (2001), for example, in his study of informal carers highlighted the need for a greater understanding of 'why individuals gravitate toward the informal care role and why they continue to care in the face of overwhelming obstacles' (p. 3).

Whitwell (2005), differentiating between science and narrative, declares that 'some of what we come across in mental health clearly needs scientific analysis, other things need narrative description'. He adds, 'The understanding of people and their journeys to recovery is a matter for narrative' (p. 59). These are journeys that we rarely hear about because those whose lives have been affected by frequent and repeated admissions to psychiatric hospital never or infrequently have the opportunity to tell of their experiences.

In line with Whitwell's views, and similar to Jones' (2001) work, the subject and emphasis of this research firmly positioned the study within a hermeneutic phenomenological framework which is contextual and in contrast to paradigmatic positivistic approaches (Sarbin 1986 p. xi). Heidegger (2001), cited in Childs (2007),

was convinced that psychiatry and psychotherapy are misled by an excessively technical understanding of scientific knowledge when he wrote:

Science means the systematic ordering of interpreted experience. Each science is rigorously bound to its subject domain, but everything does not demand exactitude in a calculative sense. The unifying pole in psychotherapeutic science is the existing human being (p. 371).

Thomas and Luckman (1978 p. 9) argue that 'the goal of phenomenology is to describe the universal structures of subjective orientation in the world, not to explain the general features of the objective world.' It is the case that hermeneutic phenomenological methodologies relate especially to the subjective. According to hermeneutics, subjective expression is not only taken for granted, but is also allowed in order to look for meanings and implications beyond the knowledge or intent of the acting, knowing or speaking subject. Further, it conceives reality as contradictory and repressive and assumes that critical interpretations should always be an attempt to develop the underlying or repressed possible actions of the subject. From this follows a double attempt to deconstruct the meanings and actions and to 'construct' other possible meanings and actions (Schwandt 1997).

Carr (1986) supports this argument, claiming that dominant quantitative approaches fail to incorporate hermeneutic dimensions of experience and thus lose sense of the lived nature of human reality and identity (p. 89). It is with this point in mind that I have built my analysis on the works of the authors mentioned above, who have been interested in how the content (what is said) and the form (how it is said) of narratives elicited in interviews can shed light on the meaning of people's actual experiences.

Pertinent to the central issue of subjectivity are the approaches of narrative analysis and Strauss and Corbin's (1997) grounded theory. Each is rooted in heuristic inquiry and deal with the subjective, but they are different from each other in the way they treat subjective data. Narrative analysis engages, explores and illuminates experiences of individuals (Riessman 1993), while grounded theory is designed to generate theory about these experiences (Strauss & Corbin 1997; Glaser 1978). As it was not the intention of this study to generate theory, but to understand people better, grounded theory was discarded in favour of narrative analysis. Comparing the two methodologies helped to establish the most suitable one for the task. One of the problems, for example, with grounded theory is its coding procedures. Although

coding addresses cognition and interaction, it fails to capture the emerging stories or the meaning of the experience for each participant. In contrast, narrative analysis, when used as a framework for creating meaning, has the potential to convey the fullness of thoughts and feelings and the richness of human experience in general, as well as revealing concerns and vulnerabilities and helping to create identity. Riessman (1993) says that 'narratives must be preserved, not fractured, by investigators, who must respect respondents' ways of constructing meaning and analyse how it is accomplished' (p. 4).

Narrative analysis is also comparable to grounded theory in that the themes and plots, as identified in the previous chapter, unfold in the course of data analysis, but it differs in that the unit of analysis is not based on coding or categories but on the structure of narratives, as in the case of Labov and Waletzky's (1967) analytical framework. It is on this analytical framework for the study of narratives that my analysis of data is based.

Returning to the notion of abductive reasoning, I identified and combined Bacon's (1960) inductive reasoning with abduction to form a complementary reasoning pair. Typically, induction is the process of inferring cause from effect; for example, within psychiatry, this form of reasoning is generally attributed to mental health professionals in assessments of their clients' problems (Bradley 1993 p. 54). In this situation, these professionals construct explanations that arise from observed symptoms or situations (Bradley 1993 p. 38 - 48).

Analytical induction is also the basis of the data analysis method used in the Biographic Narrative Interpretive Method (Jones 2001, 2004). Wengraf (2001 p. 2) describes this in terms of a 'hypothetico-inductivist model in which theory emerges from the data by way of an inductive process'. The introduction of abduction and induction should be understood within the context of theory formation as a procedure for interpreting the narrative data that is presented later in this chapter and, in this case, within a psycho-social frame of reference that recognises 'revolving door' patients as constructors of their own reality.

Josephson and Josephson (1994 p. 5) argue that abduction or inference of the best explanation is a form of reasoning, which goes from analysing data describing something, to a hypothesis that best explains or accounts for the data.

Chamberlayne and King (2000), cited in Jones (2001 p. 68), add that the process involves 'generating hypotheses contained in a given unit of empirical data, progressing to further hypotheses as to further developments and then testing these with the empirical outcome'. In this study, I sought to understand the stories told by the participants about their experience of multiple admissions to psychiatric hospital by analysing small data sets of their stories. Potentially, any data set can generate hypotheses, however, not all will be able to offer the best explanation. Therefore, to provide a set of possible explanations, abductive reasoning allows for the identification of the best possible hypotheses. The objective of abduction, therefore, is to determine which hypothesis to test (Sullivan, 1991). In order to accomplish this, the *lived life* and *told story* are initially analysed separately.

The *lived life*, or chronological chain of events as narrated, is analysed sequentially and separately. The *told story*, or thematic ordering of the narration, is then analysed using thematic field analysis, involving reconstructing the participants' system of knowledge, their interpretations of their lives and their classification of experiences into thematic fields (Rosenthal 1993 p. 61). Rosenthal (1993 p. 64) defines the *thematic field* as 'the sum of events or situations presented in connection with the themes that form the background or horizon against which the theme stands out as the central focus'. Millar (1998 p. 3) makes the important point, that objectivity is maintained by keeping each stage of the analysis discrete as well as involving different teams of researchers in a team process of hypothesising and developing the themes. Ultimately, 'Life story and life history always come together. They are continuously dialectically linked and produce each other; this is the reason why we must reconstruct both levels no matter whether our main target is the life history or the life story' (Rosenthal 1993 p. 61). The biographical details and themes are then tested against in-depth analysis of the text, examining hesitancy, repetition, contradictions and pauses. Through hypothesising how the *lived life* informs the *told story*, the case history is then finally constructed from the two separate threads of the *lived life* and the *told story*. A case structure is then formulated that validates more than one event, based upon the actions of the interviewee (Jones 2002).

In relation to induction, Thomas (2003 p. 2) says that its primary purpose is to allow research findings to emerge from the frequent, dominant or significant themes

inherent in the raw data without the restraints imposed by structured methodologies. To test or refine each hypothesis, both micro and macro influences on the storied life are examined. Induction then predicts the consequences of the hypothesis, which is a general theory that explains the observations (Wengraf 2001 pp. 256 - 260). This is done by checking which previous hypotheses can be seen as weakened or falsified by this new datum (Wengraf 2001 p. 256).

Analytical induction was at the core of the work of the Polish sociologist and philosopher Florian Znaniecki and his well known work with W.I. Thomas in, *The Polish Peasants in Europe and America* (ed. Zaretsky 1996 [originally published 1918 – 1920]). Znaniecki's analytical induction process comprises six steps (cf. Jones 2001 p. 64):

1. A phenomenon is defined in a tentative manner.
2. A hypothesis is developed about it.
3. A single instance is considered to determine if the hypothesis is confirmed.
4. If the hypothesis fails to be confirmed, either the phenomenon is redefined or the hypothesis is revised to include the instance examined.
5. Additional cases are examined, and if the new hypothesis is repeatedly confirmed, some degree of certainty about the hypothesis results.
6. Each negative case requires that the hypothesis be reformulated until there are no exceptions.

While Thomas and Znaniecki's work offers a process for induction, Labov and Waletzky's work offers some ways to look at the structure of personal narratives that were useful in this study. They identified key elements of a story: abstraction, orientation, complicating action, resolution and coda. These elements partition the text into clauses, which are underpinned by a coherent temporal progression of events (Labov & Waletzky 1997 p. 32). Thus, it provides a framework for classifying a vast array of information. A downside of this approach is that it is a very time-intensive procedure. Nevertheless, for each case I searched the transcript meticulously, looking for stories that were constructed narratively, that is, with Labov and Waletzky's elements. Mishler (1992) refers to these elements as 'core narratives' and acknowledges the significance of narrative structure, viewing these stories as identity performances (p. 147).

I also looked for interesting parts of the data that were not particularly constructed narratively, for example, description, report and argument, as identified by Wengraf's (2001). In addition, I looked for words, phrases or sentences that said something interesting about the participant. These were presented one piece at a time and chronologically to the reflective team for microanalysis (Jones 2001). With the complexities of the stories, I anticipated that different people would give slightly different interpretations of the story. In fact, there was a huge amount of variability in their interpretations.

All this was done against a backdrop of the many motifs that were found in the text. The Oxford English Dictionary (1989) defines a motif as, 'a recurrent character, event, situation or theme'. Jones (2001), in his study of informal carers, found that very early on in the story, people would announce what the story was going to be about. Jones argued that a case could be made that these early declarations represented the central motifs of the whole story (p. 76). He draws the comparison of these motifs to musical leitmotifs (one element of the score). Narrative motifs run throughout the text, sometimes in the background, sometimes underneath the recounting, with the function of creating and supporting the foundations of the *told story* itself (p. 76).

These motifs helped convey themes that emerged from thematic analysis of the textual data. The themes then operated as the main storyline, weaving together the narrative plot. Each narrative structure contained an evaluative element that constructed a sense of the participant's identity in the context of the 'revolving door' phenomenon. In this way, the discovery and identification of the relationship between different themes and plots provides biographical consistency and coherence.

While the unrelenting question of whether the mentally ill can narrate coherently remains ambiguous for many. Mishler (1999 pp. 14 -15) unpacks its meaning with a reasoned approach. He cites Schiffrin, (1994 p. 416) who asserts that 'coherence cannot be understood if attention is limited just to linguistic forms and meanings' but that 'they work together with social and cultural meanings, and interpretive frameworks to create discourse'. My approach to the interpretation of meaning in the stories that emerged in my interviews was informed and guided by his perspective. For a comprehensive discussion on coherence, see also Linde (1993).

Through a stimulating process of intuitive induction, as described above, the team was able to think critically about events in the life experiences of each participant. Through the microanalysis and predictive induction of these narratives, interpretations were reached.

The procedure for analysis, while based on grounded theory, and using Wengraf's and Jones' inductive approach, rests firmly on the principles of Labov and Waletzky's structuralised concept of narrative. A distinction, however, is drawn between Wengraf's and Jones' approaches, in that the text sequentialisation tool in Wengraf's method is abandoned in Jones' work (Jones 2004 p. 49). Jones (2004) argues that concentrating on text structure restricts the reflective team's possibilities for multiple intuitive responses to the data (p. 49). I have taken the same approach as Jones in this study by also abandoning the text sequentialisation tool for a more intuitive approach.

What has been discussed so far in this chapter is by no means the limit of the analysis process. In the next section I go on to discuss the strategy for analysing the life stories of the four participants.

6. Narrative Analysis of Four Life Stories

My intention in this section is to present the details of the narrative analyses of the four participants' experiences and what it meant to them to have been repeatedly admitted to psychiatric hospital. The underlying principle was to work from the unknown to the known by searching for events or actions to prove or disprove a hypothesis (Jones 2001). I was able to do this not only from the position of a qualitative researcher, but also as a mental health social work practitioner with the help of the reflective teams. The purpose was to narratively make sense of how participants (re)constructed their identities in relation to these admissions.

Tables 6 to 9 below, show the composition of each of the reflective teams, comprising men and women from richly diverse backgrounds, cultures, ethnicities and religious convictions. They represented the U.K., Holland, Croatia, the West Indies, Zimbabwe, Ireland and India and were aged 25 to 58. Description/Interests of the team members, as noted in the introductory exercise, are also shown. Because

interests reflected more than the professional descriptions offered by team members, and because they were encouraged to engage in a dialogue with the text of the participants, it was important for them to bring to that dialogue more than just their professional selves.

I restricted the reflective team analyses to four cases: Hannah, Michelle, Andrew and Keith. This is not to say that the cases of Kenton, Colin and Marcia were less important to the study. The four cases were chosen for a representative balance of gender, diagnosis and age, as well as a balance of the type of problems related to multiple admissions to a psychiatric hospital.

Hannah Salmon's Reflective Teams			
	Name	Profession	Description / Interests
Lived Life	Ronald	Chartered engineer	Service user/Enjoys smoking.
	Raj	Studied applied physics / Owned business with ex-wife	Service user/ Enjoys quiet moments.
	Brian	Worked on a farm	Service user/Supports Fulham FC.
	Daniel	Studied medicine	Service user/Likes going on holidays.
Told Story	Dr. Houghton	Psychiatrist	Passion for scuba diving.
	Julie	CPN	Enjoys dancing, friends and animals.
	Lionel	Student social worker	Loves his son, driving and sunsets.
	Hermione	Professional assistant	Makes clay/fire pottery. Likes animals and food.

Table 5.0 Hannah Salmon's reflective teams.

Andrew Simpson's Reflective Teams			
Lived Life	Name	Profession	Description / Interests
	Yusef	Student nurse	Was a professional swimmer.
	Janet	Student nurse	Afraid of water.
	Bongiwey	Student nurse	Took Grade 5 piano, and was a ball girl at Wimbledon.
Told Story	Gee	Youth and community leader	Jovial but deep person, Buddhist.
	Tracey	School deputy head	Learnt to swim two years ago.
	Sonia	Works for the NHS	Recently had laser eye surgery.

Table 6.0 Andrew Simpson's reflective teams.

Michelle Walton's Reflective Teams			
Lived Life	Name	Profession	Description / Interests
	Betty	Social work manager	Enjoys baking.
	Barry	CPN	Likes scuba diving.
	David	Social worker	Enjoys playing golf.
Told Story	Jane	CPN / manager	Likes scuba diving.
	Rob	CPN	Drummer in a band.
	Miranda	Social worker	Has two grandsons.
	Esme	OT	Enjoys cooking.
	Hermione	Professional Health Assistant	Enjoys pottery.
	Katija	Support worker	Single, never been married.

Table 7.0 Michelle Walton's reflective teams.

Keith Edwards' Reflective Teams			
Lived Life	Name	Profession	Description / Interests
	Miroslav	Clinical psychologist	Lived in New Zealand for 7 years.
	Mike	Social worker	Likes to take his dog for walks.
	Dr. Bowers	Psychiatrist	Married with a young child.
Told Story	Jane	Deputy nurse manager	Enjoys scuba diving.
	Pat	Social worker	Likes going on walks.
	Barry	Psychiatric nurse	Likes scuba diving.
	Hermione	Professional Assistant	Health Enjoys pottery.

Table 8.0 Keith Edwards' reflective teams.

In the process of selecting the cases for team analysis/interpretations, and in a comparative framework, certain themes were selected as yielding more detailed perspectives. For example, the interviewees selected for the analysis process were divided into two categories: by diagnosis and by gender. Hannah and Andrew were diagnosed as having schizophrenia, and Michelle and Keith were diagnosed with bipolar disorder. One male and one female were selected to represent each classification of illness. The four cases selected represented four of the most interesting biographical types with regard to the 'revolving door' phenomenon and research topic. The four participants all faced one common problem, apart from being diagnosed with a mental illness: frequent and repeated admission to psychiatric hospital.

B. PART TWO

PRESENTATION OF DATA: CASE ANALYSES

1. Hannah Salmon

Hannah's Lived Life

The interpretation of Hannah's *lived life* was done by the team of service users: Ronald, a chartered engineer; Raj, who studied applied physics and jointly owned a business with his ex-wife; Brian, who worked on a farm; and Daniel, who studied medicine. Tables 9.0 to 12.0 below, illustrates the biographical information gathered from the interviews and other sources as well as the hypothetic-inductive work of his particular reflective team. Confirmed hypotheses/predictions are indicated in amber and bold text. Unconfirmed hypotheses are indicated in white text.

Events		Hypotheses/Prediction
1972	Interviewee born	
1973	Younger brother born	<ol style="list-style-type: none"> 1. S/he will go mad.² 2. S/he will be admitted to hospital several times. 3. Brother will be written off as mad.³ 4. S/he will be diagnosed as a manic depressive.
July 1986	Psychotic breakdown while on holiday in Mauritius age 14 years.	<ol style="list-style-type: none"> 1. She/he will be a schizophrenic. 2. S/he will end up taking drugs. 3. Will end up in hospital.
	Diagnosed as hyperactive and sent home to Britain and was admitted to hospital initially, and then transferred to an adolescent unit	<ol style="list-style-type: none"> 1. Doctors will find there was nothing wrong with her/him. 2. Doctors will find that s/he was definitely mad. 3. Will find that her/his parents are mad.

² Confirmed hypotheses/predictions are in amber.

³ Unconfirmed hypotheses/predictions are in white.

August – September 1986	Not sleeping, taking off clothes, throwing objects, damaging the home. Parents could not cope	<ol style="list-style-type: none"> 1. Something disturbed her mentally. 2. Social Service will be called in. 3. That s/he was behaving this way because being in hospital had a bad effect on her/him. 4. S/he had a nervous breakdown. 5. Might have been raped.
	Admitted to a private hospital for three weeks.	<ol style="list-style-type: none"> 1. S/he will be given a diagnosis. 2. S/he was a girl and would meet a boyfriend in hospital. 3. She will be given medication. 4. She will have an unwanted child.
	Given medication	<ol style="list-style-type: none"> 1. She will be diagnosed with schizophrenia. 2. Not having a very good time. 3. Be unable to find work (I got the sense that this statement was from personal experience). 4. Family would visit her.
September 1986	Returned to school having moved from a convent school to a mixed secondary school and obtained 9 GCSE's – remained well for two years.	<ol style="list-style-type: none"> 1. She was intelligent. 2. Strong. 3. Too young to have boyfriend.
December 1988	During first 'A' level year started to become depressed.	<ol style="list-style-type: none"> 1. Will go downhill from here. 2. She would be hospitalised again. 3. Fail her 'A' level exams.
	Given antidepressant by her GP. Went high with religious ideas. Believed that people were talking about her, that she had an abortion, and that she was raped incestuously by her father. Made remarks about Hitler's evil influence in the world which had a special significance for her.	<ol style="list-style-type: none"> 1. People won't believe her that. she was raped by her father. 2. She will go into hospital again. 3. Gets better. 4. Goes into a children's home.
February – April 1989	Informal admission with depression; crying, quiet, not talking to her family.	<ol style="list-style-type: none"> 1. She will be alienated from people. 2. Diagnosed with schizophrenia. 3. Life will get worse for her. 4. Will fail her exams.

1989 March	<p>Admitted to clinic in London.</p> <p>Lying on the examination couch, crawling on the floor and masturbating publicly.</p> <p>She believed that her grandfather had pulled out her ovaries when she was 14 years old.</p> <p>Complained that she had been sexually abused by her father, grandfather, and brother.</p>	<ol style="list-style-type: none"> 1. The police will be called in. 2. She will not trust men anymore. 3. She will be raped again. 4. She was telling lies. <p>(One member of the team revealed that a woman had once called him a rapist).</p>
February – March 1990	Admitted at mother's request	<ol style="list-style-type: none"> 1. Mother wants to get her out of the way. 2. Mother doesn't want her to live at home. 3. Mother is protecting her husband.
May – November 1990	Admitted for six months with hypomania	<ol style="list-style-type: none"> 1. There was nothing wrong with her mentally. 2. This was a way for her. parents to dispose of her. 3. She will not be same again. <p>At this stage the team became a little restless and two members left and re-entered the room randomly.</p>
January – December 1991	<p>Admitted to psychiatric hospital because of unmanageable behaviour at home.</p> <p>Presentation; virtually mute, giggling inappropriately and occasionally displaying outbursts of aggression</p>	<p>Certain team members reacted angrily to the information presented, calling the family a 'Bastard family'.</p> <ol style="list-style-type: none"> 1. They felt that the parents. caused her problems by abusing her. 2. That she was not mad but psychologically damaged. 3. She will go mad if the abuse continued.

June – July 1992	<p>Age 20 years, admitted formally at the request of her parents.</p> <p>Incontinent of urine at night.</p> <p>Taken into hospital by her grandfather.</p> <p>Diagnosed with schizophrenia</p>	<ol style="list-style-type: none"> 1. Going into hospital might help her. 2. Being way from her parents will make her feel better. 3. She will fight with her father. <p>One team member shouted out, 'I'm schizophrenic!'</p>
1997 – 1999	Individual Art therapy commenced	<ol style="list-style-type: none"> 1. Will help her talk about her problems. 2. Will help her deal with the emotional side of things. 3. Will help her to be strong.
October 1999	Contacted community support services - stated that she was hearing voices telling her to blind herself as well as other people with an instrument.	<ol style="list-style-type: none"> 1. It was good that she contacted someone. 2. She will get better. 3. She was schizophrenic.
December 1999	Moves into supported accommodation	<ol style="list-style-type: none"> 1. She will get better from here. 2. Parents don't want to know her. 3. Big divide between parents/family. 4. Will not want to be anywhere near her father.
June 2000	Started relationship with boy	<ol style="list-style-type: none"> 1. She was rebuilding her life. 2. The relationship will not be good. 3. She will go to college. 4. She will need more art therapy.
April 2001	Started Art therapy group	<ol style="list-style-type: none"> 1. Things will improve for her. 2. That she will stop art therapy because of the memories it would bring back. 3. Will become unwell again.
March 2002	Moved out of supported accommodation into independent Housing Association accommodation	<ol style="list-style-type: none"> 1. She has to keep going. 2. She will get involved with illicit drugs/cannabis. 3. Life is mapped out for her. 4. Less likely to breakdown because she has a boyfriend to communicate with now. 5. She is dependent on the

2002 – 2005	Has remained well with regular attendance at the psychiatric outpatient clinic. Mood continues to be up and down.	<p>system.</p> <ol style="list-style-type: none"> 1. She will make something of her life. 2. She will be totally cut off from her parents. 3. Will break up with boyfriend and get hospitalised again. 4. Goes down, will be readmitted. 5. She will be a strong person.
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Table 9.0 Hannah's Lived Life

Hannah's Told Story

'Music got me through this'.

Setting up the interview

Hannah was the first participant I interviewed and also the first case presented to the reflective team for analysis. Hannah's participation consisted of sub-session one followed by sub-session two exactly a week later. Each session lasted twenty-five minutes.

Hannah specified a preference to be interviewed at her day centre where she felt more comfortable. I had no objections to her request and respected her wishes, as I believed that it was important for her to feel she could decide where the interview should take place. A date and time for the interview were provisionally agreed; I then contacted the manager of the day centre to book a room. This was done four weeks before the interview to maximise the chances of finding a quiet room with as little distraction as possible. I was successful in this regard, negotiating a room that was suitably furnished with a table and two chairs, which would not be troubled by interruptions or background noise. Once these arrangements had been made, I contacted Hannah to confirm the date and time for the interview.

Once we had seated ourselves in the room and taken care of formalities, I commenced by confirming confidentiality issues and the interview process with her. I checked that the tape recorder was working and that Hannah was still willing to be interviewed. Two small bottles of water were provided for refreshment.

Hannah's mental health problems started when she was fourteen years old, as she was a victim of childhood sexual abuse. This was also where she started to recount her story. Hannah has had the opportunity to process the abuse through psychotherapy before involvement in this research. This is her heartbreaking, but ultimately triumphant, story of being a 'revolving door' patient who, having recovered from her ordeal, is now looking forward to the future. The following reports are taken from transcripts of her life story, all the events and experiences she freely chose to talk about during the interview with minimal interruption from me.

The *told story* was interpreted by one of the teams comprising members of the multidisciplinary team. This team included Dr. Houghton, a psychiatrist who has a passion for scuba diving; Julie, a CPN who enjoys dancing, friends and animals; Lionel, a student social worker who loves his son, driving and sunsets; and Hermione, a professional assistant who makes clay/fire pottery and likes animals and food.

Interrupting my opening question, Hannah's opening line was:

Are we recording now, are we?

Yeah.

Okay (big sigh).

I would like you to tell me your life story, take as much time as you like, I'm not going to interrupt you...

Ah, I've got to, uhm (3)⁴ go about one, is that all right?

Yeah, that would be fine.

Okay

Okay, I won't interrupt you, but I will be taking some notes for when we have finished.

Okay

⁴ Pauses in seconds are indicated in parentheses

When we finish we'll take a break, and I'll explain about coming back to do the second interview.

The opening section above got the reflective team of Hannah's *told story* off to a flurry of hypotheses, including that Hannah might find talking a struggle, be unsure where to start, be fearful of revealing too much and perhaps not really want to be interviewed at all. Alternatively, some team members thought she might be checking out how much personal detail I wanted her to divulge, or that she was signalling that she had a lot to tell me and might not be able to fit it all in. Others hypothesised, however, that she might be indicating a reluctance to tell me everything due, perhaps, to feeling trapped and vulnerable because I was a male interviewer. Finally, another member of the team commented that she was in the driving seat, having turned the balance of power in her favour.

I was interrupted a second time by Hannah asking, '***Does it matter if I don't take that (2) long long long time?***'

The team further hypothesised that she was feeling frightened and worried about how the information was going to be used. Alternative hypotheses suggested that she was not ready to talk, that an hour was too long, that there was a need to set boundaries, and that she might have a very low opinion of herself and not want to open up.

After that she began to unravel her life story: '***Okay, well my first time I was actually taken into hospital was when I was fourteen. I'm thirty-two now***'. The team found it intriguing that Hannah should start her story from when she was fourteen and immediately hypothesised that she might be blocking out some awful thing in her childhood. The fact that she completely omitted her early childhood suggested that maybe it was an unhappy and isolated period or that some traumatic events might have taken place that she wanted to forget. On the other hand, starting her life story at that point could be because she assumed this was the part of her life I was interested in or maybe even that this is where life truly began for her.

At this stage of the analysis the team hypothesised that the person whose life they were analysing was female and that she would only talk about her illness and was not a very confident person.

It was correctly hypothesised that the next event in her life would be admission to hospital.

And, uhm, they took me to the adolescent unit (name of unit), and it was a locked place and, uhm, I wasn't very happy there.

Hannah talked about her first admission, which was to an adolescent unit. She did not mention her parents or younger brother. At this point in Hannah's account, the team began to get a sense that her story was going to be a sad one. They hypothesised that Hannah might have been a danger to herself, had come from a broken family and/or had suffered abuse. Hannah was clearly saying that she was unhappy being in the unit, but what was less clear at this stage was what led to her admission. The team, recognizing that it was more than likely that she would have had some sort of behavioural problems, began narrowing down the nature of the problem. Thus, in the next segment of text, when Hannah said, ***'Uhm, I had problems, uhm, with my, uhm, parts below. When I walked it would hurt, and I used to, I was hyperactive so I used to run around and, uhm, they used to, uhm, they didn't like it, and they use to, uhm, call a meeting'***. It was interpreted that she was either sexually active or had been sexually abused by carers, parents or other children.

The team then tried to establish her background, hypothesising that she had an institutional upbringing and was in foster care and perhaps might have had a physical disability. The team wanted to know where she was running to and from and felt that she might be uncomfortable with her gender. Hannah next spoke of developing a relationship with one of the other children on the unit: ***'I liked one of the boys there, but nothing happened because that sort of thing is not allowed to happen and, er, and stuff like that... Uhm, as I said it was a locked ward and didn't I I needed some cream for my face and, er, I think it must have been thrush that I had, and I needed to sort that out'***. Sexuality was now beginning to be established as a recurrent theme in Hannah's story. Her behaviour on the unit was interpreted by the team as being sexually promiscuous, perhaps resulting in sexually transmitted disease and/or pregnancy. Someone felt that she might run away from the unit and get arrested by the police. No one felt that the abuse was by any means over.

In her next narrative passage, Hannah's story took a shift away from the adolescent unit to another institution: ***'Then I went to back to school, a proper school, and, er, I managed to pass my exams, did 9 GCSE's, and, er, then I went to, er, I didn't like (name of school) too much, so I went to a six form down the road from me called (name of school).'***

Her move or discharge from the adolescent unit was interpreted as a change in her behaviour. The team did not feel very positive about her prospects of doing well, implying she might break down, drop out of school and continue to be promiscuous. It was no surprise for the team when they learnt in the next segment of text, that she confirmed their hypothesis: ***'And I had, and, er, I got on okay for a little while, but, uhm, I sta started to get ill again. Er, I don't know what happened, but I ended up in (name of psychiatric hospital).'***

Hannah was now on the path to becoming a 'revolving door' patient, and it was hypothesised that her admission would be a long one this time. The team hoped, at this point, that she would say why she did not like the hospital, and indeed Hannah began to open up a little bit more about readmission to hospital: ***'And again I was a bit hyperactive, and they didn't like it. They used to, uhm, run after me and stick a needle up me (3) in my bottom, and it really really did hurt when they did that'***. During this admission she was diagnosed as having a bipolar disorder. By this stage it seemed that she was starting to develop a strong resentment to the way she was being treated in hospital:

And, uhm (3), of course, after that I didn't trust them anymore, and it went round and round when they kept doing that, and making me hate them even more the whole time they did it, (big sigh), and, uhm (3), I remember (2) I had been violent. I don't know, I can't explain why I was violent and, uhm, smashed a window at the hospital.

For example, I hurt one of the nurses, gave her a black eye (big intake of breath) and, uhm, I can see it from their point of view. They thought that, uhm, the medication would send me to sleep and control me, control my behaviour.

This narrative passage was interpreted as Hannah's of perceiving the staff to be against her, a 'them and me' situation, and herself as someone out of control. The

team did not foresee any positive outcome of her situation on the ward and predicted that her unhappiness would continue.

Uhm, (sigh (2)), I was sixteen when I was in (name of hospital) at that time (3), and, er, in the end they sent me to a place in London called (name of clinic).

Hannah's life now seemed to be developing a definite pattern of discharge from hospital followed by readmission. In between these admissions, she encountered difficulties which she tried to manage but found overwhelming: '***And, uhm, I was there for awhile, and then I went back to (name of school), which was a mistake because I was bullied there***'. The team hypothesised that she would find it difficult to settle back into school life, and as a consequence readmission would be seen as providing a safe place for her.

After that, and, uhm, and then I think I went bit weird again, and I went to hospital again when I was seventeen.

This was now Hannah's fourth admission in the space of two years. So far she had not mentioned anything to do with her carers, parents or brother, which the team interpreted as implying there was something significantly wrong.

She said to me, "You're not getting the electric chair", she said, and that was just one of the staff that I actually looked her in the eyes, and she said that, and, uhm, it would really help me (3). Other than that I was basically just ignored.

The team interpreted the metaphor 'electric chair' to mean electro-convulsive therapy (ECT); a last resort treatment, applied when all other treatments fail. During the 1980s, it was likely that Hannah would have been given large doses of drugs and ECT in order to control her behaviour. The loneliness and sense of isolation is now beginning to be more pronounced, as she seems to have felt that nobody cared about her, not even hospital staff. At that time, hospital staff were probably not trained to talk to patients or even respect them as individuals, which might account for Hannah's feelings towards them.

In the outside world, the theme of her isolation, which was well established at the beginning of her story and remained throughout her admissions, seems embedded

now due to her lack of experience and social skills. Her isolation seems to have been all the more bitter and intense because of the stigma of mental illness.

When I was about nineteen or something like that, when I went home I was fairly stable for about two years (2), but I didn't actually have a job or anything. I was just left basically to live on my own home, er, with my parents.

Hannah mentions home and parents for the first time in her story. She also demonstrated a degree of recognition that she might be unwell. Her language gave the team the feeling that she was being abandoned, thrown back into an abusive situation and left to get on with life, still feeling very alone. Her mention of parents suggested that the abuse was taking place within the nuclear family, and it could be conjectured that going 'mad' was one way of escaping from them. The team felt that this would be a difficult time for her and she would become unwell again. They predicted she would be forced to leave home because of the abuse and the subsequent feelings of being isolated, bored, stigmatised and rejected by her parents would leave her desperate, vulnerable and suicidal.

She continued her revelation with the first mention of her mother, giving some indication of her role in all of this. From what Hannah said, it seemed that her mother was protective of her: ***'And, uhm, I think my mum didn't realise that I was actually quite well and could have coped with a job. Uhm, anyway, in the end I went to the day hospital, uhm, I was twenty-one'***. The team wondered whether Hannah was sending out clues to me, the interviewer, to say that her mother did not realise what was going on, confirming that her father was the abuser. Going to the day hospital/centre was considered a positive step by some team members, feeling that she would feel accepted there, which would help build her confidence and provide an opportunity to make friends. Others disagreed, suggesting that she would be victimised, bullied and further stigmatised.

From the day centre, day hospital, I went to, er, I did some temping work and then (2) after that, and I got this job in a factory. I was bullied there and ostracised by (2) others (3), and I couldn't talk about my, er, mental health because, uhm (coughs), I thought I would lose my job, so, er, also it's a private matter...And the thing is about it was, er, I didn't have much to say because all my experiences has been of the mental health system or something similar. I

went to college for two years to do 'O' levels, and I dropped out and, er, well, I took the exam, but I didn't do very well.

In this narrative passage Hannah gives some insight into her self-confidence and resilience, finding work and sticking to it in spite of the bullying. The team felt there must have been something about Hannah's appearance or behaviour that made people persecute her. Certainly, Hannah herself felt unable to confide in others and did not disclose anything about her time in hospital. The team felt that Hannah's employers would find out about her mental illness and that she would lose her job. They also hypothesised that she would give up and become acutely depressed. On the positive side, one team member felt that she would keep her job and retake her exams due to her resilience. After mentioning that her exam results were not good, Hannah made an astonishing announcement:

Uhm, then I was twenty-four (2). After my exams I found about the results which weren't very good. And I began to sense something funny about my father. And he used to get angry with me because I wouldn't order the food for for him. And felt he was being a bit sexist. Anyway, and, uhm, I just fed up in the end. He seemed to be almost threatening towards me, so uhm (3). I left and went to Open Door for a few days. And then when I came back home because obviously it was very hard (2) hard being homeless, and I didn't but, uhm, beat me up a bit, and, er, I managed to (2). I managed to phone the police (1) and lock the door of my bedroom. And then, er, the police lady came up to my bedroom, and she said we've got a place in (name of hospital) for you (2). And, er, I couldn't because I was homeless in a sense. I managed to get on, er (2), a housing list and, uhm, when I was, I stayed in (name of hospital) for a few months and (4). Uhm, I actually managed to get a shared house with a lady. And I loved it. It was great in (name of house). I was really happy, but then, er, the lady got a bit, er, ill. She had, she had heart problems and got a bit ill. And, er, we didn't get on after that, when she was ill. So I had to leave there. And then I got to another house, which was okay, with two other elderly people. And, uhm, yea I lived there for a while. Then I went to a place called (name of place). And I did two days a week there, and in the end I ended up living and move to (name of road) which was a place for people in the (name of area). And, uhm, I lived there with (name of three people) and myself. And that was

okay, I didn't go into hospital while I was there. And I got on okay, but then I thought I want to move on from (name of house), so I applied to get a flat with (name of housing association) floating support scheme, and I got a flat and I've been there (3). I've been there now for, er about three years (2), two or three years something like that, and I love it, it's great!

This got the team hypothesising with renewed vigour that her father was the abuser. This announcement was significant because Hannah had, for the first time, revealed that it was her father who had abused her. It was also hypothesised that the abuse may have been physical and that he might have had a mental illness. The team felt that Hannah would leave home again or get readmitted to hospital, and indeed Hannah went on to reveal that she left home and went to the homeless hostel for a few days. After that, she said, *'I got a flat, and I've been there (3). I've been there now for about three years'*. She mentioned that she was going to college to do administration before saying, *'That's about it really. Is that all right?'* Then, when asked if there was any more to add, she replied, *'I went into the adolescent unit when I was fourteen, but I actually think that I might have had depression or something weird since I was about 10 (4), er, I won't say what I did... And also, er (2), I had when I was fourteen I either dreamt it or, uhm, when I was sixteen I was raped. Uhm (4), I expected my mother to help, but she, when I was sixteen I think I was raped. I'm not sure who did it but, uhm (4), I (20) I (2) I found a foetus in the toilet which was mine, so I knew I was raped'*.

At this stage, Hannah appeared to be feeling more comfortable with talking about her experiences, expressing anger and disappointment with her mother for not helping her, though still protective of her parents in general. Most crucially, Hannah was able to acknowledge that something was wrong from the age of ten and that she was raped, although it is confusing when she says, *'I'm not sure who did it'*. It seemed that, even though she was clear that a rape had occurred, she felt unable to assert it was her father and instead delivers the information by saying she must have dreamt it. She seemed to feel that she might not be believed and threw in the shocking detail of discovering a foetus in the toilet, which she said confirmed that she was raped. She also said that she was not sure who did it. The team took from this that there must have been more than one abuser. They never doubted her claim. She was asked about her last admission, to which she replied, *'Sounds like a minor point,*

but the plumbing isn't working very well there. It is impossible to keep clean'.

This was interpreted symbolically to mean that she was having problems with her vagina and may have felt dirty as a result of being raped. In summing up, she seemed to be saying that when nobody was there for her, she had to rely on her own strengths: ***'Music has got me through things. It's something you can do. Uhm (4), something you can, uhm, you don't need to have money for (3), uhm, (4) and you not my music. Uhm, that's about all I can do today'.***

Second interview - Hannah's story revisited

You said, 'the first time I was taken into hospital was when I was fourteen'.

Yeah

Do you remember any more details about the story of how it all happened?

Okay, right, I was on holiday with my friend and her family in Mauritius...

Right

And, uhm, I had an argument with my friend, and it got a bit serious and I was, uhm (2), I, I don't know what happened, but I was very upset (3). I think I did, I knock my head against the wall or something. I was, wasn't behaving nicely, and, er, I was sent home on the plane on my own. And, er, some sort of medical people took me into this room, where it was all white. I, er (3), I wasn't sure what was going on at all really. I was very confused, and, er (2). I was sent, sent back home on the plane (2) where at the airport I met my mum and my granddad and then they took me to the adolescent unit I think, that's what happened.

Narrative	Sub-plots and Interpretations
<p>And, uhm, I had an argument with my friend, and it got a bit serious and I was, uhm (2), I, I don't know what happened, but I was very upset (3). I think I did, I knock my head against the wall or something. I was, wasn't behaving nicely, and, er, I was sent home on the plane on my own. And, er, some sort of medical people took me into this room, where it was all white. I, er (3), I wasn't sure what was going on at all really. I was very confused, and, er (2). I was sent, sent back home on the plane (2) where at the airport I met my mum and my granddad and then they took me to the adolescent unit I think, that's what happened.</p>	<p><u>Orientation</u> I had a serious argument with my friend</p> <p><u>Complicating Action</u> I hit my head against the wall</p> <p><u>Resolution</u> I was sent home on the plane</p> <p><u>Evaluation</u> I was very confused when I was admitted to the adolescent unit.</p>

Okay, okay, and then after that you said, 'I started to get ill again'.

Yeah, when I was in the sixth form I changed schools in to a different school in the sixth form. And they had girls and boys; it was just girls at (name of school).

Do you remember any more details about the story of how it all happened?

I remember I used to I like a boy (2) and, or, a couple boys, er, but, er, I fantasised about him and, er, I wrote him like a letter but I didn't give it to him or anything. It was just one of those silly things that you do, and, er, I put it in the bin, and someone fished it out. And, er, I was in the library, and, er, I couldn't see them, but someone read it out to everyone else, and, er, it was a private letter, and I felt very upset. I thought it was quite cruel.

Narrative	Sub-plots and Interpretations
<p>I remember I used to I like a boy (2) and, or, a couple boys, er, but, er, I fantasised about him and, er, I wrote him like a letter but I didn't give it to him or anything. It was just one of those silly things that you do, and, er, I put it in the bin, and someone fished it out. And, er, I was in the library, and, er, I couldn't see them, but someone read it out to everyone else, and, er, it was a private letter, and I felt very upset. I thought it was quite cruel.</p>	<p><u>Orientation</u> I wrote a letter to a boy I liked but I thought it was silly so I threw the letter in the bin</p> <p><u>Complicating Action</u> Somebody fished the letter out of the bin and read it to everyone</p> <p><u>Resolution</u> It made me cry</p> <p><u>Evaluation</u> I thought it was a quite cruel</p>

Following the narrative segment above, I probed for more story.

What happened after that?

Er (2) I just (2) I just flipped really and felt really bad and er (5) I just sort of let myself go and in the end I was sent to (Name of hospital), I don't know why.

And you said, 'I didn't trust them'.

Well, (2) I trust the people here, in this place, in the day centre. When I went last to (Name of hospital) I trusted them there as well, but not entirely. Actually I still think that they wanted (2) to uhm to get me in a way a little bit.

Okay, and you said, 'the medication would send me to sleep and control me'. Do you have any more thoughts about that?

Er, well, when I was in the adolescent unit they'd uhm give me medication and then I would sleep a lot, I enjoyed my sleep (2) and when I woke up I would think where the hell am I? I think the medication does help me to feel better.

Okay. And you said, 'I was bullied there'. Do you have any more story about that, when you were bullied?

Oh yeah, sort of carrying on from when I was speaking about the letter, there were a couple of girls there, and er they said that I had audacity or something, and er that just really hurt and they were calling me names and er I won't say what names and er I heard them talking and (3) there were a few people who were friendly towards me and uhm (2) uhm its quite common to get bullied at school, I didn't get physically bullied.

And you said, 'I think I went weird again when I was seventeen'. Do you remember any more about that time?

Well that was after I had been at school again, It was the summer holiday and er, I was on (Name of ward). I don't know whether I was depressed but I had this uhm (2) strange thought that uhm (3) they were going to brake every born in my body and (2) they were going to come, different people were going to come up to the ward and brake my bones. I got this feeling that I was going doing down the drain and also I had thoughts that they were going to give me the electric chair and I actually went through an experience when I was there. When I (2) I thought that was really going to happen. What happened was that I couldn't see any other people because the blinds were powerful but er eventually that went away but it felt like it was a thousand years.

Okay, do you remember any more details about that time?

Well, I think er I thought that the tele was talking about me and I thought other clients on the ward were talking about me saying that I was the devil or something.

And you said, 'Only one person seemed to care'. Do you have any more thoughts or feelings about that time when you felt cared for.

I don't know if I ever opened up to anyone trying to help me anyway. Maybe they were too busy, I don't know, I don't know.

And then you said, 'I was stable for about two years'. Do you remember any more details about that time when you were stable?

Uhm (4) sorry I don't. I'm a bit confused as to when that was.

And you said, 'I was caught up in the 'crossfire' between (Name of hospital) and (Name of hospital) closing'.

What I meant was uhm (3) because er there was (Name of hospital) and uhm (2) and they hadn't started care in the community programme much, er I was just left with my family and I didn't get the chance to go to a group home or anything like that so (2) you see what I mean.

You said, 'I began to sense something funny about my father'. Can you tell me anymore about that moment?

Uhm (2) Yeah, I thought something funny happened when I was about fourteen but I uhm I tried to block it out of my mind and er uhm when I was sixteen again (2) and er again when I was twenty four when he was er violent.

Okay, and uhm you said, 'I was thinking that I might harm myself'. Was there a particular situation or incident that made you wanted to harm yourself?

(13) I can't think of anything, No.

Okay. And you said, 'I didn't feel safe'. Do you remember any more story about not feeling safe?

No.

Okay. And you said, 'I was annoyed'. Can you remember any more details of the story about been annoyed?

I can't remember. What was I annoyed about, I have forgotten?

You said, 'when I went back to (Name of hospital)'.

Oh yeah, (Name of hospital) and er (2) I had been there a few days and I was planning on staying there for a while then they suddenly said, Oh no, you got

to go. Get your stuff, you're going back home. I didn't have much choice in the matter!

Okay, we've come to the end of the interview. Is there anything else you would like to add to what you have already told me?

No, I don't think so.

Okay, thank you very much.

I realised at this point that I had made the mistake of announcing that the interview had come to an end. This went against the protocol of the Method and was an error I was not going to repeat in the other interviews. I reflected on why I had ended it like I did, instead of allowing Hannah to make that decision herself as in the protocol of the Method. I came up with the idea that I might have subconsciously responded to Hannah's request that 'we didn't take that long long long time'.

My reflection also sparked the idea that in ending the session like I did, I might have reacted defensively, wanting to somehow protect myself from the feeling of being unable to help Hannah with her difficult issues, as in the case of countertransference in psychodynamic theory. This was, effectively, limiting the reconstruction of her traumatic story. At the same time, reflecting on what happened in this part of the session, has helped me to more completely understand the emotions and connections that can develop in narrative interviews.

2. Andrew Simpson

Andrew's Lived Life

The team looking at Andrew's *lived life* consisted of Yusef, a student nurse who used to swim professionally; Janet, another student nurse, who stated that she is afraid of water; and Bongivey, also a student nurse, who took grade five piano and was a ball girl at Wimbledon.

Event		Hypotheses/Predictions
1976	Brother born	<ol style="list-style-type: none"> 1. Sister/brother now has older brother. 2. Only boy in the family. 3. Will be the story of someone famous.
1977	Sister born	<ol style="list-style-type: none"> 1. They will like each other. 2. Sibling rivalry will follow. 3. What relevance brother and sister will have on the story is not clear?
1978	Interviewee born	<ol style="list-style-type: none"> 1. Interviewee is a girl. 2. She/he is an outsider. 3. It was a planned family. 4. More siblings to come. 5. The parents were wealthy. 6. Working class family. 7. Catholic or Muslim parents? 8. Poor white family. 9. From a predominately white community.
1984	Parents separate	<ol style="list-style-type: none"> 1. Parents were cohabiting. 2. Father ran away from responsibilities. 3. Father left for younger woman. 4. Domestic violence/abuse might have been the problem. 5. Parents were working the benefit system. 6. Burden of poverty got too much for them. 7. No need to stay together now that children are born. 8. Parents keep contact with children. <p>One team member pointed out that divorce rates in the 1970's were high.</p>
1986	First stepbrother born	<ol style="list-style-type: none"> 1. Father has new partner. 2. Mother found new partner. 3. There could have been affairs during the marriage. 4. Affair could be the reason for parents separating.
1987	Second stepbrother born	<ol style="list-style-type: none"> 1. Dysfunctional. 2. Problems will start to develop. 3. Stepchildren will feel left excluded from family. 4. Father will take custody of the

Age 11 years		<p>children.</p> <p>5. Mother will end up looking after look after the children.</p>
	Started smoking cannabis	<p>1. S/he was mixing with the wrong sort of crowd.</p> <p>2. Is the black sheep of the family.</p> <p>3. Is going to state school.</p> <p>4. Dysfunctional family maybe reason for turning to drugs.</p> <p>5. Not a close family.</p> <p>6. Her/his drug use might be a way of coping with the separation of his parents.</p> <p>7. Will go downhill from here.</p> <p>8. May become involved in crime.</p> <p>9. May not have anyone to talk to.</p> <p>10. Father may also be a smoker of cannabis – not a good role model.</p>
Age 14 years	Experienced bullying until the age of fourteen and frequently became involved in fights with other boys.	<p>1. When did the bullying start?</p> <p>2. Went to boys school.</p> <p>3. He was a 'drug head'</p> <p>4. Position in the family was not secure.</p> <p>5. He played truant.</p> <p>6. He was reacting to trauma from parents' separation.</p> <p>7. Likely to be expelled.</p> <p>8. Perception might be altered by the drugs resulting in fights.</p> <p>9. He might have gotten involved in techno music, raves, 'old skool'.</p> <p>10. Will end up taking crack, cocaine, or LSD.</p> <p>11. Will be seen by other kids as different</p>
Age 15 years	Excluded from school.	<p>1. He is mentally unwell.</p> <p>2. He received home tutoring?</p> <p>3. Will end up wandering the streets.</p> <p>4. Will not have any friends.</p> <p>5. May end up in prison.</p> <p>6. Will start working.</p> <p>7. No formal qualifications.</p> <p>8. Will feel isolated.</p> <p>9. Will start hanging around with older crowd.</p> <p>10. Will change life around/turning point.</p> <p>11. Will get kicked out of home.</p>
Age 15	Attended youth training college for three years but	<p>1. He was paranoid and may still be taking drugs.</p>

years	because of thinking that people at work were talking about him, he left.	<ol style="list-style-type: none"> 2. Did well to avoid prison. 3. He has ambition and wants to do well. 4. He may start drinking as a way of coping. 5. Will be admitted to mental hospital 6. Went to training college just for the sake of it. 7. He was a drainage on the benefit system and was unemployable.
	Unemployed for three years, mainly staying at home, or socializing with friends.	<ol style="list-style-type: none"> 1. He was living with his mother. 2. He was living with his father. 3. Friends are likely to be using drugs. 4. He may enjoy taking drugs therefore won't change his behaviour. 5. He was mixing with the wrong type of friends. 6. He was dejected and unmotivated. 7. He has no direction in life now.
	Started work as a trainee electrician with father and older brother	<ol style="list-style-type: none"> 1. Living with father. 2. Has a good relationship with father. 3. Pressure from father to work. 4. Doesn't really want to work. 5. Won't be able to hold down the job because he will become unwell again.
	Age 19 years	<ol style="list-style-type: none"> 1. He will be given a diagnosis of some kind. 2. He is still using drugs. 3. He will recovery from illness. 4. He will be against authority and refuse to listen to his father. 5. He will become envious of brother. 6. He will become very angry with life. 7. He will develop serious personality problems.
August 2001 – September 2001	Admitted under section 3 MHA 1983	<ol style="list-style-type: none"> 1. His illness would become clear. 2. He would go downhill from here. 3. He needs treatment over a longer period. 4. Will become unwell again in the future and readmitted. 5. Stays well.
January 2002 – February	Admitted under section 3 MHA 1983	<ol style="list-style-type: none"> 1. He can't stay off drugs, he is addicted. 2. More admissions will follow.

2002		<ol style="list-style-type: none"> 3. He is getting to know the system now. 4. He may enjoy going into hospital.
March 2003	Admitted under section 3 MHA 1983 when he stopped his medication followed by deterioration in his mental state	<ol style="list-style-type: none"> 1. Hospital will not help him because he is still using drugs. 2. He will escapes from hospital. 3. He will stay in hospital and take his medication.
August 2003 – October 2003	Admitted with bizarre behaviour – given accuphase. Had made threats to poke father's eyes out and delusional about the FBI.	<ol style="list-style-type: none"> 1. He will kill someone. 2. He is uncontrollable. 3. There was no way back from his condition. 4. One team member said, 'I can see more admissions'.
March 2004	Stopping working with the assertive outreach team and medication led to relapse in mental state and informal admission. Talked of being a nuclear physicists and travelling to America to join up with NASA.	<ol style="list-style-type: none"> 1. Drugs have really messed up his head/life. 2. Going into hospital has become a pattern. 3. Hospital is his second home and that he may feel safer there. 4. He might be afraid to get well because he will then have to face the reality of his circumstances (broken family, absent mother). 5. His emotional difficulties might be a reason for him stopping his medication and withdrawing from services.
June 2005 – July 2005	Admitted under section of 3 MHA 1983 psychotic with delusions of grandiosity – refused to take his medication	<ol style="list-style-type: none"> 1. The mental health system has become a safe place for him. 2. He enjoys going onto hospital. 3. As long as he continues to have emotional problems there will be no hope of him staying out of hospital. 4. It seems as though he has lost control of what happens to him.
December 2005 – January 2006	Informal for six weeks.	<ol style="list-style-type: none"> 1. Going into hospital could be a place to avoid difficult home situations, particularly as this admission took place around the Xmas holidays. <p>In addition to this, team members felt that:</p> <ol style="list-style-type: none"> 2. He may have been felt left out at home.

July 2006 – November 2006		<ol style="list-style-type: none"> 3. He doesn't get on with siblings. 4. He really enjoys going into hospital because staff and other patients have got to know him.
	Admitted under section 3 MHA 1983 following aggressive and threatening behaviour towards father and stepmother. He had been refusing his medication since February 2006.	<ol style="list-style-type: none"> 1. He is feeling frustrated with home situation and that is why his aggression is focused on people closes to him. 2. He does not have any will to make a go of his life. 3. He may have felt trapped in the mental health system. 4. He really wants his mother back - doesn't know how to cope without her – resents his stepmother. 5. He wants to hide aggressive behaviour behind mental illness.

Table 10.0 Andrew's Lived Life

Andrew's Told Story

'Schizophrenia changed my life'

Setting up the interview

This interview took place in the kitchen/diner of Andrew Simpson's home. His parents were at home, but kindly vacated the kitchen to allow the interview to take place. They spent the duration of the interview out of the way in another room.

It was a very large kitchen/diner and was in the process of being decorated. The dining area had a small table with an executive type chair in front of it and a stack of four foldaway chairs to the side of the table. On the small table was a well-used ashtray with remnants of roll ups made from Rizla paper in it. A radio cassette player was also on the table. I had the feeling this was Andrew's corner. I used one of the foldaway chairs for my tape recorder and another to sit on. We sat facing outward into the garden, which could be accessed through conservatory-type double-glazed doors.

Andrew is of small-to-medium build, about 5' 7" tall and clean shaven and, on this occasion, was wearing trainers, blue jeans and a black sweat shirt with a logo on it.

In contrast to his *lived life*, Andrew's *told story* was interpreted by Gee, a youth and community leader, who described himself as a jovial but deep person and a Buddhist; Tracey who is deputy head of a school and learnt to swim two years ago; and Sonia, who works for the NHS and recently had laser eye surgery.

The interview began with the following question:

Ok, I would like you to tell me the story of your life, all the events and experiences that were important to you until now. Start wherever you want and take all the time you need. I won't interrupt you, but I will take some notes for after you have finished telling me about your experiences.

My name is Andrew Simpson, uhm, I was born in 1978, lived a pretty normal life, uhm, went to school. Everything was basically normal until I went into hospital, uhm, that's when I suppose getting schizophrenia changed my life in different ways, (4) different parts. I don't know what different parts stick out in my life. I don't know what what what I'm going to talk about, like work. Workwise was normal. Doing work was normal, and that was good. When I was at school I had a good time. Everything was normal. I had a not bad child upbringing, (2) had a few girlfriends in my life, go to the pub occasionally, what else, (cough) like enjoying myself, I like doing different things. Uhm (2), the only problem I've got at the moment, I suppose, is my mental health and about what's happened with that, and that's one of the strangest things that's happened to me in my life, not being able to understand why I've become ill. Why why why it effects people in different ways and what what what it actually is.

This opening section of Andrew's story reveals a person whose life appears to have been disrupted by schizophrenia. He struggles initially but then settles down to narrate a story that relates to what Bury (1982) refers to as a biographical disruption. Frank's (1995) chaos narrative also applies here. Emphasis is placed on not being able to understand why he became ill, what the illness is, and why it had to happen to him. At the same time, this opening narrative account details a turning point in his life in which he seems unable to appropriate an identity for himself. It could be that he has realised how empty his life has become and feels anger at having lost an active and enjoyable social life to his illness.

In addition, this narrative passage seems to be drawing a clear distinction between what he believes constitutes normality and what impedes his ability to live 'normally'. The team suggested that he was introducing the themes of his story, a life troubled by mental illness and recurrent hospital admissions, at the same time as seeking answers to the many questions and uncertainties he was facing. His evaluation of his identity by comparing life before and after the repeated hospitalisations was, therefore, seen by the team as a way of making sense of the chaotic state he found himself in now.

The team also felt that, as a way of centring himself, he compared himself to others around him. To be able to do this, he would have had to recognise a change in normalising behaviours that mirrored established standards of his gender and peer groups.

Although his first admission happened when he was twenty-two years old, his adolescent years were plagued by cannabis abuse, bullying at school and behavioural problems, which eventually led to his exclusion at the age of fifteen. According to Erikson (1980), adolescence is when individuals attempt to discover who they are by defining their identity. For Andrew, it was a period where unsuccessful attempts at social interactions were most likely compounded by his illness and probable psychosocial disruptions at home.

In terms of his illness, Andrew states, '**Schizophrenia changed my life**'. The team felt that being told about his illness would have had a huge psychological impact on him, leaving him overwhelmed and confused about who he was as a person. This seems to follow Glover's (2003) opinion that 'the boundary between the person and the illness is harder to draw in schizophrenia' (p. 540).

The team felt that one of the reasons for this may have been because of many changes in his life. They felt the most significant of these changes was when he was diagnosed with schizophrenia.

The importance of support during such a stressful period was discussed by the team, who wondered what role his parents played. It is notable that Andrew does not mention his family in this passage, which led the team to think that his parents were missing either physically or emotionally.

In the next passage Andrew says:

It's not nice going into hospital or being involved in that environment or being stuck in that environment should I say. It's (cough) it is frustrating, and you get told that this is what's wrong with you, and you get diagnosed, and you don't know whether to trust trust what's being told to you. And you know they are professionals and they've done this job for a long time and they are people are qualified qualified to do this job. But, uhm, like I said you don't, you don't know whether to trust if you are being told the right things or not. And it's hard having to learn about mental illness and pick yourself again from when you've when you've had, uhm, a psychotic episode or a breakdown of some sort, and, uhm, that's one of the main things that sticks out in my life.

At this stage in the analysis the team offered many hypotheses, including that Andrew was poorly educated, a loner with few friends and perhaps bullied at school. In terms of family, there were suggestions that he was an only child, perhaps from a working class background or a broken home (living with his mother or in foster care). In general, the team felt that Andrew was going through intense emotional turmoil that was compounded by his distrust of people in authority, in particular, professionals in the mental health system. The team speculated that this distrust may have arisen from involvement with the police or neglect by parents. Perhaps, it was suggested, he was from a family where he had to obey his parents unconditionally and was now rebelling against that upbringing.

Surprisingly, the team ruled out any use of drugs, but they did say that he was vulnerable to everything. One team member wondered whether his questioning was part of his illness and speculated whether he was thinking clearly or imagining these problems. The rest of the team, however, thought he was not psychotic but in tune with reality. There was a strong feeling from the team that Andrew was not being listened to in hospital, perhaps because he had been sectioned, thus losing the right to have a say in what happened to him.

The next narrative passage gave clues to aspects of his personality and his relationship with hospital staff.

I dunno, it takes away a part of you because you have to bow down to what people are saying, because you know they are right about what what they are doing and how, the medical health team I'm talking about, they are right with the medication they are giving you or telling you what's wrong with you because you've obviously been in hospital for a reason. And you have to let them in and take on board what they are doing and saying, and it takes a big part of responsibility out of your life, so that's another thing, uhm.

Andrew's choice of the words 'bow down' were interpreted by the team to mean that he had little or no power in decisions about his treatment. This sense of powerlessness may have created in him a feeling of worthlessness. It could be that he was reacting to being defined by medical knowledge in which he had little confidence. They also felt that, when well, he was more critical of professionals, but when unwell, he tended to be more accepting of them.

I mean at one point everybody thinks the whole world is against them in some sort of way. But that's another thing you learn as you get older or as certain things happen to you to you learn different things about different people, different things, and you learn to take more in, you know what I mean. And that was one good thing when I went into hospital because I learnt that there are good people out there and do different things and are actually probably genuine and like most people just want to get along. But when I was ill I thought the whole world against me, sort of thing. But that's just a natural natural thought (cough). But when I was in hospital I got, thought different things, met some nice staff in there, nice clients and basically started to see things better than I did before I went into hospital.

The team noticed in this passage that Andrew's language/terminology reflected that of professionals, indicating that he had possibly been institutionalised by his frequent admissions. At the same time, the team felt that because his language was now normalised, he had taken on an ascribed identity as a mentally ill patient with recurrent admissions.

Through microanalysis of his language, the team picked up on the fact that there were certain times in his speech when he was repetitive. The team wondered if he was feeling stress at those particular times. Identifying his psychosocial stressors

was one way the team sought to understanding the crux of the problem. They wondered, for example, about his ability to cope with the feeling of hopelessness and of being overwhelmed by his situation. Ostensibly, however, he appeared to be understanding more about schizophrenia and came to the realisation that it affects people in different ways.

Is it me doing it to myself, or is it an imbalance in my brain? So that's another thing. I don't really want to find out about it. I don't want to take the time to sit down and think and diagnose myself and think what is it? That's not me.

Andrew seemed to be asking a rhetorical question here which is deeply psychological and reflects a sense of confusion. Through a process of self affirmation he appeared to be in a state of puzzlement about who he actually is. It could be that he was confused because he had lost a sense of identity, a case of what Kon (1969 p. 147) refers to as the subject viewing himself or herself as an object. Breakwell (1986 p. 95) describes this situation as compartmentalism - shutting out or not communicating with aspects of identity that he does not want to change.

Several things struck the team about this passage. Andrew at first seemed to be on the road to self-discovery by asking himself the question, ***'Is it me doing it to myself, or is it an imbalance in my brain?'*** He then, for some reason, turned around and went in the opposite direction. The team concluded that because he used the pronouns 'me', 'I', 'myself' and 'my', he must be referring to himself, but then he seemed to confuse things a little by introducing another self, saying, ***'That's not me'***.

The team drew from this that he must be in conflict with himself. One team member related this passage to the book in the bible (Romans 7:14 *New English Version*) where St. Paul seems to be at war with himself over his carnal nature: 'I do not understand what I do. For what I want to do I do not do, but what I hate I do'. Andrew appeared to be in a similar dilemma here, trying to understand why he relapses, but seemingly not wanting to do anything about it. Perhaps he did not have any control over what he became because he lost the ability to fight against his illness, or perhaps he was in denial. Breakwell (1986 p. 93) views denial as another coping strategy for resisting change in identity structure. Laing (1961) refers to this as being caught in a tangle of paradoxical injunctions in which the individual cannot do the right thing (p. 125).

The team interpreted this to mean that there might be some benefit for his being ill, for example, in circumstances where he perceived himself as lonely being at home, going into hospital would serve as a way of breaking that loneliness. The concept of loneliness is interesting, for it suggests that there is a lack of companionship and a sense of belonging. At the same time, it could refer to his lacking emotional support and close attachment to friends or family. It could also mean that he does not have the skills to take responsibility for his life. As such, he may be more likely to resist getting better because coping would be too much of a challenge for him.

The following passage gave support to some of the intuitions above:

Time spent at the moment, I'm just sitting at home doing nothing (cough). Just watching daytime TV, getting up at about 10 o'clock, watching TV, going to bed at about twelve at night, not doing anything productive, not engaging myself in anything. Hopefully that will change in the future.

The team came to the conclusion that Andrew was not particularly bothered about his situation and speculated this passivity could be because he lacked motivation to make necessary changes to his situation or that it suited him to remain as he is. In terms of his accommodation, the team felt that he was living alone and originally came from a white working-class background.

And that's that's another thing that sort of like concerns me because it's not that I don't want to stop it. It's a fact that I I've got don't have anything else to do, and I get bored easily, and I tend to smoke more, and then the time tends to pass faster, but while that's happening I'm still under the influence of alcohol or cannabis. And my brain is just seems to be wasting away, and I think this is all big factors of why I went to hospital in the first place.

The team hypothesised that taking drugs is likely to make Andrew irresponsible and apathetic and could result in his losing touch with reality. This is because as a person loses touch with his or her own life, he or she starts breaking away from others who care about him, in particular, family and friends. It was interesting to note that up to this point, the female members of the team had been empathic towards Andrew, but became less so after realising he took drugs. They also hypothesised that he might be from an affluent background.

Uhm (3), seen a couple of friends who are still in hospital, uhm (2), I don't (cough), I don't like seeing people in hospital. Uhm, seem to sort of, er, feel that they've had something sort of like done against them like this shouldn't be happening to them.

The team wondered whether Andrew was talking about himself here or whether he was referring to something he had observed on the ward. If it was other patients he was referring to, it could be that it reminded him of poor treatment he had suffered on the ward. By looking at himself through the lives of others, he was able to get a better sense of who he is as a person, which appeared to make him unhappy. Alternatively, it could be that he had taken on a moral role in which he is protective of others.

The main problem (slight chuckle in voice) at the moment is just killing boredom, boredom. I don't know what to do with my boredom. I know I've got some plans for the future with college and that, but I'm bored (bad cough). Sitting at home just seems to be getting worse, but like even when I do go to work it's it's not it's not just the work. It's coming home, and I'm still going to have the boredom, and I think that's one of the main contributing factors why I started to, uhm, have my mental sort of like mental issues. Uhm, because I was so bored and didn't have nothing to do with my time.

The team hypothesised that Andrew was unable to distinguish between being loved and being lonely and came to the conclusion that because his life is so empty, for example, he has no career, no meaningful relationships/love and no friends, it contributed to his having a poor sense of self. Later on in his story, Andrew mentions a number of things he would like to do:

You want full control of your mind and body, and I mean, fair enough, I think that's one of the reasons why people stop taking the pills and go back into (cough) hospital.

Uhm (10, lights up a roll up), I want to eat healthy (laugh), I dunno, I want to go to the gym and eat healthily and do the right thing. Erm, that's it. What shall I talk about, erm (3)?

Hopefully, yeah, I'm getting a flat soon, erm, by the council. Hopefully I can move into there, and when I start work I want to buy it. That's another thing. I want to buy a house as well. I want some sort of property.

I need somewhere just to, well, I need somewhere of my own so can put my feet up and watch what I want on the TV and, er, just have a little bit of space to myself.

I don't think I want to grow up and have nothing to show for what I've lived for, and I want something of my own (mobile phone goes off again), er, and (2) a flat or something like that is definitely definitely what I want.

Erm, going on holiday, I mean at least once a year, is got to be another thing I want to do, definitely have a holiday a year, which I mean you get older get older, it's definitely something you want to do. I want to see different places in the world. Erm, what else (12)? Can we stop for a minute?

And I don't want to be one of them people talking about it now and sort of like being recorded talking about it and not being able to, well, not not been able to do but not doing anything about it and getting to an age where I'm not been able to do anything about it so.

I find myself in situations now that, uhm, I react in different ways because of being in hospital. I'm no longer like as aggressive as I used to be, so, which is one good thing, so there are things that helped out from being in hospital, so I want to use that to to to my advantage to to get get something productive going in my life.

Andrew's vision of the future was interpreted as unrealistic given his present situation. Breakwell (1986 p. 88) suggests fantasising can be used as a strategy for blocking out a threat to identity. Fantasy has the power to wish the threat away and replace it with an acceptable form of reality. A little later in his story Andrew announced:

I mean I've changed now, and I don't want to do these things. I'm talking about them, and I know I know it's sounding good to do all these things, but there's a part of me that doesn't actually want to do anything. And I think this is the thing that's always always sort of held me back because there's one big part of me that doesn't want to do anything. And I think that's that's what makes me sort of relapse because I don't want to do anything. I get depressed and get low, and, I dunno, (2), it's just I've got to think of it as I've got so many years

left on this planet and I've got to actually do something, otherwise I will end up in hospital again and again. But it's like what do you do to motivate yourself? I mean I'm still lost, so I don't know about that.

Psychologically, Andrew's alienation seemed to have firmly taken hold of him. The team felt that he was at a very low point in his life but was not at risk of harming himself. In the passage above, Andrew did seem aware that without change readmission to hospital was a strong likelihood, but the team saw him as lacking the energy and mental strength to effect this change. One member of the team, however, said he did see a good ending to the story, perhaps feeling that things could not get any more dismal for Andrew.

Uhm, uhm (3), every time I've been into hospital I've never liked it. Uhm (2), I've met different people in hospital with different, uhm, illnesses. Uhm (2), it's it's it's it's been one those experiences that, I mean, I would have changed if I could. I wouldn't have liked to be in that situation. I would have changed it if I could, and it's it's one of those things that, uhm, that that once it's happened to you you no longer feel you are part of society. You're no longer the same person, and you no you no long you're not you feel like you're degraded in some way you've done some some outrageous act. And everybody is looking at you, or everybody is talking about you, because you're not the same as them.

The real impact of stigma seems apparent here. The team interpreted this passage as meaning that any sense of self that Andrew had was now crushed. They hypothesised that the reason for Andrew's alienation was because he felt ashamed of himself, marginalised and no longer a part of society. I wondered whether his recurrent admissions had in effect been the main cause of his apparent low self esteem.

Once you've been in hospital, you don't feel the same, and you seem to react to people differently. Uhm, (3) uhm, but the doctors will tell you that's not the case, and everything is normal. But when you drift away from society it's always going to take you a little while to immigrate into it. And the doctors normally say it could have been you before you went into hospital before this has happened to you. Could just have been you and that you probably just

imagining it. But it does seem very real at the time. And, uhm, I think that's one of the big things about getting back to reality if you like is trying to integrate again. And it just seems as if everything is going against you and all these things just build up and up and up and up, and then you think oh I've had enough of this, and then you just start drinking more alcohol, or smoking cannabis. And all these thoughts about going to work and that go out the window. And you just go back to square one again.

Andrew was able to reflect on the stark reality of going into hospital. The team interpreted this to mean he had reached the point of no return, i.e., he could never resume being the person he used to be before his admissions. They felt that he had not been listened to by the doctors and that this may have pushed him further away from the people who might be able to help him. One team member said she felt he was paranoid and that alcohol and cannabis may have contributed to his being this way. Another team member suggested that his personality was rebellious and that because of this he would not cooperate with the doctors.

And, uhm, I was just weighing up the advantages of taking medication and thinking is medication...is medication given in too much of a quantity? Is it given out too freely, and does it do the job that it's supposed to do without causing too much distress to the client as well? It seems they still want to give you a high dose of medication. And can you function as normally as you would if you weren't taking that medication? These are all things that build up and obviously the side-effects you get from taking medication is is, uhm, at the end of the day is it worth taking it?

Andrew touched on the issue of medication, raising many questions about its use. For Andrew, it would seem that doctors have become protagonists of his illness. Frank (1995) refers to this as 'becoming a victim of medicine' (p. 172). The team interpreted this passage to mean that because of his negative attitude towards medication, he did not trust doctors and might be looking for an alternative to medication. This may be because he believed the medication was negatively affecting him in some way or that he simply did not need it because there was nothing wrong with him. They noticed that Andrew spoke in a passive voice, seemingly referring to himself as 'the client'. This could be because medication is a

controversial issue and he did not want to make it known that he was not in favour of it, in case it was held against him.

Andrew's mistrust of doctors and medication may be understood as rebellion and passive-aggressive defiance of treatment generally. Nevertheless, this gives meaning to his resistance to treatment, even though he might have a valid point to make about medication.

I dunno, I have seen stuff on TV, and I've I've have heard things on the radio that doctors or mental health service are giving out too strong a dose to people. It's just the little things, it's not major, it, they're not big things, have seen on the TV. It was just a little debate that I heard on the radio as well. It was talked about that do doctors give out too strong a medication or strong dosage and stuff like this an' that's one of the things I think about as well. Do they give me too much or not the right stuff an' that?

Distrust of doctors and resistance to treatment became a recurrent theme. The team felt it was interesting that he did not come out and say it outright but made his point by referring to a TV and radio programme. It was only in the last line of the passage that he made some reference to his having such thoughts.

I've seen people in hospital, and I don't know what they were like before. But I saw them in the hospital after taking these drugs. And I've seen them dribbling and shaking. They look like they have been taking crack or something, but they haven't. They have just been taking medication.

Andrew's response to how other patients are treated in hospital was interpreted by the team as meaning that he was morally very sensitive to harm being done to others. This may be a reflection of the type of care received from his father when he was a child. It may also mean that he remembers how he was treated during his admissions and resents it happening to others. In the next passage, Andrew continues in the same vein to voice his opinion on how patients are treated.

I don't know how people could justify in making someone into a dribbling shaking nervous wreck rather than being like what they was is better for them. But I mean, yeah, obviously there's another side to that because there are other people involved. And obviously it's about care at the end of the day, and

there are other people involved, so it's about harm to other people as well as yourself. So, yeah, but it's just a question I ask you. Is it justified that making someone one way is better than having them like sort of like, well, If that person was just looked after and given care instead of given medication after a certain amount of time, would he rehabilitate or would he not? I mean, I know there is no amount of time given to people's medication, or, if he was given a lot of care without medication would he rehabilitate or not?

The team remarked on what they felt was a high level of reasoning from Andrew. One person said she did not expect it from someone with schizophrenia. Other views were that his perception had changed and he now wanted to view himself as normal.

I mean it's just funny the different people you meet along the way, when you go through life. You said to tell your life story. I mean, but a life story can go on for ages, uhm. But it's funny the different people you meet in your life and and (3) meeting different people, and and how you react. If I had never gone into hospital I would never even have known about about what it is. If someone had said to me, schizophrenic, I would have just thought, uhm, nutter, someone whose not well. But I mean it's funny how normal people are when you meet. Like, like from like if I was to meet someone from hospital they they they are just as normal. They have just got a few issues. But it's funny the different people you meet. That's what I was saying earlier. Would I be the same person now as if I didn't go into hospital and have all these things sort of like happen to me, and could it have been prevented?

In this self-reflective passage he rationalised his experience of hospital admission. Although it would appear he disliked going into hospital, he seemed able to appreciate some benefits from the experience. It would appear that as far as he was concerned, without hospital admissions he was 'normal' just like other people. At the same time, however, he accepted that we are all different with different issues in life. The team wondered whether he was projecting himself onto other patients who he felt were normal. The team was under the impression that the admission to hospital may have had a good impact on him. This was because he seemed to be saying that he recognised that his behaviour wasn't perhaps 'normal' or an acceptable mode of behaviour in today's society. The team picked up on negative aspects of his

admission, suggesting that he is now likely to be labelled as a 'schizophrenic'. The team's understanding of labels was explored during the session. They came up with the notion that labels stick and are discriminatory.

The next segment of text is an account of the effect of going into hospital:

I think from having been in that environment and meeting all these different people, I think it is hard to to sort of break away from that because cos you meet characters, and you feel like drawn to certain situation. And like you remember things and it brings back memories of how things were and different things like that. And I mean when you get put in that environment is is is that environment actually making you better or is it sort of like bringing you down in one way because you you sort of like becoming institutionalised into into sort of like everything is okay, people people are friendly people, well, people should be friendly all the time. It's inappropriate to to behave in certain ways.

I mean it's as almost as if you're closed off from reality. Because when you're in hospital and everything is normal and it seems like a big thing. When you come out of hospital you got all these worries. I get worried about my personal health, physical health, sorry not my personal health, physical health. And, uhm, I'm always sort of worried about that. When I was in hospital it sort of shut off everything to me.

The team interpreted this passage as meaning Andrew was now feeling the effects of being institutionalised. Perhaps in hospital he had support, but in the community there was no one to talk to or to test his sense of reality.

Yeah, I see a fight yesterday, and I tried, and that was another thing that's what I said I was reacting differently. I see a fight yesterday, and I tried to break it up. I see these three people kicking this one person in the head. So I broke it up. Well, I got all the person's blood over my top. It's like that. Normally I wouldn't react like that, but I mean. There is a part of me now that that that that sort of like, I dunno, like caring. I don't know what it is. I mean, like, I see this person getting beaten up. Normally I would have walked pass. But now I just tried to break it up, and I stopped it. I'm thinking now, why, why am I doing the things

like this, cos I could have got myself into trouble anyway. I could have got into the fight and into the situation.

Narrative	Sub-plots and Interpretations
<p>Yeah, I see a fight yesterday and I tried, and that was another thing that's what I said I was reacting differently. I see a fight yesterday, and I tried to breaking it up. I see these three people kicking this one person in the head. So I broke it up, well I got all the person's blood over my top. It's like that. Normally I wouldn't react like that, but I mean. There is a part of me now that that that sort of like, I dunno, like caring. I don't know what it is. I mean like, I see this person getting beaten up. Normally I would have walked pass. But now I just tried to break it up, and I stopped it. I'm thinking now, why, why am I doing the things like this, cos I could have got myself into trouble. Anyway, I could have got into the fight and into the situation.</p>	<p><u>Orientation</u></p>
	<p>Came across two people fighting and tried to stop the fight.</p>
	<p><u>Complicating Action</u></p>
	<p>Got blood over his clothes.</p>
	<p><u>Resolution</u></p>
	<p>He was able to break up the fight.</p>
	<p><u>Evaluation</u></p>
	<p>I have changed into a caring person. I'm a different person now, but I don't know why I've changed.</p>
	<p><u>Coda</u></p>
	<p>I took a risk and could have got myself into trouble.</p>

This passage conveys actions and events that are related, in a chain of cause and effect, which portray Andrew as a hero. Andrew's hero status could be interpreted as a reflection of how he believes his father would have acted and, as such, he was just following his instinct. Having his father as a role model, he would want to do the kind of things his father would have done. It could also be that he was just trying to be responsible in the areas of his life where he has some control. The team felt that this would have probably given him confidence in his judgement and a stronger sense of identity.

You said, 'I was born in 1978, lived a pretty normal life'. Can you give me an example of uhm, what normal life was like?

Doing what boys do, riding around on my BMX as a youngster. Playing with others, climbing trees, making tree houses, having games of war, playing manhunt, going to play schemes when I was younger. When I got older going to Youth Clubs, meeting different people when I got older, when I got to seventeen; going out drinking to pubs, just normal things, go swimming with my friends, just normal, anything normal, day-to-day activities. Anything to occupy my mind in the six week holidays or weekends, as long as it wasn't hurting anyone else, or hurting myself. That's what I mean by normal. We just played, bowling, swimming going to cinema, eating burgers and chips, asking my dad for money going to shops for sweets, until I got older and going to work then going down pub with friends at the weekend.

The team found this passage of text interesting in that there was no mention of his mother, other siblings or family life. They interpreted the text as meaning Andrew was farmed out to activities. This is usually the case when children become bored with what their parents can offer them by way of recreation. The team felt this was a dangerous time for Andrew, as it is a time when children can turn to drugs and alcohol. I wanted to find out more about his father, so I asked the following question:

You mentioned your dad, can you tell me more about the relationship you had with him?

Yeah we've got a good relationship, had since I was young. I always asked him for money when I was younger. He taught me what was right and wrong, always been there for me, even when I was caught for stupid things when I was younger, like caught for stealing. He was always there for me and supported me and basically got me my job, showed me how to do electrical work and stuff like that. He has been there for me all my life, and through that we've built up a strong relationship. The only breaking point was when I had my psychotic episode and found out I had schizophrenia and the relationship had a rocky time. But it's back to how it was. That's another reason why I would like a place of my own because I've lived here for twenty-seven years, and it doesn't matter how much you get on you need a certain amount of your own space. We have

had a very good relationship. I was accident prone when I was younger and used to hurt myself, and my dad always took me to hospital.

Andrew seems to have formed a strong psychological attachment to his father during his early childhood. The team felt that his father represented a good role model for him, in terms of doing the practical things expected of him, but because of his parental style his father was unable to offer emotional support when it was needed. In particular, at the crucial time of his diagnosis, Andrew states that '***the relationship had a rocky time***'. Perhaps he also resented his mother for not being there for him at this time. As there was no mention of his mother in this passage, the team took this to indicate that his relationship with her was probably not good and that she might even have abandoned him.

Can you tell me about a particular accident when your dad took care of you?

Yeah, I jumped off a bridge at the end of the road and broke my leg. And he took me to hospital. And he didn't have a car so he had to get a taxi up there. And we didn't have enough money to get home, but we had enough to town. So I had to walk up town with a broken leg, and I couldn't. So he carried me when I was younger. So that was one incident. It's just things you remember that your father is always there for you and your family is there. I was quite lucky that me and my dad built up a strong relationship when I was younger.

Narrative	Sub-plots and Interpretations
<p>I jumped off a bridge at the end of the road and broke my leg, And he took me to hospital, and he didn't have a car, so he had to get a taxi up there, and we didn't have enough money to get home, but we had enough to town, so I had to walk up town with a broken leg, and I couldn't, so he carried me when I was younger. So that was one incident. It's just things you remember that your father is always there for you and your family is there. I was quite lucky that me and my dad built up a strong relationship when I was younger.</p>	<p><u>Orientation</u> Accident prone</p> <p><u>Complicating Action</u> He is from a poor family; father did not have any money.</p> <p><u>Resolution</u> Father resolves the problem by carrying him to the hospital.</p> <p><u>Evaluation</u> My father is always there for me</p> <p><u>Coda</u> I am lucky because my father and I built up a strong relationship</p>

In this narrative passage, Andrew talked about a particular incident where his father came to his rescue. It could be that because of this early caring relationship with his father, Andrew had come to expect that his father would always be there for him. If this was the case, it would suggest that he might find it intensely difficult to bond with any other person with whom he had not developed a caring relationship. The team felt that this showed that even though he experienced problems later in life, his childhood experience of a caring relationship with his father was perhaps his saving grace.

This had occurred to me during the interview and made me want to find out how he viewed his mother and stepmother. I anticipated that the relationship had deteriorated and was now very fragile. I asked the following question:

You spoke about your dad, but you haven't mentioned your mother.

Yeah, my mum and dad split up when I was younger. I was about four and don't really remember it. My stepmom I don't really get on and never have. And it's one of those things that it's uncomfortable being around her. So I try not to be around her. Me and my dad, the relationship with my stepmother, I don't think

she would want anything to happen to me, but we don't talk to each other so we stay out of each other's way, and it's manageable to me (8).

Andrew referred to a long-standing problem between him and his stepmother. He did not get along with her, and they avoided each other by not talking. The team suggested that he blamed his biological parents for his situation. It could be that he had unresolved feelings about the break-up of the family. This seems to connect with Laing's (1961) claim that 'interpersonal life is conducted in a nexus of persons, in which each person is guessing, assuming, inferring, believing, trusting, or suspecting, generally being happy or tormented by his fantasy of the others' experience, motives, and intentions' (p. 154). He adds that family interactions are often dominated by these issues.

It could also be that his father was unable to challenge the conflict-avoidance pattern of interaction or relieve the profound isolation and disconnection underlying the apparent closeness and harmony in the family. It could also be that his father just wanted to keep the peace, but by doing so, he seemed to inadvertently cause divisions within the family. Alternatively, the father may have worried that he would lose his wife's love if he took sides with his son. Andrew may have perceived him as simply too weak to resolve this relational issue, inducing a feeling of abandonment. A further hypothesis could be that because of the psychosocial disruptions at home, admission to hospital may have been an escape from difficult home circumstances. His parents' actions may have further reinforced Andrew's resistance to treatment; he might have misconstrued the parents as domineering and, in perceiving the doctors as his parents, further increased his resistance to treatment.

Andrew actually had his first admission to hospital in 2002 under Section 2 of the Mental Health Act 1983. I asked him to tell me some more about this episode:

You said, 'mental health was one of the strangest things that have happened to me, not being able to understand why I've become ill'. Can you give me anymore details about that particular time when you were told you had a mental illness?

Prior to that I had a thought, and I knew it wasn't real, but I was letting it play on my mind, and the more I let it play on my mind the more it was effecting me. And then I believed it more and more to the point I had a fight with my dad. And

he knew there was something wrong, and he called the mental health services (heavy coughing). And that was nothing, and they said it was a drug induced psychosis, but came out of hospital and went in hospital and went in hospital two more times and was told I had schizophrenia.

Narrative	Sub-plots and Interpretations
Prior to that I had a thought, and I knew it wasn't real. But I was letting it play on my mind. And the more I let it play on my mind the more it was effecting me. And then I believed it more and more to the point I had a fight with my dad. He knew there was something wrong, and he called the mental health services (heavy coughing). And that was nothing, and they said it was a drug induced psychosis, but came out of hospital and went in hospital and went in hospital two more times. And was told I had schizophrenia.	<p><u>Orientation</u> Attempts at deconstructing psychosis. (Establishing framework for understanding behaviour)</p> <p><u>Complicating Action</u> Cognitively and emotionally impaired. (Changes in the way Andrew sees himself, his ways of acting and relating)</p> <p><u>Resolution</u> Professional intervention. (Unable to take responsibility for his decisions and direction in life)</p> <p><u>Evaluation</u> Consequences. (Multiple admission to psychiatric hospital; restriction of liberty, social control).</p>

Here Andrew showed an awareness of his condition, however, he responded to his thoughts in the same way that he had learnt to respond to negative emotions in the past: he got into a fight with his father. The team wondered about the reasons behind the fight with his father, with whom he was supposed to have had a close relationship. One of the hypotheses offered was that, perhaps subconsciously, Andrew resented his father for being in a relationship with his stepmother, whom he disliked. Another was that he felt stigmatised by his father and stepmother and angry that his father had let him down by not protecting him from his distress. Acting out these thoughts by fighting with his father, was perhaps one way of understanding

how his life had been impacted on by learning about his condition and having to go into hospital against his will. An assessment under the Mental Health Act 1983 revealed that some schizophrenic features may have interacted with the stresses of his life at the time.

That's great! You said, 'My first admission was in 2000, and I had admissions after that...'

Yeah nine admissions.

Indeed, this was Andrew's first admission following a fight with his father. It was alleged that he threatened to kill his father with a knife. He was reassessed in hospital and placed on Section 3 of the MHA 1983. I asked Andrew if he could tell me any more about these admissions.

To tell you the truth I don't know why it's happened. And why I keep letting it happen. I don't know why I was going into hospital, at the time. I was just down and depressed. I didn't have anything constructive in my life to do and that's one of the main things that start me off. But the way I feel about it, it shouldn't have happened. I can't explain it. It's just horrible, the worst feeling going into hospital and to happen nine times is obviously something going on in my mind, and I'm too stubborn, and I know it's part of the illness. I keep fighting the system. That's why I keep relapsing, and I've relapsed nine times.

At the same time, a divided life prevented Andrew from realising his ultimate goals. Andrew stated that he had nine admissions, and we know from his biography that these admissions were all under Section 3 of the Act, except one that was under Section 2 and another which was informal. The admissions were of variable lengths, the longest being of six months.

3. Michelle Walton

Michelle's Lived Life

The team looking at Michelle's *lived life* comprised: Betty, a social worker/team leader who enjoys baking; Barry, a CPN who likes scuba diving; and David, a social worker who also enjoys scuba diving.

	Lived life	Hypotheses/Predictions
1957	Michelle was born to very privileged background with wealthy parents.	<ol style="list-style-type: none"> 1. She will be sent to boarding school. 2. High parental expectations will follow. 3. Parents will spoil her. 4. Will be isolated from peers in community. 5. Will be bullied by local children. 6. Upbringing will be different from other children. 7. She will have strict disciplinary parents. 8. Will be privileged in terms of travel and experiences.
	Family moved to Hertfordshire with father's job where she grew in a large Edwardian house with swimming pool and pony	<ol style="list-style-type: none"> 1. She would be everyone's friend. 2. She is a single child / or younger child. 3. She will have limited contact with father. 4. Move will have disrupted her social network – affect her confidence. 5. The family will lack affection for one another.
	Age 11 years Pony stolen but parents bought another one	<ol style="list-style-type: none"> 1. This was instant gratification – no time to grieve. 2. Pony was important to her. 3. Parents believed money can substitute affection. 4. Not seen as an individual by parents.
	Parents went away to Canada to visit their other daughter who was living there, leaving Michelle with her other two sisters and two brothers and were not around when Michelle took her 'A' levels.	<ol style="list-style-type: none"> 1. She would feel abandoned and unimportant. 2. Older siblings would be unable to look after her. 3. Parents will be unable to respond to her emotionally.
	Did well at school gaining 10 'O' levels	<ol style="list-style-type: none"> 1. A bright and intelligent child. 2. Not emotionally connected and had no friends.

Age 18 years		3. Growing up in context of women's lib – lots of social unrest.
	Went on to do 3 'A' levels	1. Travel abroad / Package holidays. 2. Gets involved in fashion and music. Refuse to go to university. 3. Follow track laid down by older siblings - fulfilling parental expectation by going to university.
	Went to Art college but really wanted to do music and drama, feels that she was pushed into Art. Nevertheless obtained Diploma in Art.	1. Michelle was following someone else's agenda and not her own. 2. She would miss out on having close friends and a social life. 3. She was probably hoping that university would change her life. 4. Was still living at home.
Age 19 years	Became depressed, took overdose	1. Feeling isolated. 2. Struggling with adult life. 3. Wanted the world to stop. 4. Wanted to be listened to.
	Attempted suicide by crashing her car following a nervous breakdown and going walkabouts in the area where she lived without anyone knowing where she was. Eventually she was found and admitted to psychiatric hospital for the first time for four months	1. She was feeling lost. 2. Recovering and feeling despair about the future. 3. She has got all this and still feels depressed. 4. She is stuck. developmentally and in social skills. 5. Can't talk about it, has to act out. 6. It's just Michelle being different again.
	Following her discharge from hospital Michelle worked with horses for awhile training to be a riding instructor. She however stopped her medication and became unwell again.	1. She will be stigmatised by family and others. 2. Will be blamed for breaking the family mould, bringing disruption and chaos into the family. 3. Will be thought of as a naughty girl. 4. Will be without family support therefore requiring professionals to take over.

1978		5. Will be more attached to horses than her family because she would get unconditional love from them.
	She recovered quickly and then worked for Butlins before going back to Art College for a year to do a Diploma in Art. After which she worked as a Youth Art Worker, part-time driver/messenger and temporary welfare assistant.	<ol style="list-style-type: none"> 1. University will not be an option for her. 2. She will find own goals in life. 3. She will become unwell and admitted to hospital. 4. She will struggle to find directions in her life because she is casting around for a role in life. 5. She will not be able to deal with stress of full-time work.
	Went on holiday with some friends. And on one particular occasion during the holiday thought she was Jesus and could walk across the water. She took all her clothes off and swam across a river and when she got to the other side of the river did a streak and was arrested and admitted to hospital.	<ol style="list-style-type: none"> 1. She lacks insight into her condition. 2. She was using drugs or she was delusional or manic. 3. Streaking was fashionable around that time. 4. Hospital was the only way of containing her.
	Age 22 years	<ol style="list-style-type: none"> 1. Diagnosed with manic depression. 2. Would refuse her medication because she enjoys being high. 3. More hospital admissions are going to follow.
	There was a period of stability during which time she met the man who would turn out to be her husband. They had a long engagement and were very much in love. Michelle wanted children; she wanted to get married and to have a house.	<ol style="list-style-type: none"> 1. She would become unwell again and the marriage would end. 2. Husband will be supportive. 3. She will be unable to have children.
1984	Dreams came through her parents bought her a house, she got married and became pregnant soon after, however she had to have an abortion	<ol style="list-style-type: none"> 1. Parents were still over-compensating and making life easy for her. Finances not a problem – supported by family with money.

	because she was on Lithium Carbonate at the time. It was considered by professionals that being on Lithium would harm the baby. This was devastating for her because she desperately wanted to have a baby. After the abortion she made the decision to slowly come off Lithium so that she could try for another baby. She ate all the right food to help her conceive and gave even up smoking.	<ol style="list-style-type: none"> 2. Will be angry with lack of medical advice – angry with doctors and others for her loss. 3. Losing the baby will cause marital problems.
1989	It was an especially joyous occasion when eventually she became pregnant for the second time and in 1989 gave birth to a son. That whole year was for Michelle a particularly happy time.	<ol style="list-style-type: none"> 1. She would become unwell again by having manic episodes. 2. She will not be able to cope with the baby. 3. The demands of family life will be too stressful for her. <p>One team member predicted this would be a turning point in her life and that she would not have any more manic episodes.</p>
	Her son had his christening when he was nine months old, on his father's birthday. Michelle's parents arranged a party to celebrate which she enjoyed, describing that time as the happiest of her life.	<ol style="list-style-type: none"> 1. She would not be able to cope with a growing child. 2. She would not meet emotional demands as she did not learn these as a child. 3. She will see parent's role from different angle. 4. Will move back nearer to her parents.
February 1997 to March 1997	Admission	<ol style="list-style-type: none"> 1. Things had gone wrong in her marriage. 2. Trying to cope with her eight year old son was too much for her. 3. More admission will follow this on. 4. She will take an overdose 5. She will do something outrageous.
March 1999 to May 1999	Admission	<ol style="list-style-type: none"> 1. Michelle would come to depend on hospital as a way of coping.

October 1999 to November 1999		<ol style="list-style-type: none"> 2. Home life would go bad and hospital would provide a refuge for her. 3. Things would be okay from here on in.
	Admission	<ol style="list-style-type: none"> 1. A pattern of admissions will unfold. 2. Medical team would find out that she was not mentally ill but was only using hospital as an escape from marital problems. 3. Her husband would leave her 4. She would try to take her life.
August 2000 to November 2000	Admission	<ol style="list-style-type: none"> 1. Because of her manic illness more admissions will follow. 2. Separation from her son will have a negative effect on her. 3. Her relationship with her son and husband will suffer.
December 2000 to November 2001	This time she was admitted for almost a year.	<ol style="list-style-type: none"> 1. This lengthy admission would result in break-up of her marriage. 2. She would lose custody of her son. 3. After leaving hospital she will go back to live with her parents. 4. She will stop taking her medication and be readmitted.
December 2001	Separated due to volatile marriage.	<ol style="list-style-type: none"> 1. She will feel rejected by important male in her life. 2. There would be no more admissions because her husband is not around to give her stress. 3. Other admissions will follow because she has not yet learnt how to manage stress.
February 2002	The marriage eventually ended through divorce. There had been a history of marital difficulties, partially due to her	<ol style="list-style-type: none"> 1. Will attempt suicide. 2. Will move back to live with her parents. 3. Will be readmitted to

March 2002	illness, and on a number of occasions these involved physical altercations	hospital and have another lengthy admission.
	Another admission happened after she presented herself to the ward with concerns that she had multiply physical problems including cancer and that she was pregnant.	<ol style="list-style-type: none"> 1. Her mental state will continue to deteriorate. 2. She will feel contained in hospital. 3. She would not recovery from her condition.
	Michelle now lives on her alone in a one bedroom flat and smokes 30 – 40 cigarettes a day. Her son who is 17 years old lives with her ex-husband and new partner.	<ol style="list-style-type: none"> 1. Michelle will find it difficult to form close meaning relationships. 2. She will find life unfulfilling. 3. Will be feel stuck, alone and isolated.

Table 11.0 Michelle's Lived Life

Michelle's *Told Story*

'Altogether really my life has been a bit of a mess.'

Setting up the interview

Michelle's name was put forward by her care coordinator as a suitable participant for the study. The care coordinator informed me that Michelle agreed to take part only because she thought I was a nice person (I had previously met Michelle on the hospital ward. I remember stopping to have what was a pleasant chat with her).

In setting up the interview, I contacted Michelle by phone to introduce myself and to explain the research in general terms. I then sent her a patient information leaflet to read and discuss with relevant others. I rang her again a week later to find out whether she was still interested in taking part. She said she was, and at that point a date and time for the interview were agreed upon.

Michelle preferred to be interviewed in her flat, which is situated at the front of a block of about four or five other flats, and is facing the road and not too far from the town centre. It was neat and tidy and tastefully decorated. We sat at opposite ends of a large mahogany dining table by the window overlooking the road, rather like royalty.

Michelle showed me some stunning photos of herself, taken many years ago. She was hardly recognisable from them because of aging and weight gain. She also showed me photos of her 18-year-old son, who is currently living with his father in another part of the country. On the walls of the flat hung pictures that she said she painted many years ago. Also in the room were small ornaments of various descriptions and a small bookcase stacked with books. She offered me a glass of lime juice, which I cordially accepted. She also made one for herself. Before beginning the interview she lit up a cigarette after asking me if I minded her smoking; of course, I had no objections.

For Michelle's *told story*, the team was made up of Jane, a CPN/team leader; Rob, a CPN who is also a drummer; Miranda, a social worker who has two grandsons; Esme, an OT who likes to cook; Hermione, whom I previously introduced as a professional assistant who enjoys pottery; and Katija, a support worker who introduced herself as single and never married.

In the opening lines of her story Michelle made it known that she had wealthy parents and was from a privileged background: ***'I came from a very privileged background; both my parents were quite wealthy'***. The team explored her reason for this declaration with much interest. They were interested to find out why she made this declaration. Perhaps things had changed, and she was no longer so wealthy. Or perhaps she was pointing out that because she was so wealthy she regarded herself as respectable and someone of whom notice should be taken. In some ways, she seemed to be like the main character Hyacinth Bucket (or should I say, Bouquet) in the BBC sitcom *Keeping Up Appearances* (1990 to 1995). Another reason was that she may have been checking out my social position and values, in which case she might have expected me to respond to her statement.

Other thoughts were to do with her being established financially, and her illness getting in the way of her social future. Perhaps this was the story she was preparing to tell. A team member wondered whether her social situation changed because of her parents' wealth. The same team member felt that her relationship with her parents was only monetary and that she was a spoilt child. Another team member thought that her parents had died and that she was experiencing a sense of loss.

Counter to all these hypotheses, someone hypothesised that this would turn out to be a delusional statement; that is, that she did not have wealthy parents.

In the next passage of text presented to the team, Michelle mentioned, '***I remember fighting a lot with my brothers and sisters, but all children do that (1). My mum was quite neurotic and a lot of the time. She couldn't cope***'.

The team pointed out that Michelle was now saying that even though she was from a wealthy family, life was pretty normal. Describing her mother as neurotic and not able to cope, was interpreted as her having a mother with whom she could not communicate, resulting in the family's living a chaotic and undisciplined life. They wondered where the father was in all this. One member of the team hypothesised that he was an absent father; that he might have been away in the Navy or was a businessman. At this stage, the team was unsure about whether the interviewee was male or female. Regardless, they wanted to know how many siblings there were and where Michelle fit in the family. One team member hypothesised that Michelle was setting up the story to talk about violence and aggression in the family because she mentioned that she used to fight with her brothers and sisters. The same team member pointed out that Michelle qualified this statement with '***but all children do that***', more or less to say it is acceptable to fight with siblings.

Indeed, Michelle's next revelation was about how she had been treated within the family: '***My dad was always working. He was a high flying business man. He used to get very aggressive (4). They weren't always nice to me, but I don't want to go into that***'. This statement confirmed the previous hypotheses about her father being a businessman. It also continued the early theme of aggression that seems to be threading its way through her story, indicating that there was tension and conflict between her and her parents. The team was curious to find out who '***they***' were, who was being aggressive, and the nature of the aggression. By saying that she did not want to go into that, was interpreted as 'I will tell you, but I'm just checking out whether it is safe to do so', a kind of narrative dance. Whatever she had to tell me, it seemed as though it was still emotionally painful for her. The team was unsure if this was a conscious or subconscious decision. In any case, they prepared themselves for some kind of revelation later. As expected, Michelle openly revealed the following:

We lived in a beautiful Edwardian house, had own swimming pool and own pony and very spoilt and very happy until I took my A levels.

The team hypothesised that she had a nervous breakdown during her 'A' levels and that this was probably due to trauma, bereavement or loss. They also felt that she was forced to grow up too quickly and that this may have caused her to have the nervous breakdown. They hypothesised that her parents may not have given her proper love or attention, which made her unhappy. They pondered on what happiness meant for her. Was it having lots of luxury and material things or feeling loved? Whatever it was, Michelle seemed to be forecasting a change in her situation which had contributed to her becoming unhappy. Indeed, she revealed later on that her parents went to visit one of her sisters in Canada. This was during Michelle's 'A' levels. The traumatic event that seemed to have taken place appeared to be their going away. It could have been that Michelle was left on her own for the first time and had to take responsibility for herself. She might have found dealing with day-to-day living difficult to cope with. Being a spoilt child, she may have found this even more difficult to do. At the time, Michelle was eighteen and had reached puberty, however, she appeared to have been experiencing psychological and related problems with growing up. Evidently, she was resistant to growing up:

I didn't want to grow up. I wanted to do music and drama when I left school. But I was pushed into art college, and I hated it, and I got very depressed. In fact, I got clinically depressed. Basically I had a nervous breakdown and was put into a hospital for three or four months, which I hated, and I kept trying to kill myself, trying to take overdoses. This was (name of hospital), and I hated it there. Then I got better, then I worked with horses for a while, training to be a riding instructor.

Independence probably came too quickly for her. Socially she may not have been adequately prepared with the skills or confidence necessary to cope with life. Her actions could also have something to do with learnt behaviour. She would have seen how her mother dealt with things (or not, as the case was) and would also have witnessed the behaviour of her sister, who suffered with depression, and her aunt, who had bipolar disorder. Also, she may have perceived her parents' going away to Canada at a crucial time in her life as rejection. Being made to take art, instead of

music and drama, seemed to have disastrous consequences. It was interesting that she chose to work with horses instead of pursuing her career in music. The factors behind this may have been that she was unable to concentrate due to the medication she was taking. It could also have been related to her relationship with horses as a child. It was something she loved doing and may have retreated to when things were not going so well. The team picked up on the fact that she was behaving rather like her mother, shunning responsibility as a consequence of not been able to cope with life.

Her first psychiatric hospitalisation was probably an unpleasant experience since, in the 1970s, confinement in mental hospitals was deemed inhuman and degrading (Jones 1993). It was no surprise that during this first admission she tried to kill herself several times by taking overdoses. Certainly, psychological suffering would have occurred as a consequence of being denied the comfort of her home environment. Rosenhan (1973) identifies the consequences of hospitalised patients as powerlessness, depersonalisation, segregation, mortification and self-labelling (p. 12).

Following her discharge from hospital, Michelle continued her work with horses for awhile, training to be a riding instructor; however, she stopped her medication and became unwell again. She quickly recovered, though, and worked for Butlins before going back to art college for a year to do a Diploma in Art. After this, she worked as a youth worker, part-time driver/messenger and temporary welfare assistant. This rather productive spell was, however, disrupted when she stopped taking her medication and became unwell again, as described in her next narrative passage. In the summer of 1978, she went on holiday with some friends and became unwell:

I was just crazy mad. I thought I could start a revolution, and I thought I was Jesus Christ. And I saw the water, and I thought I could walk across the water. So, I took all my clothes off, and I sunk, so I had to swim, and of course, it's a three mile distance across the river. How I did it I will never know. I was drowning. It was freezing (loud laugh). I couldn't help myself.

Narrative	Sub-plots and Interpretations
<p>I was just crazy mad. I thought I could start a revolution, and I thought I was Jesus Christ. And I saw the water, and I thought I could walk across the water. So, I took all my clothes off, and I sunk, so I had to swim, and of course, it's a three mile distance across the river. How I did it I will never know. I was drowning. It was freezing (loud laugh). I couldn't help myself.</p>	<p><u>Orientation</u> 'I was just crazy mad. I thought I could start a revolution, and I thought I was Jesus Christ. And I saw the water, and I thought I could walk across the water.</p> <p><i>Presentation of delusional beliefs.</i> These beliefs are grandiose in nature and could have come about as a result of stress. Michelle is understood by the team as having a lost sense of reality.</p> <p><u>Complicating Action</u> So, I took all my clothes off, and I sunk</p> <p>There is an immediate feeling of danger that she may drown after jumping in the river.</p> <p><u>Resolution</u> So I had to swim, and of course, it's a three mile distance across the river.</p> <p>Michelle engages in a massive attempt to preserve her life by swimming across the river.</p> <p><u>Evaluation</u> How I did it I will never know</p> <p>She is not sure how she did it but was glad she did.</p> <p><u>Coda</u> I couldn't help myself</p> <p>She uses humour to hide the seriousness of what happened.</p>

The team interpreted this narrative as Michelle's internalising of her situation. Her use of the personal pronoun 'I' was significant, as it meant she acknowledged that it was she who was behaving in that way. It also set up the plots of the narrative: Michelle's losing contact with herself by thinking that she was Jesus and could walk

across the water; Michelle's losing her self-consciousness by removing her clothes and streaking around; the intervention to protect her from further harm – being arrested and put in a cell. This whole narrative was interpreted by the team as Michelle's being a person who needed protecting when she lost the sense of who she was. When her sense of identity became confused, to the point where she believed she was somebody else and was in danger of doing harm to herself, professional intervention became necessary.

Before this happened, she had another admission. Sadly, during this admission Michelle alleged that she was raped by one of the nurses on the ward.

I don't know how he got away with it. It's such a cheek, isn't it, such a nerve. I was in the observation room (loud laugh), but it's not funny really. It was horrible, but I didn't dare tell anyone...After that, other admissions weren't too bad. Because after that I kept going high. It was different because I'm bipolar. I'm manic depressive.

The team was shocked by Michelle's disclosure and was certain that it would have unearthed some painful memories for her. Again Michelle used humour to hide what was viewed as another traumatic experience for her. Their perception was that she was probably feeling the emotions of shame and anger because of the fact that he was able to get away with the alleged incident. They concluded that she chose not to tell anyone, because she probably feared the consequences of not being believed. She might have held the belief that because she was perceived to have a mental illness it would be considered that her allegation was part of her illness. In any case, the 1970s were probably not a particularly patient-centred period in the history of mental illness (Griffin (1983), cited in Greenhalgh and Hurwitz (1998 p. 154).

The team made the point that this incident may have impacted her self-esteem and made her vulnerable to further incidents of exploitation as a result. Internalising her illness, with the statements such as '***I'm bipolar***' and '***I'm manic depressive***', suggest that she was now engulfed by her condition and a total loss of self/identity (Ralph & Corrigan 2005 p. 156). The social implication of this was that she was now labelled by the mental health system and likely to assume the role and identity of a mental patient (Ralph & Corrigan 2005 p. 152). The team conveyed a collective empathic response to what seemed to them to be a time in her life when her identity

took on the characteristics of a mental patient. Michelle mentioned that she took herself off the drugs, meaning medication: ***'I didn't like what they were doing to me. I didn't like the feeling they gave me. They were horrible. I was on Depixol and Largactil, horrible drugs. Don't know if you know them'***.

Michelle was now speaking from an expert position in terms of her medication and her condition (Watson 2003 p. 138). According to Foucault (1967), she was now being socially controlled by the mental health system.

Things seemed to be changing for her when, in 1984, her dreams came true. At the age of twenty-six, her parents bought her a house. She got married and became pregnant soon afterwards. Sadly though, she had to have an abortion because she was on lithium at the time. It was considered by professionals that being on lithium would harm the baby. This was a major disappointment for Michelle because she desperately wanted to have a baby. After the abortion she made the decision to slowly come off lithium so that she could try for another baby. She ate all the right foods to help her conceive and even gave up smoking for a while.

Michelle was asked about her parents: ***'Can't really say though because it's going to put my parents in the shit (10). It's a long time ago'***. The team believed that Michelle was playing games with me, the interviewer. They noticed that she made sure to get my attention for what she was about to say. They also thought she was trying to protect her parents; first, she announced that ***'it's going to put my parents in the shit'***, followed with ***'It's a long time ago'***, and then proceeded with the following narration:

They thought I was drunk, and I gate crashed a doctor's party at the (name of hospital). It was a BBQ. I took a flagon of cider. They thought I was drunk. My parents had to pick me up because they thought I was drunk.

I said "I'm not high, I'm not ill, I'm not high, I'm just drunk", and they believed me. But I was going high, but my parents had to give me a lift because I had to leave my car there, because I couldn't drive and be drunk obviously, and when I got in, my father tried to strangle me.

Narrative	Sub-plots and Interpretations
<p>They thought I was drunk, and I gate crashed a doctor's party at the (name of hospital). It was a BBQ. I took a flagon of cider. They thought I was drunk. My parents had to pick me up because they thought I was drunk.</p>	<p><u>Orientation</u></p> <p>They thought I was drunk, and I gate crashed a doctor's party at the (name of hospital)</p>
<p>I said I'm not high, I'm not ill, I'm not high, I'm just drunk, and they believed me. But I was going high, but my parents had to give me a lift because I had to leave my car there, because I couldn't drive and be drunk obviously, and when I got in, my father tried to strangle me.</p>	<p>Gate crashed a doctor's party. Irresponsible behaviour</p> <p><u>Complicating Action</u></p> <p>They thought I was drunk.</p> <p>Confusion over whether she is drunk or manic. Michelle can't be trusted.</p>
	<p><u>Resolution</u></p> <p>My parents had to pick me up because they thought I was drunk.</p> <p>Parents had to pick her up and take her home.</p>
	<p><u>Evaluation</u></p> <p>When I got in, my father tried to strangle me. It was really frightening.</p>

The narration continues with the following:

And my mother and father poured cold tap water all over me to try and sober me up. It was really frightening, and my father tried to choke me... and I ran away. I ended up in a home for the homeless called (name of home). Do you remember (name of home)? It was horrible, a very horrid place (3), but I refused to go into hospital. You see, I get like that. I can be real awkward (loud laugh).

Narrative	Sub-plots and Interpretations
<p>And my mother and father poured cold tap water all over me to try and sober me up. It was really frightening, and my father tried to choke me...and I ran away. I ended up in a home for the homeless called (name of home). Do you remember (name of home)? It was horrible, a very horrid place (3), but I refused to go into hospital. You see, I get like that. I can be real awkward (loud laugh).</p>	<p><u>Orientation</u> And my mother and father poured cold tap water all over me to try and sober me up.</p> <p>Parents try to sober her up from drunken state.</p> <p><u>Complicating Action</u> My father tried to choke me.</p> <p>It could be that Michelle had been defiant, leading to problems with her father.</p> <p><u>Resolution</u> I ran away. I ended up in a home for the homeless called (name of home).</p> <p><u>Evaluation</u> The place was horrible but better than going into hospital.</p> <p><u>Coda</u> I can be awkward at times (loud laugh).</p>

The team felt that the plot of Michelle's narrative illustrated her behaviour as awkward and irresponsible. The point as to whether she was drunk or mentally unwell also illustrated her lack of self-awareness or, put another way, her disinhibition.

Well, the Doctor came round (1). They called an ambulance. I went absolutely crazy and screaming. I started screaming. I told him that my father had tried to strangle me. He thought I was making it up or hallucinating or something. He didn't believe me (laugh). My father really did try to strangle me!

Narrative	Sub-plots and Interpretations
<p>'Well, the Doctor came round (1). They called an ambulance. I went absolutely crazy and screaming. I started screaming. I told him that my father had tried to strangle me. He thought I was making it up or hallucinating or something. He didn't believe me (laugh). My father really did try to strangle me'!</p> <p>'The ambulance took me to the hospital, and I managed to con the psychiatrist that I was ok – I'm quite an actress – then went up the (name of home) the home for homeless (2). Then after that my father felt so sorry for me for what he had done and everything he bought me a house in Devon. I was very happy in it for a while (2)'.</p>	<p><u>Orientation</u></p> <p>The Doctor came round (1). They called an ambulance.</p> <p>Assessment team visited and requested an ambulance to take her to hospital.</p> <p><u>Complicating Action</u></p> <p>I started screaming. I told him that my father had tried to strangle me. He thought I was making it up or hallucinating or something. He didn't believe me (laugh).</p> <p>The ambulance took me to the hospital, and</p> <p><u>Resolution</u></p> <p>I managed to con the psychiatrist that I was ok – I'm quite an actress – then went up the (name of home) the home for homeless (2)</p> <p><u>Evaluation</u></p> <p>My dad felt sorry for me and brought me a house in Devon. I was able to get a house out of behaving badly.</p> <p><u>Coda</u></p> <p>I was very happy in it for a while (2).</p>

The team concluded from this narrative that Michelle was being assessed under the Mental Health Act 1983. They inferred that '*they*' must have been the assessing team and not Michelle's parents. The team was empathic towards Michelle's situation of not being believed. They noted Michelle's use of laughter to hide negative emotions. It could have been that her parents were abusing her and that she had to run away

from them for her own safety. The team also commented on the fact that this narrative was a continuation of negative and violent themes in Michelle's story.

The ambulance took me to the hospital, and I managed to con the psychiatrist that I was ok – I'm quite an actress – then went up the (name of home) the home for homeless. (2) Then after that my father felt so sorry for me for what he had done and everything he bought me a house in Devon. I was very happy in it for a while (2).

It occurred to the team that Michelle might have now, because of her frequent and repeated admissions to hospital, learnt how to behave in order to convince doctors and other mental health professionals that she had recovered from her 'illness episode'. A phrase that is commonly used in the mental health field is 'manipulation of the system'. Rosenhan's (1973) famous experiment illustrates this point. Briefly, pseudo-patients feigned hearing voices and features of bipolar disorder in order to be admitted to a mental hospital. The aim of the experiment was to show that it is difficult to distinguish the sane from the insane in psychiatric hospitals.

This aside, the team interpreted her parents' buying a house for her as a way of getting her out of the way. Perhaps they regarded her as an embarrassment to the family and so believed that the further away she was, the better. Michelle's own evaluation of her parents' action was that they must have felt guilty about trying to get her admitted to hospital. Because having a house was one of the things she wanted, she was at least happy in it for awhile.

She became seriously unwell again when she was twenty-two years old and was diagnosed as having a bipolar disorder and put on lithium medication. A period of stability ensued during which time she met the man who would later become her husband. They had a long engagement and were very much in love. She wanted children; she wanted to get married and to have a house.

After moving to Devon, she met her husband in 1984. Socially she was now able to claim the identity of a married woman, but this was not all she wanted to make her life complete and fulfilling. She dreamt also of having a baby. Having had to have an abortion, she was left devastated, but her determination to have a baby was too strong to let go. The next narrative passage illustrates her forward-looking story:

I really wanted a baby, and that is why he is so beautiful. I really worked hard for him; did all the right things, ate yoghurt and fish and milk. I stopped smoking, and I tried so hard for him. I really desperately wanted a baby. When you have lost one, it makes you want one more. He really is beautiful. He is stunning. He was nine months old when he was christened, and it was Jack's birthday, and my mum threw a party, and I was so happy.

The team admired her careful planning and determination. They saw this as strength of character which could have contributed to her having a renewed sense of identity as a mother, wife and homemaker. Sadly, when all she seemed to have wanted had been achieved, there came a shattering blow to remind her of her past. This time it was in the form of domestic violence.

He hit me and kept hitting me. In fact, he beat me up, so I was admitted to hospital to keep him away from me. I nearly prosecuted him, but I didn't and nearly got a divorce.

In this passage of text, the team returned to the violent themes of earlier. It also portrayed Michelle as a vulnerable person who, in spite of her husband's behaviour towards her, was still prepared to stay with him. The team saw this as typical of abused women. In this type of situation, the victim blames himself or herself for what is happening. Michelle stated that she nearly prosecuted him and nearly got a divorce. What happened in the end was Michelle's being admitted to psychiatric hospital to keep her husband away from her. The team wondered whether she had to pretend to be mentally ill or whether the hospital was just there as a refuge for her. In the next passage of text presented to the team, Michelle gave an account of other experiences of being abused. At first she stated, '***Uhm, well I don't really want to go into it. It's a bit personal (4)***' (a four-second pause followed), then she said, '***I've been abused a lot really by other people, when I'm on a high. People can't understand why I'm like that, and they take it out on me, but I can't help going high. It's something I've got inside of me.***

For the team, this statement seemed to sum up Michelle's psychological state. The team interpreted this as Michelle's being misunderstood. Perhaps she gave the wrong signals to others when she was unwell, which invited them to take advantage of her. What the team found most interesting, however, was Michelle's ownership of

her behaviour. The team believed that she was actually saying 'I can't help the way I am'. Sartre (1956) refers to this notion as 'bad faith'. Essentially what this means is that Michelle was running away from her responsibilities. Another way to understand this is that Michelle was vulnerable to abuse because of her poor self esteem.

In the interview itself, I was interested in finding out more about what happened between her and her parents, to learn whether they had any relevance to her hospital admissions, so I asked the narratively pointed question, 'Can you tell me what happened?' She responded, '**Well, they end up hitting me or hurting me, which I think is wrong. They shouldn't do that**'.

Without thinking I asked, 'Who hit you?' in a protective tone, but afterward realised that I may have disrupted the *gestalt* of her story by introducing my own need to find out who did the hitting. Interestingly, the team interpreted this as an emotional response which came about from being a social worker concerned about the welfare of vulnerable people. Their view was that I was trying to show Michelle I cared about her. In any case, Michelle responded to my question, stating after a short pause:

(4) My parents and my husband have done that. I think it's totally wrong. They shouldn't do that. They don't understand me (3). They see it as Michelle going high and Michelle can't help it and Michelle is ill. They see it as Michelle as being naughty, that she is not behaving herself (2).

The team picked up on Michelle's use of the words 'naughty' and 'not behaving herself' and associated them with language children would use. This was interpreted as meaning Michelle was still the little girl who does not want to grow up. Perhaps her parents reinforced this childlike behaviour by providing for her every need. Whatever the case may have been, the team saw her very much as a juvenile. A little later on in the interview, Michelle spoke about the fact that she had not '**gone high**' for two and a half years. This signified to her that she did not have any admissions during this time.

But I haven't gone high or low for two and a half years now, so touch wood I'm doing alright. Maybe it's the end of the illness. Hopefully, whilst I keep taking

my medication. The medication does help (2). I'm not pooh poohing the medication.

The team wondered whether Michelle was trying to convince herself that medication was really the answer to her problems. By announcing that she was not '***pooh poohing the medication***', she signalled to the team that she was probably not convinced it would help keep her out of hospital. She continued by saying:

(3) I suppose when you go into hospital they put you on medication don't they? So therefore it is a help, isn't it? It's a way of controlling the illness (3). Otherwise I don't know where I would be (8).

The team took this to confirm their earlier suspicion that she was not totally convinced about medication. At this point, she tried to draw me in by asking for reassurance in response to her question about whether medication helps. The team sensed certain desperation in her language and wondered what this meant.

I used to like horse riding, cycling, swimming and that sort of thing, but I won't do it because I'm so big (loud laugh). I get comments all the time from people (3). They are so rude, especially men. Men are really rude to me "You ought to go on a diet love!" (loud laugh) (2) I've been on a diet!

In this passage of text Michelle reflected on her life, remembering the activities she once enjoyed. She was able to compare life now to what it was then. Inferences were drawn from the text that suggested that Michelle regarded herself as unattractive and to compound matters was lonely and sad. This was a complete reversal from the time of her youth. The team noticed the use of humour popping up again to cover what they interpreted as shame and embarrassment.

Michelle then spoke about her marriage:

My marriage? Well, basically he took me for a ride, because I had inherited some money. He got me to buy a car, house and business. Ok, I was going to benefit from these things, but he walked off with another woman.

The team interpreted this text as Michelle's feeling hurt by her husband's actions. It could be that she was trying to come to terms with the pain of losing everything she

regarded as important in her life, and her husband's leaving her for another woman. Michelle, in the next passage of text, explained:

He has married her (4). Imagine how I feel (2). I couldn't help being ill (2). I thought marriage was meant to be in health (2). What's the saying, in sickness and in health? But I thought marriage was in sickness in health, but he divorced me anyway. He found someone else, very hurtful.

Michelle mentioned again that she could not help being ill. This self-limiting theme throughout her story made the team come up with the view that this belief might relate back to memories of her childhood and her mother's not being able to cope with bringing up a family.

I feel a bit bitter, but I am determined to enjoy my life even though I have got this horrible illness, and I kept having to go in and out of hospital. But I am determined to enjoy, and I am determined to keep out of there too.

Michelle's attitude seemed to indicate to the team that she still had the hope of living an enjoyable life. She was optimistic about her future but realised that to be happy means keeping out of hospital. The team hypothesised that this was only likely to be possible in the absence of stress in her life. So far Michelle had suffered major, stressful life events, for example, moving home, an abortion and then getting a divorce. Indeed, her recurrent hospital admissions seemed to have been associated with these stressful events.

I think as long as I keep taking my medication and doing things properly I won't have to go in there again, at least I hope not, unless there is another crisis in my life.

The team interpreted this passage as meaning that Michelle attributed hospital admissions to crises in her life. In this regard, the team felt that she was manipulating the system. She seemed to regard hospital as a place to go to deal with difficult issues in her life. She placed her trust in medication, but this to her was no guarantee that she would remain well. In the next passage of text, she was philosophical about life in general, stating, '***Life is what you make of it, isn't it?***' By tagging the question at the end, she suggested to the team that she was not entirely convinced by her statement. It could be that she was trying to be positive, but the team saw this as her

being very broken and dispirited. Her narrative tone in this passage conveyed sadness, which continued in the theme of resignation when she said, '**I have definitely changed. I'm much more placid. I accept things more. I accept what happens to me**'.

In the next passage of text, there was an uplifting time to her story, a cause for jubilation, when she announced, '**I've been well for two and a half years, and I have been taking my medication to the book. I've got into a routine now; I treat myself as if I was in (name of hospital). I've got exactly the same routine as they gave me in (name of hospital). I take my tablets dead on time, and I have regular blood test**'. Counter to this jubilation, however, the team felt that Michelle was now institutionalised, even though she was no longer in hospital. They wondered whether she was on the road to recovery and whether or not there would be any more admissions.

Michelle then went on a reflective journey, beginning with her parents:

My parents have been wonderful, but have been upset by it all. Couldn't have more supportive parents (3). I bet they get a bit fed up with me. I try not to pester them too much; they seem to want to help (3). They want to help. They still think it's their fault, but it's not their fault at all. It's just something I've got, can't help it. I rebelled against them when I was young, but most teenagers do (3).

This passage of text was interpreted by the team as Michelle's feeling guilty for her rebellious adolescent years. She was defensive of her parents, attributing the difficulties they had to deal with as having more to do with her illness than anything else. Perhaps she felt that she did not have the ability to predict or control the onset of her condition. She was also defensive of her own behaviour when she repeated the phrase '**but all teenagers do**'. This seemed to signify to the team that Michelle was unable to move beyond the belief because she had internalised her condition as something that was inside of her. This seemed to suggest that she was not responsible for her behaviour because she considered it something she had no control over.

She confessed in the next passage of text:

I wanted to leave home, kept running away. Wasn't the right way to go about it was it? I wanted to go on stage (5). Altogether really my life has been a bit of a mess (4). Nothing I can do about. It's all past now anyway. Can't change the past can you?

The team read from this that she regretted wanting to leave home, as she now believed that she may have gone about things the wrong way, viewing her life as a bit of a mess. It could have been that at the time she was full of life and had a strong belief in herself; who she was and what she wanted to be. This was one of the 'I want' phenomena that popped up at the beginning and now reflectively towards the end of her story. Realising that her dream of going on the stage was not going to happen, was seen by the team as her being just as disillusioned about never having to go back into hospital.

Sometimes I'm joggling along all right, and I think I'm doing fine, then I think I'm not going to be ill again. I've combated this illness. I'll keep taking my medication. I'm not going to be ill again. Then something happens, and it comes back. It's quite frightening, it really is. It's horrible!

The team viewed this narrative piece as conveying the feeling that she was resigned to the fact that she will always be unwell and have the need to take medication. Furthermore, living with bipolar disorder is a constant battle in which hospital admissions cannot be prevented. This second session was brought to an end by Michelle's coughing fit. On reflection, it would seem that my next question to Michelle may have been prompted by her coughing fit. Not wanting to see her suffer, I may have inadvertently helped her to bring the interview to a premature end by asking her a closed question.

Can you think of anything more you want to talk about?

Nothing I can think of (coughing excessively), except I wanted to do music and drama, and I wanted to be a star, that's all.

Well, you've been a star today, thank you.

4. Keith Edwards

Keith's *Lived Life*

The team looking at Keith's *lived Life* was made up of CMHT professionals: Miroslav, a psychologist who lived in New Zealand for seven years; Mike, a social worker who likes taking his dog for a walk; and Dr Bowers, a psychiatrist who is married with a young child.

	Event	Hypotheses/Predictions
Born 1974	Keith is the eldest of three brothers from a family of five.	<ol style="list-style-type: none"> 1. He lives in council house. 2. Will be into Punk music / drugs. 3. Parents have separated. 4. He was from Irish Catholic background. 5. An unwanted child. 6. Will have high expectations as an older male.
	Parents were both teachers when Keith was growing up.	<ol style="list-style-type: none"> 1. Home environment might be more stable. 2. He lives in a leafy suburb. 3. He will rebel against parents. 4. Will have loving parents.
	Mother is Dutch and taught French and German. Father taught English	<ol style="list-style-type: none"> 1. His mother will be an authoritarian. 2. His mother will be emotionally unavailable. 3. He was a post-war baby. 4. He will have strong academic expectations.
July 1992	Left School with A-Levels with Place at Queens' College, Cambridge to study mathematics	<ol style="list-style-type: none"> 1. Will be diagnosed as having Schizoid / damaged personality. 2. Will have 'Geeky' tendencies. 3. Will have poor interpersonal relationships.
Sept 1992 – March 1993	Taught English in a mission school in Calcutta. Often quite depressed, feeling very isolated and lonely	<ol style="list-style-type: none"> 1. He would come back filled with religious interests. 2. Will feel rejected by society. 3. This will be onset of schizophrenia. 4. He underwent some religious conversion. 5. This was a GAP year.

April 1993	Interview at Queens' to change onto a natural science degree, thinking of specialising in genetics in third year	<ol style="list-style-type: none"> 1. He was becoming grandiose in his thoughts. 2. He was becoming manic. 3. They also wondered about his interpersonal relations. 4. He wanted to be amongst the elite at Queens. 5. Realised – DNA – leaders were at Cambridge. 6. Wanted to emulate leaders.
August – Sept 1993	Worked as a play-leader on mobile play-scheme. Had an intense relationship with fellow play-leader, lots of mad socialising	<ol style="list-style-type: none"> 1. He had found sex for the first time. 2. He was not sure of his sexuality. 3. He will become involved with drugs. 4. He would fall in love.
October 1993	Started physics, physiology, cell biology and maths at Cambridge. Came into contact with medics whose subjects seemed more interesting. Left Queens after four weeks	<ol style="list-style-type: none"> 1. He will be diagnosed as suffering with bi-polar disorder. 2. He will find studying too difficult. 3. He won't return to university.
Nov – Dec 1993	Attempted to sell encyclopaedias but failed.	<ol style="list-style-type: none"> 1. He made poor work choices. 2. That he was grandiose. 3. He was in financial difficulties and desperate for money.
Jan – May 1994	Paid off debts to parents by working in a local hotel	<ol style="list-style-type: none"> 1. He was working below his capacity. 2. He will be sectioned under the Mental Health Act 1983. 3. He will find it difficult to make friends. 4. He will become unwell and lose his job.
May – Sept 1994	Worked as a waiter in beach hotel in Greece. Came back extremely energetic, hyperactive	<ol style="list-style-type: none"> 1. He will end up homeless – sleeping rough. 2. Will self-medicate with drugs. 3. Will be impulsive – not able to stick at anything. 4. He will be less socially isolated in Greece.
Sept 1994	Started medicine degree in Edinburgh	<ol style="list-style-type: none"> 1. Will hold it together. 2. Earns money in summer for this. 3. Will drop out of university. 4. Will change his mind again

		about what he wants to do.
Sept 1994 – May 1995	First year medicine in Edinburgh (anatomy, physiology, biochemistry)	<ol style="list-style-type: none"> 1. Completes academic year at prestigious university. 2. Becomes manic again. 3. Will become more confident in making choices.
June 1995	Admitted to psychiatric hospital in very elevated state, claiming to be the Second Coming and denouncing free will	<ol style="list-style-type: none"> 1. First year finals will precipitate admission. 2. Will be diagnosed with bi-polar. 3. Will not return to university. 4. Parents will be frustrated. 5. Maybe judgemental. 6. Other siblings – similarly high achievers / expectations.
June – August 1995	Various manic capers, ending in hospitalisation	<ol style="list-style-type: none"> 1. Chaotic / irresponsible. 2. Self medicating. 3. Will move back home.
August 1995	Sat exams, failed biochemistry. Had to re-sit the summer term of first year	<ol style="list-style-type: none"> 1. On the road to recovery – retained some functioning. 2. Will become more settled with girl-friend. 3. More fulfilled on holiday. 4. Will become more relaxed.
Feb 1996	Went to Essex to do voluntary work in a home for disabled people. Fell in love with a Polish woman	<ol style="list-style-type: none"> 1. Will be more settled and relaxed. 2. Will break off relationship with Polish girl. 3. Girl-friend will be of equal intelligence. 4. Will become manic again.
April 1996 – June 1997	Very successful completion of first year of university, summer with girlfriend in France, happy second year of medicine	<ol style="list-style-type: none"> 1. Life no longer chaotic. 2. Has fully recovered from illness. 3. Will become unwell again and readmitted. 4. Will be unable to maintain relationship.
Christmas 1997	Got engaged to Polish girlfriend	<ol style="list-style-type: none"> 1. Will not finish degree. 2. Finishes degree. 3. Ends relationship. 4. Becomes manic.
June 1997	Called off engagement, started going out with woman in Edinburgh	<ol style="list-style-type: none"> 1. Is manic again. 2. Gains insight and is compliant with medication. 3. New girl-friend will not be able to cope with behaviour. 4. Girl-friend will end

Summer 1998	Met another woman on medicine course	relationship. 1. Will spend a longer period at university than planned. 2. Accumulates lots of debts. 3. Becomes depressed. 4. Readmitted.
Oct 1997	Abandoned medicine and changed to maths – straight into second year	1. Searching for meaning, does not know what he really wants. 2. Long history with mental health services. 3. Will have a good second year. 4. Will drop out of university.
Oct 1997 – June 1998	Very happy, successful year of maths, great relationship	1. Family not very supportive. 2. Parents unable to understand what has happened. 3. Will be readmitted. 4. Parents fear for other siblings that they may become unwell.
Oct 1998 – June 1999	Third year of maths and statistics, a few admissions to psychiatric hospital, but still comfortably passed exams	1. Will try to find work. 2. Will want to go further academically. 3. Will meet another girl. 4. Will be admitted again.
Oct 1999 – June 2000	Fourth year of degree. Seven admissions to psychiatric hospital prevented him from completing the year. Split up with girlfriend at end of year	1. Family not very supportive. 2. Parents unable to understand what has happened. 3. Will continue to get involve with women. 4. Will do the year again. 5. Parents fear for other siblings that they may become unwell. 6. Drops out of university.
Oct 2000 – June 2001	Re-sat fourth year (straight maths). Hospitalized at Easter 2001 but finally finished degree. Met Scottish girlfriend just before Easter	1. Determination will see him through. 2. Depressive period will follow. 3. Functions academically when manic. 4. Relationship with Scottish girl will end just like the others he had before.
Sept 2001 – Sept 2002:	Masters in Environmental Biology in St Andrews, living with girlfriend	1. Will have a more stable relationship following success with Masters. 2. Masters is not enough will go on to do his PhD. 3. Marries girl-friend. 4. Relationship with girl-friend ends.

Easter 2002	Choir tour to Frankfurt, went high and ran away from choir having left a note saying he was heading for his birth-place in Zambia.	<ol style="list-style-type: none"> 1. Having a manic episode. 2. Hospitalisation will follow. 3. Will be picked up by the police. 4. Leaves the country. 5. Found and sectioned under the Mental Health Act 1983.
July 2002	Final hospitalisation after manic episode in Liverpool. Splits up with girlfriend.	<ol style="list-style-type: none"> 1. He would have further admissions. 2. He would go on to do further studies. 3. Gets back with his girl-friend. 4. Meets new girl.
May 2003	PhD in Statistics at the University of Nottingham.	<ol style="list-style-type: none"> 1. This would be a turning point in his life. 2. His life would stabilise. because he would no longer be under any pressure from his parents to do well. 3. Mania actually helped him academically.

Table 12.0 Keith's Lived Life

Keith Edwards' *Told Story*

'I regard all my experiences as being positive.'

Setting up the interview

This interview took place on 7 January 2007 in Nottingham. My social work colleague put forward Keith Edwards' name as a potential participant because she felt he had an interesting story to tell. She had known him personally for many years and had been eye-witness to many of the events in his life. She offered to speak with him about my research study and get back to me about whether or not he would like to take part. True to her word, she came back to me after two weeks and gave me the good news that he was very interested in taking part in the study.

Having been told this, I rang him straight away to introduce myself and to talk briefly about the research. Following our conversation, I posted a copy of the Patient Information Leaflet to him to read and discuss with others if he so wished. I allowed two weeks for him to do this. After the two weeks were up, I nervously made the call. What I had been told about his life by my social work colleague made me so

interested in interviewing him that if he had said no, I would have felt that an opportunity to hear a great story would have been missed.

You can imagine my excitement when I heard his pleasant sounding voice in my telephone say, 'Yes, I would be very happy to take part'. In fear of his changing his mind, I speedily made arrangements to do the interview, which we agreed would be in four weeks' time. Being the courteous person he was described to be, he even apologised for not being able to meet me earlier. He explained that he was in the process of writing up his own PhD thesis.

The team that looked at Keith's *told story* consisted of Jane, who was also a member of the team for Michelle's *told story*; Pat, a social worker who likes going for walks; Barry, already mentioned as a member of the team who looked at Michelle's *lived life*; and Hermione, who was also involved in Michelle's *told story*.

Keith, thank you very much, for your willingness to be interviewed. I would like you to tell me the story of your life. Take as much time as you like. I won't interrupt you, but I will be taking notes. When you have finished, we will take a break for about 15 – 20 minutes, and when we resume, I will be asking you a few more questions based on the notes I have taken and what you have told me.

Ok, right. Well, I finished school in 1992, and I had a very very successful time at school in terms of academic achievement, and generally I had a very well rounded life at school.

For the team, beginning his story at the point of finishing school signified accomplishment. It showed Keith as a person with high self-esteem and highly motivated towards achieving academically. Other interpretations were that he was cold in his approach and that he was pushed into doing well, probably by his parents. The team hypothesised that he would go downhill from here or follow this success with other successes. Being the person that he was perceived to be, it is possible that Keith was offering a context for the subsequent narrative.

So, I played a lot of music, piano, clarinet, saxophone and viola. I was part of the rugby team. I did karate, uhm, and then I was part of the venture scouts and all sorts of things, so I had a very busy and active life as a school child and

ended school with 6 A's. Very successful academic record and things seemed to be set for a very successful life after that.

With the information presented so far, the team perceived Keith as a dynamic person, full of life and academically astute. At the same time, he seemed self-centred. The team hypothesised that he may have gone to boarding school. The psychiatrist in the team diagnosed him as being manic.

In the next passage of text Keith said: ***'Immediately after leaving school I went to India for six months. I spent six months working in a mission in Calcutta teaching English, and that was a very difficult time for me'.***

This statement got the team hypothesising that he was preparing to tell a big story. They wondered whether he became unwell in India. Perhaps things became too much for him. Because he was doing lots of activities, the team concluded along with the psychiatrist that he must have suffered a manic episode there.

Keith continued his story with the following narration:

When I left school I had a place at Cambridge to study maths, but during my time in India I thought about it and thought, "Well, I'm not sure maths is not quite the right subject for me", and I ended up changing to natural sciences.

The team regarded his going to India as an attempt to 'find himself' or to do good works. They wondered what had led to his changing direction. Was it because of a manic episode or an experience he had had in India? In all of this, the team perceived him as a strange, lonely person whose educational accolade was going to Cambridge University. They wondered whether the fact that he wanted to do maths – which they regarded as a cold subject – was in any way symbolic of his character, which they also perceived as cold.

I started the degree in Cambridge in October 1993 doing natural sciences. I was doing physics, cell biology, erm, maths and physiology, so it was quite an even split between physical and biological sciences. I was quite undecided really about what I wanted to do there, erm, then I left Cambridge after four weeks.

The team was unsure about what was going on in his head at this time. They saw him as confused and chaotic in his thinking. His leaving Cambridge after only four

weeks raised a question for the team about whether this was the beginning of a downhill spiral. He mentioned no supportive network from either parents or friends, which again led the team to conclude that he was a lonely person. Later on, however, he spoke, for the first time, of a relationship he had had with another person:

There was a girl whom I started going out with during that time...I was still going out with her when I attempted to start the degree in Cambridge, but then because of trouble that came up with that relationship that was a contributing factor I think as to why I left Cambridge so early. So, I left Cambridge in a sort of flurry of activity and just came back home to my parents, erm, for a bit. And then started reconsidering and thought "Where do I really want to go, what do I want to do with myself?" and settled on medicine.

The team wondered whether he was influenced by his girlfriend to change direction. They also hypothesised that she might have found out that he had a mental illness and left him. They all agreed that he sounded manic and predicted that a period of feeling low would follow his mania (this is usually how the features of bipolar polar disorder manifest themselves). At this point in his life, the team felt that his life was very much up in the air. They speculated about whether there was parental pressure to succeed, and he was finding it all too difficult. In the next narrative passage, the educational theme continued. The earlier hypothesis of being manic was also confirmed.

I started at Edinburgh in a very high state, quite an elevated frame of, erm, mind, but it was wonderful. I really loved it, full of excitement, a wonderful city. I was meeting a lot of exciting people. I was enjoying the medical aspect of things. I got through to the end of May, erm, and that was really when the trouble started. I was giving away money and talking as though everything was on its own journey, and you couldn't really implement anything, so I was in a very strange state of mind, and I ended up in hospital on 1 June 1995. That was my first visit to hospital... I gave away everything that I had. I left all of my possessions in front of charity shops in big bin bags including my shoes. I just had two pairs of trousers and two tee shirts, and I owned nothing else in the world.

For the team his revelation was anticipated and did not come as a surprise to them. They wondered about the psychological impact of the admission and how his studies might have been affected. A hypothesis was that another hospital admission would inevitably follow this one. In the next passage, this hypothesis was confirmed.

I had some time in a hospital in (name of town) as well in a psychiatrist hospital in (name of town), so I missed my exams in the summer. I had to resit my exams in September time, and I failed biochemistry. I only failed biochemistry. I passed anatomy, passed physiology but failed biochemistry, so I had to have two terms away from university.

Following this disastrous start to his first year at University, he became involved in religion heavily. Amongst other books he was reading *A Course in Miracles*.

I thought, "Right, let's just sit down and read them", so I did. I pretty much literally did that. I reckoned that I probably sat and read continuously for about sixty hours. So from Saturday right through to Monday or Tuesday or whenever it was and, er, it was a very interesting and fascinating time. I was reading lots of ideas, and I could feel these ideas just growing and building in my mind, and there was this big sort of crystal structure of ideas that I was constructing, and the more I read the faster I was able to read, and things were getting faster and faster, and it was a very exhilarating time of trying to assimilate different things and, er, coming to my own conclusions about who Jesus was, and I learnt a lot of other stuff along the way as well.

The team picked up on the fact that a new theme of religious ideas was developing here. They saw involvement in religion as evidence of his constructing a reality that was not aligned to others around him. At this stage, the team had no doubt that Keith was very much unwell. Despite his having a period of time in a psychiatric hospital, they still perceived him as being unwell and lonely. Themes of religion and of his forming relationships continued in the next two passages.

I read somewhere, don't quite remember the line, suggested to me that I was Jesus, so I concluded as a result of all this reading that, oh yeah, I do understand who Jesus is. I'm Jesus (laughs). So this was the mentality that I was carrying with me after this big process of reading all these books. And,

erm, there was a funny story really that came up in February 1996 which was that I went down to (name of county) to do voluntary work in a home for disabled people, and I met a Polish woman there and fell in love with a Polish woman there. Her name was Magdalena Maria, and so as I was in this sort of “I’m Christ” kind of mentality I felt that this was my Mary of Magdalene.

The team speculated that he must have eventually completed the first year of his medicine course, which they regarded as a great achievement given the turmoil that he was experiencing.

And then, I suppose the trouble started again in 1997. It was the summer term of my second year of medicine course, so after I had resat the first year and, erm, I started to see quite a lot of a woman in Edinburgh. Her name was May. In that, that summer in 1997 or something, we had a holiday to Barcelona together. This holiday in Barcelona was a disaster really. May was depressed for reasons that were a little bit difficult to understand, but May was depressed and didn’t really want to spend much time much time with me in Barcelona, so we sort of spent a lot of the time on our own, which seemed a bit weird having gone to Barcelona on holiday together. And we came back to Britain after that holiday, May went back up to Edinburgh, and I went to stay with my parents for a week or so before I was due to go back to Edinburgh to start the third year of the degree.

The team felt that while he was ambitious academically, he lacked emotion and sensitivity towards women. They believed that he must have still been manic when he went on holiday and that this was counter to his beliefs about his girlfriend who was on the trip with him, whom he described as being depressed.

So during the time I was at my parent’s house I was in a very strange state of mind. In some ways I withdrew from the world. I was not really interacting normally with people, and I had a time when I stopped believing in other people. I stopped believing that other people existed, which is a philosophical idea which is called solipsism, so this solipsistic universe where there was only me who existed. I was really living that, and also I was reading a book called A Course in Miracles, which is a very dense spiritual text about obtaining Christ in consciousness, and there was a moment in the book when

they talked about something called the “golden instant” or something like that... And, er, I decided that I would try and go through the pain barrier and try and discover connection with God on the other side of that pain barrier, and my brother has been on a fire walk. He had walked on fire and had not burnt his feet at all, and found that a very spiritual experience. And I decided to put my hands into boiling water as a way to go through the pain barrier and obtain this connection with God...So I boiled up the kettle and boiled the water and put the water in the sink and put my hands in the water for about six seconds or something, and then I withdrew them. And I was so angry with myself for not having gone through the pain barrier that I didn’t put them under cold water, and they blistered very very badly.

Narrative	Sub-plots and Interpretations
<p>So I boiled up the kettle and boiled the water and put the water in the sink and put my hands in the water for about 6 seconds or something, and then I withdrew them. And I was so angry with myself for not having gone through the pain barrier that I didn’t put them under cold water, and they blistered very very badly.</p>	<p><u>Orientation</u></p> <p>An attempt to make connection with God by putting his hand in boiling with the hope of going through the pain barrier.</p> <p><u>Complicating Action</u></p> <p>Attempt failed because he withdrew his hand. His hand was blistered very badly.</p> <p><u>Resolution</u></p> <p>Coming to terms with the realisation that he failed to go through the pain barrier</p> <p><u>Evaluation</u></p> <p>Was very angry with himself that he failed.</p>

The team interpreted the action as Keith's being a person with a strong sense of conviction and a willingness to act on his convictions. Because of this, they regarded him as a vulnerable person.

In the next narrative passage Keith talked about the time he called off his wedding plans with Maria.

We went into a phone box one night. It was about 1.00 am in the morning, and rain was coming down, and May just said to me, "We can't carry on like this Keith. You have got to make a choice between Magda and me", and this was presented so starkly I thought, "Well, ok, I really do have to make a choice here", so I left. May went home and thought about it for a bit, and Magda was supposed to be coming over that summer from Poland, so, erm, I spoke to Magda I think two days before she was due to set off from Poland to come and visit me in Edinburgh and said very curtly, "Oh, I don't want to marry you anymore".

Narrative	Sub-plots and Interpretations
<p>'We went into a phone box one night. It was about 1 am in the morning, and rain was coming down, and May just said to me, "We can't carry on like this Keith. You have got to make a choice between Magda and me", and this was presented so starkly I thought, "Well, ok, I really do have to make a choice here", so I left. May went home and thought about it for a bit, and Magda was supposed to be coming over that summer from Poland, so, erm, I spoke to Magda I think two days before she was due to set off from Poland to come and visit me in Edinburgh and said very curtly, "Oh, I don't want to marry you anymore".</p>	<p><u>Orientation</u></p> <p>Conversation with May</p> <p><u>Complicating Action</u></p> <p>Realisation that things cannot continue as they have been doing. He is put on the spot to choose between Magda and May.</p> <p><u>Resolution</u></p> <p>Calls off wedding plans with Magda.</p> <p><u>Evaluation</u></p> <p>My approach was very curt.</p>

Later on in his story, the team learnt that he went back to Edinburgh to start his third year, which was the clinical aspect of the medicine course. He stated, ***'I found that really hard, so I changed from medicine to maths'***. In that year, things went wrong again: ***'I don't know what it was anyway, so, third year I went into hospital seven times or something, and then I had a go at fourth year maths'***.

This statement interested the team a great deal. First they were taken aback by his matter-of-fact approach to the number of times he was admitted to hospital. One member described his attitude towards these admissions like 'water off a duck's back'. The same attitude was picked up on again when he spoke of his experiences in the fourth year of university. Again he used this matter-of-fact manner to report further admissions in his fourth year: ***'And during my fourth year I was in hospital a lot of times, probably seven times in my fourth year and ended up having to re-sit my fourth year'***.

His not elaborating on the admissions suggested to the team that they were not as important as educating himself. The team was amazed by his strength of character and his determination to do well. One team member commented that Keith's resilience demonstrated the 'Recovery Model'.

In the next narrative passage, Keith talked once more about his relationship with women:

I started going out with a girl at the beginning of that year. I met her in Fresher's week, and we had a very tumultuous relationship for six weeks or so, and it ended with a bang, and it was a difficult start to the year, but apart from that at times I felt very very happy, very connected to people around me, and at other times I just wanted to be on my own and withdrew a bit from things.

A theme was beginning to build around relationships, which the team picked up on. They also began to get a sense of how Keith was affected by his condition. The team was in agreement about the cycling of moods, being elated one moment and then depressed the next. Keith did some reflective work, linking his relationships with religious themes:

And I sort of kept looking at patterns in my life and sort of saying things like, well, I have been out with Magda for a while then went out with May for a while

and then during my final year went out with a girl called Marion for a while, so there was kind of a M M M theme there, and Marion is obviously a bit like Mary again, and so the Christ theme was still sort of running through it all.

After finishing his studies at Edinburgh University, Keith went to St Andrew's for a year, where he studied for a Masters by Research in Environmental Biology. In the next narrative passage he talked about his last admission to hospital.

So my last visit into hospital I had some time in Liverpool before then with a female friend of mine who I had lived with in Edinburgh. That was Diana, and we had a bit of a fling, Diana and I, and Marion found out about this, and that caused lots of problems, and I think part of the reason for going into hospital there was that I was conscious that my relationship with Marion wasn't really working...So again relationships came into it, and I didn't have the emotional maturity to deal with it in a way other than by going high.

Anyway, so I did recover from that and sat my final exams, and they were all fine, and I got a First in the end, so I got a degree I deserved even though I had had all these episodes in hospital.

Not satisfied with his degree, Keith started a PhD in 2003.

I think the very significant part of that has been meeting Chrissie, the fiancé I'm now with. I met her one and a half years ago through a theatre company called (name of company). We were doing a project together, a theatre project working with people with mental health problems, and Chrissie was there because she was the activity leader.

In the second interview, I asked Keith a more direct question concerning his relationship with his parents:

You mentioned your mother. Can you tell me more about her?

Well, my mother is Dutch, and her father was a very successful businessman, and my mother and all her siblings as well really had very well defined sense of self. They were very well individuated people. Emotionally my mother is quite a charged personality.

Can you give me an example of a memorable time spent with her?

Yeah I think a very memorable time was just around this time, June 1995, when I was in hospital and she came up to see me from home, and her first conversation with the consultant who was seeing me was all about an experiment he wanted to do where he wanted to take her blood to find out about possible genetic implications of my disease, and she had a bit of an argument with him then I think, but then she took me away from the hospital for a day's walking. So we went walking on the coast near Edinburgh, and the doctors were saying, "Oh, Keith will run away if you do this", and she said, "No no no, I know my son, and I will take him on a walk, and we will be fine". We went on this walk, and I ran away from her. I think she was very surprised at my action there.

Narrative	Sub-plots and Interpretations
Yeah I think a very memorable time was just around this time, June 1995, when I was in hospital and she came up to see me from home, and her first conversation with the consultant who was seeing me was all about an experiment he wanted to do where he wanted to take her blood to find out about possible genetic implications of my disease, and she had a bit of an argument with him then I think, but then she took me away from the hospital for a day's walking. So we went walking on the coast near Edinburgh, and the Doctors were saying, "Oh, Keith will run away if you do this", and she said, "No no no, I know my son, and I will take him on a walk, and we will be fine". We went on this walk, and I ran away from her. I think she was very surprised at my action there.	<p><u>Orientation</u></p> <p>Visit from mother during first admission. Request made to take Keith out for a walk.</p> <p><u>Complicating Action</u></p> <p>Mother has argument with doctor and then takes Keith out for a walk against medical advice.</p> <p><u>Resolution</u></p> <p>She ends up taking him out against medical advice. Keith runs away from her.</p> <p><u>Evaluation</u></p> <p>My mother was surprised by my action.</p>

Another example of a memorable time was my mother, erm, (3) well I suppose when they came to see me in Edinburgh when I was studying in Edinburgh my parents came to see me. They would pick me up for meals, and we would go on walks together, and they always gave me the impression that they were very prepared to spend time with me and to do things with me, and I felt very warm towards them, and I was very appreciative of the efforts they put in to coming to see me.

There was a great time in Burton-on-Trent, which were a few years later near my parent's house. There I really felt as though I had almost psychic ability to read people. I was very sensitive to new (unclear word) and people's body language and people's, whatever they were doing with their eyes and all sorts of things. But I managed to communicate with this guy. I was sitting next to him talking to him, and he was throwing daggers at me. And I held onto his arm, and he started throwing all sorts of verbal abuse in my direction, and I just kept hold of his arm and kept talking to him gently and softly, and I could see the iciness the frosty iciness melting in him and changing, and I actually connected with him and was able to communicate with him. He was absolutely full of conspiracy theories. The whole world was full of conspiracy theories for him, and I just tackled that head on and talked to him openly about it, and he really seemed to open up, and that seemed very satisfying.

Narrative	Sub-plots and Interpretations
<p>There was a great time in Burton-on-Trent, which were a few years later near my parent's house. There I really felt as though I had almost psychic ability to read people, I was very sensitive to new (unclear word) and people's body language and people's, whatever they were doing with their eyes and all sorts of things. But I managed to communicate with this guy. I was sitting next to him talking to him, and he was throwing daggers at me. And I held onto his arm, and he started throwing all sorts of verbal abuse in my direction, and I</p>	<p><u>Orientation</u></p> <p>Powerful beliefs about own ability. Attempts to communicate with another patient whom he described as holding conspiracy theories.</p> <p><u>Complicating Action</u></p> <p>At first the patient resisted the contact by being verbally abusive.</p> <p><u>Resolution</u></p> <p>Keith, however, did not give up but persisted with his attempt, eventually</p>

just kept hold of his arm and kept talking to him gently and softly, and I could see the iciness the frosty iciness melting in him and changing, and I actually connected with him and was able to communicate with him. He was absolutely full of conspiracy theories. The whole world was full of conspiracy theories for him and I just tackled that head on and talked to him openly about it, and he really seemed to open up, and that seemed very satisfying.

connecting with him.

Evaluation

I felt satisfied having done this.

Towards the close of his story, Keith began to summaries his experiences.

Well I suppose part of what the admissions have been about, it's very often been friends who have put me into hospital, and part of the realisation that I have come to as a result of going through all these admissions into hospital is a very keen sense of the consequence of my actions...

...and I think the way I view it was a very much an experimental phase in my life. I was pushing the boundaries of consciousness and just exploring what was possible in terms of my own mind...

...and at certain points when I was doing that I neglected self care and that sort of thing, and my friends would say "Let's get this guy in hospital", so the way I view the admissions is that they were the sort of safety guards on my experiment.

Keith drew his story to a close with the continuation of positive thinking and no regrets. Most of the team marvelled at his spirited tone, but one member wondered whether he was not allowing himself to feel weak in any way.

I certainly wouldn't trade it in for anything. I think if I was given the opportunity to run my life again without going into hospital those times, I don't think I would want to do that. I think it has helped me have a very good understanding of my moods and of people in general really.

The next passage of text refers once again to academic achievements.

I have finished my PhD, which feels like an enormous achievement. I have maintained stability for four and a half years, which is again an enormous achievement and so as well as writing my PhD over the last three years.

I'm trying to think if there was anything else. Well, I think that's enough of the story really. I can't think of anything else that stands out.

That's great. Thanks very much, and I think you did very very well.

Thank you.

C. CONCLUSION

The interpretive work of the teams (looking at the *told story*), and the hypothetic-inductive work of the teams (looking at the *lived life*) came together to produce interesting and important insights into the remarkable and extraordinary lives of four of the seven 'revolving door' patients whom I had the privilege of knowing in this study. Both the *lived life* and *told story* represented two distinct activities in constructing the stories of multiple admissions to psychiatric hospital as illustrated above. The *lived life* represented the lived reality of the participants while the *told story* represented the psychological and emotional investment in these events. They operated simultaneously in the telling of the story, yet they were distinctive in that they conveyed the contrasting structures of knowledge and feelings embedded in the narratives.

It made a labour-intensive effort to produce a full account of the lives of these participants. Nonetheless, what was revealed in the historical constructs of the *lived lives*, was the skeletal frame of life events on which each participant gave an account in the *told story* as they remembered and understood them.

Chronologically examining these events, by way of imaginative and predictive hypothesising, teams were able to gain progressive insight into the *lived lives* of the four participants. Thus, they were able to trace and relate each confirmed prediction (highlighted in amber) to the chronological sequence of the life events. In this way they reconstructed a story that was credible as well as historical. Indeed, Gergen

and Gergen (1988 p. 19) say that, to understand is to place events within a context of preceding and subsequent events.

In the interest of transparency, I wanted to make every step of the data analysis as visible as possible. I did this by clearly illustrating the procedures involved. In doing so, I not only opened up the scientific process for critique and replication, but also demonstrated the rigour of the Method.

While having their own individual skills and expertise, members in the two separate teams worked together intuitively to come up with insights about the *lived lives* of the participants and the stories they told.

A key factor in this process was to bracket any preconceived assumptions where it might be possible to interpret the data to fit a given view. This was interesting because it opened up my mind to alternative perspectives. The stories told, not only reflected the experiences of those caught up in the 'revolving door' phenomenon, but also highlighted the implications of social, psychological and political conditions for this particular group.

In the section that follows, I extend the reflective team's work further by considering psychological theories and the implications of the 'revolving door' phenomenon on socially constructed identities. Because this study adopts a social psychological approach to analysis, it is not possible to understand how identity is socially constructed without considering the social and psychological content of the experience. This view implies that from these two interrelated constructs it will be possible to connect meanings derived from the analysis to form a coherent understanding of the whole life of the participant.

Kinderman (2008) suggests that disruptions or dysfunction in psychological processes constitute a final common pathway in the development of mental disorder (p. 94). He identifies social factors such as poverty and social deprivation and circumstantial factors of life events such as childhood sexual, emotional or physical abuse as factors that can lead to mental disorder because those factors adversely affect psychological processes.

Significantly, the psychological processes in each of the four participants presented above, are characterised by the social dimensions of the lived experiences, inclusive

of stressful life events and experiences. These events and experiences are regarded as authentic accounts of the participants' subjectivity. In reference to authenticity of the stories, I rely on my knowledge of the participants, which was informed by clinical records and my interaction/encounters with each of them. Whether the stories 'ring true' or not is not part of the concerns of the study. My intention is not to question the narrative authority of the participants, but to regard each person wholeheartedly as someone for whom the present is dependent on what could be remembered of the past, and how such memories were co-constructed in the stories that were told.

Having said all that, in the synopsis below I will now present some of the key findings of the reflective teams' analyses of the stories told by the four participants chosen for team analysis. Because the construction of identity is a unique process embedded in diverse and stratified contexts, conclusions presented below should not be taken as definitive or representative of all 'revolving door' patients. Instead, focus should be on the multiple perspectives that were brought to bear on the participants' narratives.

Accordingly, inferences made from participant's narratives should be considered as 'naturalistic generalisation' as proposed by Stake and Trumbull (1982). 'Naturalistic generalisations', according to Stake (1980 p. 69, cf. Robinson and Norris 2001 p. 306), 'develop with a person as a result of experience. They form the tacit knowledge of how things are, why they are, how people feel about them and how these are likely to be later or in other places with which this person is familiar'. As an alternative to statistical generalisation, 'naturalistic generalisation' is considered appropriate in this study because of its strong association with narrative case study. It is also appropriate because of the value of understanding complexity over generality. According to Robinson and Norris (2001 p. 307), 'naturalistic generalisation', shifts the responsibility away from the researcher towards the reader, policy-maker or practitioner. Therefore, in generating understanding of the 'revolving door' phenomenon it is expected that the data presented will resonate experientially with a broad cross section of readers.

1. Summary of the Four Case Studies

Hannah Salmon, told an amazingly emotional and traumatic story. Her account portrayed a woman who survived childhood sexual abuse only to become a 'revolving door' patient in the mental health system, in which psychiatric diagnosis obscured psychosocial issues. Some of the questions that I asked myself included the following: What did the abuse and so many admissions to psychiatric hospital mean to her? What were her thoughts on it all? In response to these questions, I had no doubt that her story was authentic and an honest representation of her fragmented life. Indeed, I trusted my instincts, raising them above the need to question her integrity.

What made her story so compelling was that, despite the traumatic nature of her experiences, she could now speak openly about them to me, a male researcher and complete stranger. This was truly a fascinating achievement. How does anyone recover from such horrendous experiences? What is it about Hannah that made her want to tell her story to a complete stranger? I wondered whether she may have found it easier to talk to me because I was a stranger. It may have also helped her, to know that I had knowledge of mental health issues and, therefore, would have been able to empathize with her. Another possible reason that came to mind was that she probably wanted to speak out to all those others like herself that might be hiding, or that are struggling, so that they can also survive; in other words, to give everyone hope that they, too, can survive if something happens. Also, I concluded that I must have given her the impression that I was interested in her story and that it would be handled sensitively; otherwise, she may not have felt comfortable talking to me.

The telling of her story reminded me of Riessman's (1992) research in *Making Sense of Marital Violence*. Although the context was slightly different, the stories were related in that both women were victims of rape and violence by men. As a male researcher, I felt that the interactional context of the interview raised my consciousness to what both women's experiences must have been like. In reliving the experience, Hannah was also redefining her identity.

Hannah told her story scene-by-scene. Each scene unravelled more of her troubled life. Her approach was so frank and to the point that it made me feel that reliving her

pain took great courage. While I am still unclear about what exactly motivated her to tell her story, I am certain that, ultimately, she would have had to incorporate the many events and experiences in her life in order to construct a sense of identity. Traumatic as they were, such experiences would either have led to her becoming emotionally fragile and cautious or would have transformed her into an emotionally stronger person.

Hannah's seemingly apprehensive and nervous start to telling her story was in some way symbolic of the struggles she encountered in her many admissions to psychiatric hospital. It also seemed that her story had occupied her mind for some time, and now, having been presented with the opportunity to tell it, she readily did so. It was interesting that she took full control of the interview session, demonstrating a position of power. This stood out against her earlier life, when powerlessness meant a loss of control, as evidenced by abusive parents and frequent hospitalisations; for example, in a state of powerlessness, she expected support from her mother, but it was not forthcoming. Jones and Morris (2007) say that 'when a mother supports an abusive father and disbelieves her daughter this impacts upon the child's identity, self-worth and her experience of maternal love' (p. 225).

This was an amazing turning point in her life. To me it conveyed a sense that she was a much stronger person than before. On the other hand, psychologically, she may have felt that she had to assert herself in order to be noticed. What was also interesting was that she was not afraid to speak about the traumatic events in her life concerning both her abuse and her experiences of going into hospital repeatedly. Four of the themes identified in her story as problematic were to do with her sexuality, isolation, stigmatisation and generally being unhappy. Her frank approach in talking about these issues probably meant that she had come to terms with all that had happened and had reconstructed her identity as a survivor based on having a stronger sense of the person she had become.

Andrew Simpson's story is a tragically poignant reconstruction of a life troubled by drug abuse and psychotic symptoms. The story is poignant because of Andrew's seeming helplessness in preventing the 'revolving door' phenomenon from happening to him. Goffman (1961) refers to this cycling of events as 'the moral career of the mental patient' (p. 122). At the beginning of his story Andrew seems to

be saying that life was pretty much 'normal' for him until he was diagnosed with schizophrenia. He goes on to tell a story in which he grapples with notions of the true or false self.

Trying to understand the meaning of Andrew's story meant paying particular attention to the nuances of each theme and the motifs of the story. A strong theme was loneliness. This may have been because I perceived him as a needy child, having experienced a traumatic separation from his biological mother at an early age through divorce. He found himself alone and cut off from his emotional feelings. This emotional state was reinforced by the fact that his biological mother and siblings were out of the picture. For Andrew, these areas may have been too painful to talk about; hence, there is no mention of either mother or siblings in his story. Also for Andrew, psychiatric diagnosis came at adolescence, an age when he was discovering himself as a person.

Erikson (1980 p. 120) regards adolescence as a psychosocial moratorium during which the individual may find a niche in some section of society which seems to be uniquely made for him or her. In finding it, the adolescence gains an assured sense of inner continuity and social sameness which will bridge what he or she was as a child and what he or she is to become. This notion is interesting, as it implies that if unsuccessfully negotiated, the world of the individual shrinks.

If separating from his family was too painful, having a mental illness may have been a way of stopping him from thinking or reflecting about painful memories to do with the separation. In this way, going into hospital may also have been a way of avoiding these painful memories. At the same time, because Andrew had constructed a good relationship with his father from an early age, he may have perceived that his father would always be there for him. Andrew's perception, therefore, might have been that there was a risk of losing his father to his stepmother. If this was the case, then going into hospital served to keep him in a needy position and dependent on his father for support. This also served as a secondary gain function of keeping him within the family.

Seeman (1959), writing on alienation, divides an individual's emotion into five different modalities: powerlessness, meaninglessness, normlessness, isolation and estrangement. From a social-psychological perspective, Andrew may have felt

powerless due to the belief that his life would never be any better than it was at the present time and an inability to gain perspective about what has happened to him. This was, in turn, compounded by isolation due to his tendency to do that which is illegal, for instance, taking drugs to get any enjoyment out of life. Finally, he may have felt lonely due to having few friends, strained parental relationships and a feeling of disconnectedness with the community. Andrew's smoking of cannabis could be understood as his forming attachment to substances instead of friends. In this way, the risk of his being let down by friends was significantly reduced. Erdner, Nysrom, Severinsson & Lutzen (2002 p. 457), in their study of psychosocial disadvantages in the lives of people with long-term mental illness, identify three themes which were also found in Andrew's story: feeling lonely but being unable to establish friendships, knowledge of what to do but lacking initiative, and awareness of the need for support but not wanting to be subject to control.

The story **Michelle Walton** told of her life was filled with misery and a reality disrupted by frequent and repeated admissions to psychiatric hospital. Michelle dreamt of getting married, buying a house, having children and being an actress. These were all the things she wanted in her life. In fact, the theme of 'I want' ran throughout her story, signalling to the team that these wants or dreams may not have become reality for her. Michelle told her story against what could be described as a wall of humour. This wall seemed to protect her emotionally from her heartbreaking and devastating revelations. Indeed, two of the recurring motifs of her story were of her vulnerability and victimisation, in which themes of violence and aggression weaved throughout.

Michelle's description of her family background was significant in grounding an understanding of her life. First, her description of her mother; labelling her as neurotic, suggests that containment was not offered in the family unit and, therefore, not learnt from her parents. Because of this early lack of containment, it could be said that her actions later in life reflected a lack of structure and normalisation.

A strong theme in Michelle's story was her having wealthy parents who were able to provide her with material wealth. An interesting question that the team raised was whether Michelle's wealth was replacing her being loved emotionally by a mother who was not able to cope and an emotionally distant father. Was it guilt or her

parents' being protective – knowing that she had a terrible time with them? Also, was she differentiating between self as individual and unique, or was she comparing herself with her siblings?

Michelle's adolescence and early teens represented for her a period when, as a way to contain her unconventional social behaviour, she was admitted to psychiatric hospital. Perhaps Michelle's mood swings were more to do with her not being able to cope with things herself. In this way, her grandiosity might have been a way of avoiding emotional pain; it is much more pleasant to believe you are Jesus than an unloved person in society without any social positioning. It was the above interpretations that helped me understand why Michelle might have been the person she was and consequently the person she had become.

From living a life of uncontained behaviour, Michelle's life could now be regarded as governed by a more rigid internal parent, the structure of the mental health system. It could be said that because of her many admissions to psychiatric hospital, Michelle had found an institutionalised way to look after herself.

For **Keith Edwards**, the reward for my driving to Nottingham and the anxieties I experienced in setting up the interview, was that I was able to be involved in the process of co-constructing an amazing story. Indeed, Keith told a truly inspirational story about resilience in the face of adversity and recovery from over fifteen admissions to psychiatric hospital to live a fulfilled life.

Overcoming life challenges, whatever they might be, is not easy for many people, especially because one never knows when a challenge or crisis might arise. When they do, one has to deal with them or risk being consumed by them. As a 'revolving door' patient, Keith showed that it was possible to not only overcome these challenges or crises but to go on to achieve his goals through strong determination. Keith told his story with speed and vigour but, more interestingly, with no regrets.

Keith's story was dominated by educational themes as well as romantic attachment themes. One of a number of motifs that were identified in his story, was of success irrespective of the disruptions caused by recurrent hospitalisation. The theme of perseverance characterised his story, ultimately creating a success story.

Keith's desire for success could be understood by the influence of an academically minded family, as he so described them. Both his parents were university lecturers when he was growing up. In psychoanalytical terms, it would be said that he possessed a harsh ego that made no allowance for failure. From this perspective, his manic episodes could be understood as a way of protecting himself from his own vulnerabilities, in other words his defence.

Keith, however, regarded his many hospital admissions as positive experiences. He resisted deviating from his life script despite all the difficulties that his illness imposed on him. This seemed to emphasise his strength of character. The toughest part of having an illness such as bipolar disorder is that it gets in the way of plans and the disruptions that it causes through hospitalisation. I wondered whether these setbacks made Keith realise his vulnerability in any way. If they did, there would have been a need for him to understand himself enough to realise that as long as he got back to the plan he would be fine.

2. The Final Analysis

The similarities and differences that arose from the analysis of the four participants' emotionally challenging life stories are presented in Table 13.0 below. For each of the four participants I have collapsed the columns of the table into motifs and themes. The emergent themes from the stories are compared and contrasted across the four participants. The number of admissions to psychiatric hospital for each participant is also illustrated.

	Hannah Salmon	Andrew Simpson	Michelle Walton	Keith Edwards
Number of admissions	Seven	Nine	Nine	Fifteen
Motifs	Abuse	Confusion	The family	Success
Themes	Sexual Childhood sexual abuse Distrust Education Loss Sadness Vulnerability Resilience Violence Aggression Victimisation Betrayal Powerlessness Fear	Loneliness Alienation Social isolation Resistant to control Lacking initiative Fantasising Drug abuse Loss Sadness Confused Vulnerability Worry	Violence Wanting a house, to get married and to have a baby Uncontainable Rebellion Suicidal thoughts Rape Humour Vulnerability Aggression Victimisation	Academic achievement Determination Romantic attachments Religion Motivation Resilience Perfection Fixation on names Vulnerability Happiness Confidence

Table 13.0 Summary and Comparison by Motifs and Themes

In considering each person's life story separately, certain conclusions were drawn. Considering the four life stories collectively, allowed me to compare and contrast the central themes pervading each participant's life.

In the narrative space of their life stories, the space that opens up in our lives when we realise that there are many new options and possibilities available to us, Hannah, Andrew, Michelle and Keith all told different stories. These stories revealed key motifs and themes that emerged from birth and changed with experience throughout the generative life cycle: the motif of Hannah's story, for example, was abuse; that of Andrew's was confusion; Michelle's was the family; while Keith's was to do with success.

As much as their narratives have an undercurrent of individual determination, they mostly communicate a sense of resilience that parallels narratives in recovery from mental illness and success in overcoming adversities. As resilient narratives, these stories also help to convey a sense of how these individuals (re)constructed their self/identities. To get a sense of the unique perspectives implicit within each story, with reference to the stated research question and to the theory of identity, one can look at the stark contrast between the stories told.

Hannah and Keith both recognised the need for change and both acknowledged the importance of taking ownership and responsibility for their lives. Hannah, when she was given the opportunity to tell her story, showed a side of herself which was less evident in Andrew's or Michelle's story. Hannah revealed a person obligated to better herself, and went back to college to do further studies.

Keith moved himself through narratives toward external relations and constructed an identity in relation to the happiness exuded from being amongst others. Rather than internalising his problems, he focused on this happiness. Each in his and her respective narrative bypassed an identity that might have followed a stereotype of what people often understand as not being able to cope mentally, and instead, each constructed a self/identity indicative of determination to succeed, despite the odds.

In his story of confusion, Andrew returned to a place he was once in, and Hannah brought herself closer to a world she never knew as an adolescent. She constructed a situation that gave meaning to and provided relief from her suffering. Their differences are constructive. Hannah went back to college, whereas Andrew normalised his behaviour of refusing his medication by describing situations where medication was portrayed as harmful. He was resistant to medical interventions, yet he told an alternate story that conveyed the sense that he was a caring person; a trait he identified in his father when he told the story of his father physically carrying him when he was unable to walk.

The themes in Michelle's narrative point to a dominant story of wanting a family and wanting to be a 'star'. Despite this, a recurrent theme, particularly in the earlier stages of her life, was rebellion. Towards the later stages of her life story, however, she was able to tell an alternate story of accepting the routines that the hospitals imposed on her as a way of stabilising her mental state.

The focus of Michelle's story was not only the events that gave rise to a spoilt childhood and rebellious adolescence, but also, the humorous way in which she depicted each scene of the story. She was probably using humour as a kind of defence mechanism to lessen the pain of what had happened in her life.

All of the stories narrated illustrated how identities are created, and made the claim that the dominant theme of each person's story was the courage to survive. They

were stories that defined the strength of their will in terms of resilience and endurance. Reconstructing who they were, compared to who they had been, highlighted the tension of two lives, one past and one present.

The concept of resilience was identified as a way of understanding how these four individuals survived traumatic events in their lives in spite of prevailing health and social problems. In relation to the 'revolving door' phenomenon, being diagnosed with schizophrenia or bipolar disorder and admitted to psychiatric hospital repeatedly was considered to be extremely challenging for them.

What these challenges represented was a process of identity reaffirmation whereby these individuals deepened their understanding of themselves while living with the doubts, uncertainties and anxieties which seem increasingly to be associated with resilience. The concept of resilience is complicated and difficult to define due to the significant variability across individuals. Put simply however, resilience could be understood as a quality that helps an individual resist and recover from adversities (Newman 2002). Since I had not been thinking about resilience when I began this research project, my task was to define what I thought the participants were expressing. To assist me, I constructed a conceptual framework of resilience based on my reading of literature on the subject. Please see Table 14.0 below:

Factors	Components
Cognitive	The capacity for emotions, intelligence, self-reflection, creativity.
Psychosocial	The capacity for forming relationships with others, showing empathy, compassion, caring, happiness. humour, social and family support, religion/spirituality.
Control	The capacity to manipulate ones environment, self-esteem, autonomy, sense of purpose, aspirations, altruism, optimism.

Table 14.0 Factors and Components Associated with Resilience.

Three factors were identified as constituting resilience: cognitive, psychosocial and control. For each contributory factor, components associated with that particular factor were identified. I made connections with features relevant to resilience by linking specific narratives with this conceptual profile; I was able to locate thematic components within individual narratives. Through the analyses of their narratives I became aware of experiences that connected with components of resilience. Based on these interconnections, I now have a better understanding of participants' self/identity during a time of major disruption due to repeated admissions to psychiatric hospital.

I believe that the uncovering of resilience as an over-arching theme or theory applicable to this study is the singularly most important contribution to knowledge that this research makes. I also believe that the concept underpins strategies which participants employed in order to cope with threatened identity (Breakwell 1986). It does this by acting as a self-correcting mechanism that enables participants to find some sense of balance despite what happens to them. Also, resilience plays a part in participants not regarding their situation as fixed and hopeless, but as having the possibility of change.

Having introduced and discussed resilience, the next chapter concludes the thesis by offering a discussion and further reflection on the implications of the research findings.

CHAPTER VI

CONCLUSION AND RECOMMENDATION

The Principal goal of education is to create men and women who are capable of doing new things, not simply repeating what other generations have done.

*Jean Piaget (1896 – 1980)
Swiss Cognitive Psychologist
(cited in www.lhup.edu)*

1. Introduction

The final chapter of this thesis draws together and reflects on the key findings of the research. It is divided into three parts: Part One provides an overview of the research and Part Two presents the key findings of the study and reviews how a qualitative approach has enabled me to answer the research question by revealing the idiosyncratic and psychological characteristics of the participants. In Part Three, I summarise what I regard as the opportunities unearthed by this study and suggest some possibilities for future research.

2. Towards a Theoretical Understanding of Self/Identity

In line with Erikson's (1980) psychosocial development theory, I have argued in this thesis that self/identity is fluid because it is socially constructed and constantly revised by the individual throughout his or her life. In other words, the stories that a person tells to construct their self/identity are shaped and reshaped by the perceptions others have of him or her (Chapter Two). This fluidity and reshaping is a key factor in allowing people to overcome adverse experiences.

A number of theories on self/identity were identified (Chapter Two), but understanding how the 'revolving door' phenomenon influences self/identity is largely neglected in the literature. Although not directly related to the study of the 'revolving door' phenomenon, a model of self formation which I found relevant was Breakwell's (1986) Identity Process Theory (IPT). I used this theory of the self to consider the processes by which 'revolving door' patients determine their identity. What happens,

for example, when a patient feels that his or her identity is being threatened? How does that patient maintain a state of stability in his/her perception of him/herself? Before I present my key findings, I will briefly restate the research problem by providing an overview of the study.

A. PART ONE

1. Restatement of the Research Problem and Aim of the Study

To understand how participants' perceptions of multiple admissions/illness affected their identity, I formulated the following research questions, which underpin the aim of the study:

- How does each 'revolving door' patient construct meaning and reality?
- How does that enacted reality provide a context for shaping his or her identity?

Reflecting back, what became apparent through listening to participants' stories and the examination of the narrative data, was that I was really looking at how multiple admissions to psychiatric hospital affect a patients' sense of identity and self-determination. This intriguing question served as the basis for the data analysis. This question has relevance in this study because, according to Frankl (1962), it is the case that doctors often view patients as machines - having a disease to be cured or put right, and not as human beings that are complex, with a multiplicity of thoughts and emotions. To counter this view, the personal experiences and views of patients were given priority in this study.

Literature Review

I found from my review of literature on psychiatric patients' experience of repeated admission to hospital that, although there are historical accounts of the changes in services and the treatment for mental illness, very little is recorded about the personal experiences of the patients themselves (see Chapter Two). Dahlberg, Drew & Nystrom (2002 p. 212), in particular, drew my attention to the fact that many of the insights of individuals with severe and enduring mental illness remain relatively unvoiced and thus unavailable to a wider society. This lack of a full and authoritative

study of patient's stories, and my personal curiosity about the 'revolving door' phenomenon, convinced me of the need for methodologically sound research that would contribute to a better understanding of this phenomenon from the patients' perspectives.

Methodology

Because memory relates to who we are, it was important to employ a method that would enable me to obtain patients' memories of the events and experiences in their lives and then analyse these experiences for meaning. To get to know these patients, seven were invited to take part in this qualitative study. I was impressed with the Biographic Narrative Interpretive Method as a data collection and analysis tool (see Chapter Three) and adopted it for eliciting and understanding their stories. Participants were interviewed using an open-ended, minimalist interviewing technique based on the protocol of the Method, described in Chapter Three and Five.

The participants in the study, like all of us, have identities that grow and develop in relation to others and how they are treated. As stated in the body of this thesis, empirical evidence suggests identities are not only socially constructed, but are also fluid in nature (Ricoeur 1981; Miller 2000) and not fixed, as theories on personality traits or types have traditionally maintained. In a sense, these individuals and their notion of self, exist in webs of meaning which derive from their being embedded within society (see Chapter Two).

It was by listening to participants' stories about their life events and subjective experiences as they remembered them that I was able to come to an understanding of what those experiences meant to them. These memories were noted as reconstructions of the past narrated in the present. For each participant, a chronology of the life was constructed, which represented the *lived life*. The *told story* comprised the co-constructed stories told during the actual interviews. Finally, a psychosocial approach was used for framing the analyses. This approach offered personal interpretations of each biographical (re)construction using reflective teams. Abductive/inductive reasoning facilitated the process of hypothesising and meaning-making.

Political Underpinnings of the Study

As a contextual background to the study, I acknowledged the many changes that have taken place throughout the history of mental healthcare in the United Kingdom. In Chapter Two, I gave an account of the history of mental illness in the UK, including the period of deinstitutionalisation in which the following contributory factors played a part:

- Introduction of new anti-psychotic drugs;
- Economic limitations (increased costs of running the asylums and the fiscal crisis of the state [see Pilgrim & Rogers 1999 p. 153]); and
- Integration of human rights into mental health care.

The introduction of the NHS and Community Care Act 1990 was also significant in setting up the context for the study. Alongside these historical changes were other dramatic governmental reforms and initiatives for modernising mental health services, the focus of which was largely to do with the provision of community-based services. The ideological assumptions of these changes were that they would offer 'revolving door' patients a better quality of life, more choice and greater control over their lives. Emphasis was also placed on the opportunity for them to move from a situation of dependency to independence. So far, these expectations have not been realised. For 'revolving door' patients, these changes have meant very little, since it remains the case that they are still being readmitted to psychiatric hospitals, as illustrated in the life stories of the seven participants. In fact, government policies seek to widen the scope for identifying behaviours that are considered to be anti-social. This is likely to see more people brought into the mental health system and becoming 'revolving door' patients. Having restated the research problem and aim of the study, I will now briefly reflect on the study itself.

Personal Reflection

To answer the research question objectively required exploration and understanding of the participants' psychological experiences. It also required exploration and examination of my own motivation for conducting this study; why did I want to challenge assumptions about 'revolving door' patients? What new knowledge did I

seek and how has that new knowledge or understanding changed my notion of the 'revolving door' phenomenon and patients who experience it?

To ask these questions, I must have wanted to make a difference to people's lives by answering them. Ultimately, in understanding 'revolving door' patients I also reaffirmed myself as somebody connected to others. Part of this procedural understanding comes from me being a social pedagogue and being driven by humanistic principles and values. Another part comes from my perception of what constitutes fairness and justice (in other words, equality). If I perceive there are injustices to a group or an individual, I make connections to my own experiences of suffering injustice. In this way, I have become empathetic toward others whom I perceive as vulnerable to discrimination and marginalisation.

The use of the reflective teams in this study enhanced my own reflective process by offering alternative perspectives. Maintaining an open mind to fresh interpretations through questioning, and not necessarily relying on my own perspective, allowed me to gain insight into the differences between interpretations and how they were arrived at. To this end, I was able to open up my thinking to encompass alternative points of view. The next part of this chapter presents the key findings from the study.

B. PART TWO

1. In Search of Meaning - Key Findings to the Research Question

This study is the first of its kind in which this Method is used to develop an understanding of how the identities of 'revolving door' patients are constructed. As such, it breaks new ground in advancing the case for patient-centred or meaningful outcome research and extends the validity of this innovative Method. I will now summarise the findings that answer the research question: ***'How do multiple admissions to psychiatric hospital affect a patient's sense of identity and self-determination?'***

As a mental health social work practitioner, I was aware that I had preconceived, socially conditioned ideas about what admission to psychiatric hospital represented for patients, for example, the notion that repeated admission to hospital is a process

that can bring with it periods of change and discontinuity. These periods have the potential to fragment and weaken the patient's identity by disrupting their biographies. Although my view of these patients was borne out in this study, it was also my observation that each participant reacted differently to their circumstances, for example, Hannah and Keith overcame their traumatic situation while Andrew and Michelle were not so successful in dealing with their problems. This observation led me to take a closer look at what made these participants different from each other and how these differences enabled them to cope (or not) with multiple admissions. In this endeavour I noticed that I felt more empathetic towards Andrew and Hannah than I did towards Michelle. I wondered why this might have been so. I concluded that my attitude towards Michelle might have been connected with the fact that I came from a humble background and, therefore, had more in common with the other participants who were from similar backgrounds.

Nonetheless, I can report that the human aspect of listening to participants' stories made the interviewing a fascinating experience and often, emotionally touching. Indeed, a common theme that emerged from the narratives was that admission to psychiatric hospital is an emotional event - what Pillemer (1998) refers to more formally as personal event memories.

2. Conceptualising Resilience

The concept of personal event memories discussed in Chapter Two, gave some insight into how participants constructed meaning from their experiences in relation to the concept of resilience discussed in Chapter Five. In this section an explanation is given of how I was able to link participants' memories of events, through the stories they told, to the concept of resilience. I was able to do this in two ways. First, knowledge of the participant's biography, the *lived life*, made me aware of the changes that had taken place in that person's life, influenced by generational, cohort and historical effects. Second, from the *told story*, I was able to evaluate how that person had coped (or not) with those changes from the account they gave of their experiences.

So how does resilience help a patient construct meaning and reality? From a psychological perspective, factors associated with resilience include positive emotions, happiness, humour, religion/spirituality and social and family support. Cognitive factors include: intelligence, self-reflection and creativity. Self-esteem, autonomy, optimism, sense of purpose, altruism and the capacity to recover from negative events are all indicative of someone being in control of their life. In addition, having the opportunity to express one's imagination, to tell one's story; to connect one's inner experience and feelings to the outer world, is a powerful recovery tool in the lives of the mentally ill, especially those living with the challenges of the 'revolving door' phenomenon.

Drawing on Labov and Waletzky's (1967) evaluative element of analysis enabled a deeper understanding of the differences between participants' responses to the 'revolving door' phenomenon. In evaluating his experiences, for example, Keith remarked, **'All of my experiences were positive'**, but Andrew stated, **'Schizophrenia changed my life'**. These and other utterances, such as Michelle's **'All my life has been a mess really'** and Hannah's **'Music has got me through this'** signified a re-appraisal of their self/identity and recognition that their lives had changed in some determined or undetermined way. I found that:

- Keith and Hannah's evaluation of their experiences were positive; but
- Andrew and Michelle were not so positive

Even though Andrew and Michelle's evaluation of their life was not as positive as Keith's and Hannah's, I considered all of them to have told resilient stories. Hannah suffered childhood sexual abuse followed by multiple admissions, first to adolescent units and then to psychiatric hospitals for adults. She was able to recover from these traumatic events enough to regain a strong sense of identity and purpose in life, as evidenced by her recent return to further education.

Andrew's early separation from his parents and involvement with drugs was perceived by the team as contributing to his mental health problems and multiple admissions to psychiatric hospital. Although Andrew's experiences brought about some positive changes, he still found himself resisting the system. He stated: **'I mean I've changed now, and I don't want to do these things. I'm talking about them,**

and I know I know its sounding good to do all these things, but there's a part of me that doesn't actually want to do anything. And I think this is the thing that's always always sort of held me back because there's one big part of me that doesn't want to do anything. And I think that that's what makes me sort of relapse because I don't want to do anything. I get depressed and get low, and, I dunno, (2), it's just I've got to think of it as I've got so many years left on this planet and I've got to actually do something, otherwise I will end up in hospital again and again. But it's like what do you do to motivate yourself? I mean I'm still lost, so I don't know about that'.

In this passage, Andrew still appears to be defining himself by his hospital admissions and not to have managed to move on. In fact, he actually states that he does not want to do anything. Ladyer (2004 p. 23) notes, 'Vulnerability of self/identity frequently translates itself into avoidance and withdrawal from social life, sometimes even self-imposed isolation'. Despite this, Andrew's resilience to the 'revolving door' phenomenon, while not so strong as the other participants, may be understood as his surviving everyday life.

Michelle met many obstacles in her life that got in the way of her realizing her dreams. Her world was turned upside down when she lost everything that was of value to her, including her marriage, son, career and mental health. Her way of coping now appears to be an acceptance of her situation. Keith set himself the goal of achieving a good education. In spite of numerous disruptions due to hospitalisation and breakup of relationships, he was, in the end, able to gain a PhD in Statistics.

The quality of resilience displayed in all these interviewees can be contrasted with that of the Charles Dickens character Miss Havisham in *Great Expectations*. Miss Havisham's life is defined by a single tragic event: being jilted by her fiancé minutes before her wedding. Miss Havisham is determined not to move beyond the heartbreak of this traumatic incident and her life stops at the exact moment of her discovery of betrayal.

The ability of these seven participants, in spite of prevailing health and social problems, to survive traumatic events in their lives clearly signifies aspects of resilience. A key point I wish to make here is that it is important for researchers and mental health professionals to acknowledge this ability which I identify as strength.

It was important in this study to be aware of notions of an oppressive/authoritarian society in which power can deny the possibility of freedom and resistance (Foucault 1990). How participants coped with the oppressive elements of psychiatry was important in understanding the process involved in constructing their self/identity. That power exists in the hands of governments and is administered through institutions such as psychiatry and mental health services, is a point that Foucault (1973, 1974; 1977) makes most forcefully. He identifies psychiatry as a way of implementing political power to control the mentally ill. For Foucault (1990 p. 95), power is intrinsically related to resistance, therefore, wherever power can be identified, resistance is possible. Although Foucault was writing about sexuality and resistance, it is the ability of 'revolving door' patients to resist the often oppressive nature of psychiatry that is so remarkable. Resilience, however, is not just about resisting; it is about learning to live.

Hannah was able to move from a position of having a fragile sense of self to a more confident determined persona. She was able to resist the overwhelming social stigma of childhood sexual abuse, mental illness and multiple admissions to become a stronger person. She was most probably able to do this with support from mental health services. First, she would have had to decide that she needed help, and be willing to cooperate with professionals, in order to overcome her traumatic experiences. Having reached a stage in her life where she could talk comfortably about her experiences, signalled to me an amazing turning point for her. Her story of resilience was moving from a state of powerlessness to retake control of her life - a story she wanted to share in order to give hope to others like her.

Andrew's psychological difficulties were understood by the reflective team as stemming from a problematic family life. In particular, his parents' divorce when he was four years old was seen by the reflective team as a contributory factor to his mental condition. Andrew described his life as normal until '***schizophrenia changed my life***'. Since then, Andrew's existence has been one of disconnectedness from his community, plagued by loneliness. He talked about getting a job, buying a house and going on holidays, but these are only fantasies held in place by a lack of initiative and an aversion to being controlled. Andrew dealt with the disruption to his life; being diagnosed as having a mental illness and admitted to hospital, by socially withdrawing himself from society and by turning to drugs. This was his way of dealing

with the difficulties he was experiencing. His rejection of interventions from mental health services could be understood as his answer to what Frank (1995) would regard as the chaos in his life. The consequence of this is that he is likely to continue to be a 'revolving door' patient.

Unlike Keith, Andrew lost his ability to determine his happiness by allowing himself to be overcome by the events in his life. Andrew had only fantasies about the possibility of living a more fulfilled life. His struggles to construct a positive identity for himself happened during his adolescent years and this would seem to support Erikson's (1980) theory that if the adolescent stage of development is not successfully negotiated (the forming of appropriate relationships), the world of the individual is likely to shrink. A strong theme that emerged from Andrew's and Michelle's stories suggested that their dysfunctional families did not really help them but, instead, probably caused their illness.

Michelle's life story could be described as the little girl who had everything a girl could want, except for true love and affection. She was very spoilt as a child by wealthy parents, her father was not around much due to work, and her mother was described as neurotic. Perhaps as a result, Michelle never learnt to control her emotions and often found herself, whether consciously or not, behaving in a way that resulted in being admitted to psychiatric hospital. She wanted very much to be an actress, to get married, and to have a house and a baby.

Her dreams of setting up home and having a family did become reality, but were short-lived due to a problematic relationship with her husband. She subsequently lost everything; her marriage ended in divorce, her husband got the house her parents had bought her, and she experienced further losses when she was forced to have an abortion because she was taking lithium medication when she became pregnant. To add to her misery, her only child ended up living with his father following her divorce. She now lives alone. The thoughts she had of becoming an actress, however, are still very much in her mind. She has also internalised the structure of the mental health system as a way of coping and of keeping herself out of hospital; for example, she followed the daily routine of the hospital: taking her medication on time and keeping her appointments with mental health professionals. In order to do this,

Michelle needed to evaluate her own behaviour and come to the realisation that her behaviour was unacceptable.

Keith summed up his life story: ***'I certainly wouldn't trade it in for anything. I think if I was given the opportunity to run my life again without going into hospital those times I don't think I would want to do that. I think it has helped me have a very good understanding of my moods and of people in general really'***. Keith had a life script that he would be successful. He seemed to have overcome thoughts of being a failure. In addition, he seemed not to be affected by the social stigma of being a 'revolving door' patient.

In terms of being successful, it could have been that he felt (because of his self-confidence and ego) that he should always be successful. His confidence could have come about from the success of his parents who were also academics. He might have felt that, if he applied the same commitment to education, he too would be destined for success. He also had strength of character that enabled him to find his feet after each and every hospitalisation; there were fifteen in total. His equally strong sense of self/identity was evident through his story and gave the impression he was always going to achieve his aims. Ultimately, he regarded his experience of being a 'revolving door' patient as positive.

The psychological processes in each of the four participants presented above were characterised by different upbringings and surroundings (the social dimensions of the lived experiences). Keith's upbringing/surroundings, for example, were very different from that of the other participants. He had a close and supportive relationship with his parents and siblings who were themselves academics. In addition, he had supportive friends who would take control during the times that they felt he was out of control. Also, because of his sociable nature, he was always going to have people around him that would look out for him. According to Erikson (1980), it would seem that Keith successfully negotiated his developmental life stages. This would have enabled him, therefore, to have a stronger sense of identity than the other participants.

Andrew can be perceived as being opposite to Keith. As mentioned above, Andrew failed to negotiate the adolescent stage of his development and, therefore, was unable to form the kind of relationships that would have enabled him to develop a more positive sense of identity. He came from a dysfunctional family background and

was affected by the separation of his parents and a stepmother with whom he was unable to get along. On top of that, Andrew's schooling was problematic and eventually ended in him being excluded. His illicit involvement in drugs seemed to have further reduced his life chances and was likely to have contributed to him having a poor sense of identity.

Examples of resilience were implicit in all of the participants' stories. It was Keith's tremendous self-belief in his abilities, for instance, that made the difference in him achieving his aims. Keith's life script of being destined for success, and his strong sense of identity, contrasted with Michelle's, whose sense of identity was seen by the reflective team as weak. She was dependent on her parents, who provided for her material needs; it may have been that Michelle never really managed to take control of her life in any major way. Interpreting her story, the reflective team highlighted the need for professionals to intervene in her life in order for her to remain well and to prevent her from harming herself and having to be admitted to hospital. The psychological construct that Michelle has in place seems to stem from beliefs that her sanity is dependent on following a strict routine: ***'I've been well for two and a half years, and I have been taking my medication to the book. I've got into a routine now; I treat myself as if I was in (name of hospital). I've got exactly the same routine as they gave me in (name of hospital). I take my tablets dead on time, and I have regular blood tests'.***

In one sense she has identified what keeps her well - routine and drugs - and is sticking to it, indicating a possible case of demonstrating resilience. It could also be, however, that she has accepted the medical view that she cannot survive without medication and perhaps even that there is no recovery, only management of symptoms.

Michelle's decision to stick to the routine she was given in hospital is significant because it signifies a change in her thinking about being responsible for her actions. Her reliance on medication and maintaining a routine connects with, and is supportive of the Hunt, Bergen & Bashir (2002) and De Graeve, Smet, Mehnert, Caleo, Miadi-Fargier, Mosqueda, Lecompte & Peukenset's (2005) study of compliance with medication. This study implies that taking one's medication is likely to extend the frequency between hospital admissions.

As one of the two females in the study, I recognised Hannah's sense of identity as more vulnerable than the others. Her experiences seemed more harrowing and as such, she seemed to have suffered the most: first, the devastating effects of childhood sexual abuse and second, being a 'revolving door' patient. Yet, somehow, it seemed that she was the more productive of the two in terms of overcoming her problems. Perhaps I regarded her as more vulnerable and as having suffered the most because, emotionally, she had the most impact on me. Now, however, she seems to have a stronger sense of identity. This was demonstrated through her telling me the story of her life and her motivation to study and find employment.

It may have been the case that hospitalisation became a means of escape from her abusers. On the other hand, through this escape, she became a victim of the 'revolving door' phenomenon. Because of her abusive childhood, she developed a fragile sense of self at certain stages in her life, however, what seems to have enabled her to cope with the inconsistencies, incoherence and discontinuities in phases of her life was a determined attitude to life. I interpreted this as meaning she was not going to let the abuse or hospitalisations get in the way of her life. In Chapter Four, I similarly interpreted her attitude/motivation for taking part in the study as her desire to tell her story. For her, such an endeavour must have been a monumental undertaking and an extraordinary commitment to overcoming past traumas. Her resolve to develop herself and not be defined by what happened to her was probably what made the difference in her response to the 'revolving door' phenomenon. Ultimately, this amounted to a stronger, more resilient sense of self/identity.

The element of resilience, so explicit in Hannah's story, is not found in Andrew's story. Andrew chose to tell his story through a mixture of first and second-person narratives. He struggled with himself, trying to understand his behaviour and what was happening to him: ***'Is it me doing it to myself, or is it an imbalance in my brain? So that's another thing. I don't really want to find out about it. I don't want to take the time to sit down and think and diagnose myself and think what is it? That's not me.'*** Erdner, Nysrom, Severinsson & Lutzen's (2002) study of psychosocial disadvantages in the lives of people with long-term mental illness seems relevant here. They identify three themes which were found in Andrew's story: feeling lonely, but being unable to establish friendships; having knowledge of what to

do, but lacking initiative; and awareness of the need for support, but not wanting to be subject to control.

Andrew's lack of self-understanding may have resulted from his feeling of not being listened to by doctors, as well as from the many unanswered questions in his head. He may have felt powerless to change his situation (drug taking, social isolation), and as a result, he gave up hope of things improving for him. Consequently, having been admitted to hospital several times, he is resistant to changing his attitude.

The importance of taking one's medication, as emphasised by Hunt et al., (2002), connects with the theme of non-compliance found in Andrew's story. Unlike Michelle, Andrew chose not to take his medication. His belief was that it was morally wrong to force someone to take medication that caused a lot of side-effects. He had experienced these side-effects himself and had witnessed how medication affected other people on the wards. His decision was based on clear evidence therefore; it was perceived, however, by mental health professionals that he was being non-compliant with his treatment. Conversely, Andrew felt that he was not being listened to by doctors and so there was a complete breakdown in communication between them.

Mental health services often prevent patients from being able to make informed mistakes, which are necessary for self development. As a mental health social work practitioner, I am also conscious that the work I do often traps people in the mental health system. This comes about by iatrogenic practice, which takes away service users' responsibility for themselves and then drip feeds it back. By the time we are ready to give it back to them fully, they may have lost their sense of who they are. Therefore, if we are to take patients' sense of responsibility away from them, we need to find ways of returning it successfully so that they can start to rebuild their lives.

C. PART THREE

1. Conclusion about the Research Problem

The application of resilience research to the study of 'revolving door' patient's self/identity reveals the following key points:

- The construction of self/identity is complex and diverse;
- Most participants have the power to change their lives;
- Upbringing/surroundings are important factors in resilience;
- Changes in self/identity can happen over longer or shorter time periods depending on the circumstances of the individual.

These findings are set against the background of a mental health profession that believes that some conditions are chronic and that there can be no recovery. This study presents both the complexities and value that in-depth interpretations of such cases can provide. These findings challenge previous thinking about 'revolving door' patients and encourage social workers and others to no longer cynically view readmissions to psychiatric hospital as simplistic.

In the sections below I discuss the value of the study in terms of:

- Contributions to knowledge
- Implications for theory
- Implications for policy
- Limitations
- Implications for further research

2. Contributions to Knowledge

One of the most important aspects of the co-constructed narrative accounts in this study of the 'revolving door' phenomenon is that the individuals involved actually lived their stories and transformed them into spoken words. These words form narratives that reflect strength and resilience, which helps these individuals to overcome and achieve positive outcomes in their lives, and are a welcome balance to the tendency to medicalise human problems. Indeed, the uncovering of resilience

as an over-arching theme or theory applicable to this study is the singularly most important contribution to knowledge that this research makes.

Because I believe 'revolving door' patients, like all members of society, draw meaning from the events and experiences in their lives, it is important to understand what these experiences mean for them. The key truths, therefore, that these stories illuminate are:

- Mental illness is not the final definition of a person. It is often the case that once a person has an episode in a psychiatric hospital, they are viewed as permanently affected by the admission. The stories in this study illustrate that this does not necessarily follow because each person is unique, with their own histories and anticipated futures.
- 'Revolving door' patients show their resilience by a willingness to return to a life that is considered 'normal' by society in the face of perceived threats of discrimination, stigmatisation and further admissions to psychiatric hospital.
- There is a multiplicity of ways in which participants' idiosyncratic characteristics affect their self/identity.
- Circumstances make us who we are; when we know 'revolving door' patients' stories, we understand who they are and how they come to understand their own self/identity.
- The complexity of these stories illuminates the difficult decisions that social workers and other mental health professionals have to make in the course of their work.
- This study illustrates the need for social workers to recognise and value the diversity that exists amongst 'revolving door' patients, including their individual cultural uniqueness and needs.

Given these illuminations, what then are the lessons for mental health services, and social work more specifically?

Within the existing model of mental healthcare, the NHS and Social Services have tried to meet the needs of 'revolving door' patients by providing day centres that patients can attend. Patients can also expect visits from either a social worker or a community psychiatric nurse (CPN). These visits are time limited (usually one hour, once or twice a week) and are concerned with monitoring the patient's mental state (looking for signs that indicate relapse). The rest of the time the patient is left to cope on his or her own. Consequently, readmission to hospital often occurs (Chapter One). Once in hospital, the patient enters into a false environment where there is routine and support. If they are there long enough or often enough, they risk becoming institutionalised. Back in his or her environment/community after discharge, they discover that they are treated differently. There is no routine or things for them to do, yet they are expected to behave as they did when they were admitted. This approach certainly does not work in preventing the 'revolving door' phenomenon from happening. This means that a different approach is needed in the way community services are designed if the 'revolving door' phenomenon is to be prevented. In designing services to meet the needs of 'revolving door' patients, the following points need to be taken into consideration:

- Not every patient recovers in the same way.
- 'Revolving door' patients need to have more choice in their care and freedom to make informed mistakes; in this way, they develop a stronger sense of self/identity.
- Revolving door patients have psychological strengths which must be identified and incorporated in an empowering way. These strengths function as sources of resilience which, in turn, offer potential for change.
- Social workers and other mental health professionals need to help 'revolving door' patients construct meaning, by allowing them to talk about what happened to them and by helping them build a positive self/identity based on their capacity for change, self-belief and personal control.
- If interventions designed to prevent the 'revolving door' phenomenon from happening are to be successful, resilience needs to be considered as key to

understanding the process in which the patient is able to evaluate his or her own self/identity and form perspectives on his or her circumstances.

- Social workers and other mental health professionals need to engage with 'revolving door' patients in the spirit of discovering what it means to be that person. It will mean working with patients in their social context and listening much more carefully to their lived experiences. This process would imply a moving away from the power dynamics that position the social worker/mental health professional as expert or authority on a patient's social and psychological needs.
- Social workers and other mental health professionals need to be curious. There is a definite need to keep searching for meaning, leaving aside the fact of chemical imbalance and instead accepting that revolving door' patients, like the rest of us, have a story.

In Chapter Three, I used an archaeology metaphor to convey the sense of buried artifacts. This was to emphasise the work undertaken in this study as a task of uncovering stories that would otherwise remain hidden as memories of the participants. Indeed, the stories were meticulously excavated through a careful, respectful and dignified approach. In conducting the research, I arranged for a safe environment in which participants were able to speak freely without fear of being judged, ridiculed or demeaned in any way. Indeed, these individuals gave their stories unreservedly, without coercion or recompense, an important concern in acquiring participants' personal stories. Conventional quantitative approaches using questionnaires or semi-structured interviews would not have been able to obtain the kind of information that using a biographical approach offered. In fact, biographical research provides a reflexive space for the researcher to learn as well as gain understanding of research participants. Etherington (2006 p. 36) states: 'Reflexivity requires self-awareness but is more than self-awareness in that it creates a dynamic process of interaction within and between ourselves and our participants, *and* (her emphasis) the data that inform decisions, actions and interpretations at all stages of research'. So, in listening to the remarkable and extraordinary set of circumstances that affect 'revolving door' patients, one can gain a better sense of that person's life and the meaning that certain behaviours have for that person's self/identity. The

methodology thereby connects with contributions to knowledge/understanding of 'revolving door' patients by providing information about their identities that otherwise would have been missed using conventional methods.

Amongst the most interesting aspects of this study, which makes it unique, is the use of the Biographic Narrative Interpretive Method as a data collection and analysis tool. The Method contrasts greatly with more traditional approaches to qualitative research. The key significance of this approach is that the research agenda becomes that of the person being interviewed and not necessarily that of the interviewer or research sponsor, as is often the case. The importance of not disrupting the *gestalt* of the person's story highlights the Method's uniqueness. Additional significant innovation is accomplished by providing people with mental health problems greater opportunities to have their voices heard in research studies. These innovations will be useful for mental health professionals, researchers and policy makers in future research projects involving participants with mental health problems. Mental health professionals can also better understand complex inter-relationships by using this approach in their work. Indeed, one of the prime benefits of this approach is that it facilitates the (co)construction of an in-depth understanding of the reality of marginalised and vulnerable individuals.

Researchers will benefit through knowledge of the Method as an appropriate research tool applicable to social inquiry in relation to this particular research group or to others who may be perceived to be particularly vulnerable to systems and misunderstanding. This Method suggests a new paradigm for researching vulnerable adults and sensitive topics. Not only that, it empowers the interviewee in the research situation by challenging power relations, while aiding reflexivity in the research process. For policy developers, this study challenges the low priority given to qualitative research. The study demonstrates that 'revolving door' patients have a wealth of information about their circumstances and are in an 'expert' position in relation to influencing policy.

3. Implications for Theory

My approach throughout this thesis has been based on the (re)construction of 'revolving door' patients' identities. The intention was not to generate a 'grand' theory because this is not the purpose of postmodern research. Rather, interpretations of the study's findings provide knowledge about self/identity of 'revolving door' patients and contribute to mid-range theory development in the field of mental health which, can be used to inform social work research and practice.

The reflective team could be described as being a fragmented approach to data, as it embraces a wide variety of perspectives. In fact, a broad range of interpretations is one of the strengths of this method. Before the study, participants were regarded as living one-dimensional lives. Although it is commonly accepted that any *lived life* is complex and multi-dimensional, within the mental health field it is often the case that people with mental health problems are not afforded such complexity and their lives are seldom considered beyond their illness. This study dispels this myth and encourages an approach that appreciates that every life, (of the 'mentally ill' as well as the 'mentally well'), is made up of a variety of complexities and diversities.

4. Implications for Policy

I anticipate that this study will give mental health professionals and policy makers a better understanding of the complexities of experiences that 'revolving door' patients are subject to within mental healthcare systems. Indeed, this study has been about how 'revolving door' patients (re)construct their identities and how multiple admissions affect resilience. Given that it is through storytelling that a person comes to know and form his or her identity, it would seem essential that attention should be given to an approach in both research and social work practice that affords them this freedom.

The therapeutic value of telling one's story should not be underestimated. It was demonstrated in this study that a biographical method is a powerful data collection and analysis tool for constructing knowledge/understanding about 'revolving door' patients as well as valuable in helping participants redefine feelings about their experiences. This study is therefore important in two ways:

1. It provides an examination of the cycling of patients in and out of psychiatric hospitals and suggests potential prevention measures which could stem this tide; and
2. It offers a paradigm shift in the very way 'revolving door' patients are conceptualised in the first place, which relates to the Recovery Model in healthcare and the wider government framework for determining actions.

Walker (2006 p. 79) clarifies the point when he argues that: 'You can have the best recovery program in the world and still be linguistically casting clients in roles in which they are in fundamental ways different from the rest of society'. Walker is referring here to the language of the medical model in which individuals are described by terms such as 'patient' and are ascribed identities which tie them to their diagnosis (for example, schizophrenic). This practice re-enforces prejudices, stigma and discrimination.

There is no doubt that mental healthcare in the United Kingdom is rapidly changing. Kinderman, Sellwood & Tai (2008 p. 93) argue, however, that many commentators, particularly sociologists and psychologists, view systems as remaining wedded to this medical model and not 'fit for purpose'. In their attempt to bring about change, they identified a psychological model of mental disorder as assisting mental health service policy development and implementation. The findings in this study support this view. They also provide evidence through which the status quo of healthcare can be challenged.

This thesis identifies the complexities and multiple divisions within society and key issues in social policy such as: Who gets what? And who is in control of this decision-making process? Indeed, one of the dominant questions often debated is the extent to which the NHS meets the needs of 'revolving door' patients.

With the implementation of Primary Care Trusts (PCTs) come renewed opportunities for patient's stories, such as those told in this study, to give a better understanding of the work necessary in modernising and developing mental health services. Until recently, changes have tended to be without input from the people affected directly by them (see Chapter Three). This study emphasises the need for policy makers to listen to the stories told by 'revolving door' patients, as it is only by doing so that changes will get to the root of the problem of the 'revolving door' phenomenon.

5. Limitations

In this study, the complexity of the 'revolving door' phenomenon was examined using specific criteria. The selection of seven cases brings with it many limitations as far as making generalisations are concerned. Each case was a unique representation of the life events and experiences of one individual. The representativeness of the seven participants relative to the 'revolving door' phenomenon can, therefore, be best understood as individual cases. In addition, because the Method produces large amounts of data, it is too time-consuming and unrealistic to expect to analyse the wealth of data generated. Thus, only key sections of the data were selected for in-depth analyses in this study. In certain instances, the text selection process consisted of searching the data for shifts in the mode of narration by the interviewee, for example, I searched for text containing Labov and Waletzky's (1967) five principles of a story. Text was also selected for its ability to bring to light potential themes and their development, like humour, and emotional states, such as happiness and sadness. In one case, for example, the interviewee's use of sighs and coughing was microanalysed for meaning and theme development by analysing the dialogue surrounding these physical utterances. All narrative microanalysis followed the order in which they were expressed by the interviewee.

6. Implications for Further Research

Based on the findings of this study I make the following recommendations for further research:

Single Case Study

The conclusions as well as the limitations of this study bring forth some interesting possibilities for future research. A more thorough understanding of the 'revolving door' phenomenon as it relates to one person could be achieved by considering a single case in more detail. Biographical investigation of members of a person's family or relevant others, for example, might offer another dimension to the case.

Multidisciplinary Approach

The limitations of the study of 'revolving door' patients could possibly prompt further exploration of the 'revolving door' phenomenon from the perspectives of mental health professionals across disciplines. This would enable researchers to compare and contrast approaches to mental health service delivery.

Ethnic Awareness

A biographical study of black and ethnic minorities in relation to their experience of mental illness may be a good avenue for further research. This is because it is a widely-held view that black patients are over represented in the mental health system and have far more readmissions than their white counterparts. It would be interesting to research what multiple admissions mean for these individuals. It would also be interesting to research the generational life stories of black people, in the same context of multiple admissions to hospital, to see what sense each generation made of their lives.

Dissemination

Another recommendation would be to produce training videos from this study which would be available to researchers, practitioners and service users so that they can learn from each other about what it is like to be a 'revolving door' patient. The video would be useful for stimulating discussion in workshops, seminars and at conferences.

7. Concluding Reflections on the Analytical Approach

In this thesis, I have demonstrated the fact that the experience of having multiple admissions to psychiatric hospital has not been addressed in-depth and in a meaningful way within medical and sociological research spheres. I have criticised quantitative/deductive approaches and highlighted the need for qualitative/inductive methodological approaches to help understand the experiences of 'revolving door' patients.

I have also shown that the Method belongs to a growing branch of qualitative methods that focus on story, its composition and its telling. It is a useful data

collection and analysis tool for understanding the psychology/subjectivity of the individual. While there were some barriers to interviewing this particular research group, such as the possible difficulties of narrating a coherent story in times of crises, when personal identity is necessarily in a state of confusion and flux, I propose that the Method is a means by which people can relate experiences from everyday life and, in this way, provide opportunities for us to come to some understanding of what those experiences mean to them.

I have presented in the sections above an understanding of how the psychological differences between the particular participants in this study have contributed to the different responses to the 'revolving door' phenomenon. In so doing, this thesis answers the research question and makes the claim that it bridges the gap in knowledge identified in the literature review. These findings move the study of identity and multiple admissions to psychiatric hospital forward on two planes. First, it adds to theories of identity by relating the study of self/identity to the 'revolving door' phenomenon. Second, it asserts that the nature of self/identity is complex and exists within a cultural matrix of social and psychological constructs. This acknowledgement heralds a new approach that proposes to redress the current problems of reductionism and lack of subjectivity existing in positivistic approaches. It can, therefore, be concluded from the findings of this thesis that the aim of this study was achieved.

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Appendices A- F

- A. Introductory Letter to Potential Participants
- B. Patient's Information Leaflet
- C. Consent Form
- D. Sample Interview Transcript
- E. Example of Thematic Field Analysis
- F. Published Works

Appendix A

Date

Name

Address

Dear

Introductory letter to potential participants

Thank you for your interest in my research.

Your care coordinator, (Name) spoke to you about taking part and has given me your name as a possible participant. I would value the unique contribution that you can make to my study and I am very interested about the possibility of your participation in it.

The purpose of this letter is to offer you an interview where we can discuss the study in depth and answer any questions that you might have. At the interview I will give you a consent form to sign, but you will have up to seven days in which to consider whether or not to take part in the research.

Would you be happy if I come to see you at (Name of place) on **(Date) at (Time)**.

If this date and time is inconvenient you can contact me on **Tel: 07971 728346** or **01727 830031**, alternatively you can write to me at the above address and I will rearrange. Otherwise I look forward to meeting you then.

Yours sincerely

Everton Bolton

Principal Researcher

Copy to: (Care Coordinator)

Patients' Information Leaflet

Invitation to take part in a research project

Date: 22 January 2005

Principal researcher: Everton Bolton

Introduction

My name is Everton Bolton and I am a mental health social worker employed in the St Albans Community Mental Health Team.

I am conducting a piece of research and would like to invite you to take part, but before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with relatives, friends or your GP if you so wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

I will be conducting this study in accordance with the requirements of the De Montfort University, Leicester for the PhD in Mental Health.

You may decline to take part in the study at any point, if you so wish.

Below are some questions that you might want to ask about taking part in the study.

Question 1: What is the purpose of the study?

Family, friends and even professionals often misunderstand people with mental health problems. This is not surprising given the lack of accurate information about their experiences.

This study aims to do the following:

- Explore service user's experiences of living with mental illness through the personal stories they tell.

- Present the findings of this study to hospital and community based professionals, those involved in the planning of social care policy, De Montfort University and, of course, the patients themselves.

Question 2: Do I have to take part?

No. It is up to you to decide whether or not to take part. You will be given at least seven days to consider whether to take part or not. You will be given this information sheet to keep and if you do decide to take part you will be asked to sign a consent form. You will be free to withdraw at any time without giving a reason, and if you do, it will not affect the standard of care you receive in any way.

Question 3: What are the benefits of taking part?

The study may contribute to new understandings of the ideas people have about themselves in the mental health system. In addition, it may help to de-stigmatise mental illness itself.

Depending on the results, it may provide direction for the development of support services for the mentally ill.

Question 4: Why have I been chosen?

You have been chosen because:

- You have a diagnosed mental illness.
- You are aged between 18 – 65
- You live within St Albans and Harpenden districts

Question 5: What will I have to do if I take part?

If you decide to take part in the study you will be asked to participate in at least two interviews. I will be asking you to tell me your life story, all the events and experiences that were important to you up to now.

A third interview maybe necessary to ask more specific question relating to the area of particular of interest.

Interviews can take place in your home or at a mutually agreed upon time and place and can last for up to one hour.

You will also be asked to allow me access to your medical records and permission for me to discuss you treatment with your care team. This is to make sure your care team are aware of your taking part in the study and to ensure that support is available should you need it.

Question 6: What if I wish to make a complaint?

I will take every care in the course of this study. If however, you are harmed in this study due to negligence, then you may have grounds for a legal action for which you would need to pay. There are no additional compensation arrangements for participants in this study.

The normal NHS complaint mechanism is available to you if you wish to complain about any aspect of the way you are approached or treated during the course of this study. Formal complaints should be addressed to:

The Complaints manager or

The Chief Executive

Trust Head Office

99 Waverly Road

St Albans

Herts AL3 5TL

Tel: 01727 897725 or 01727 897701 respectively.

Question 7: Will I be compensated for my time or loss of earnings?

There are no special compensation arrangements for participants. Participation is entirely voluntary and the principal researcher does not take any responsibility for any loss incurred other than travel expenses.

Question 8: Will my taking part in this study be kept confidential?

Yes. All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it.

The findings of this study will be presented to hospital and community based professionals, those involved in the planning of social care policy, De Montfort University and, of course, yourself.

Your name and personal details will not appear in any writing that arises from the study, such as the PhD thesis, or any reports that I write. I will make sure that it will not be possible for anyone to identify you from what I write.

Question 9: Are there any circumstances when my confidentiality might be broken?

I am legally obliged, regardless of the demands for confidentiality, to prevent particularly serious future violations of the law or intent to harm self or others.

Any disclosure of intent to:

Commit acts of terrorism

Fraud

Child abuse

Sexual assault

Arson

Burglary or any other acts that may put you or others at risk will be reported to the appropriate professionals.

Question 10: What will happen to the results of the research study?

The results of the study (but not your individual details) will be shared with hospital staff; those in policy and development departments and De Montfort University.

The results of the study are likely to be available December 2007. A copy will be sent automatically to you about then. You will **not** be identified in any report/publication.

Question 11: Who is organising the research?

Everton Bolton (Principal Researcher)
Department of Health and Life Sciences
De Montfort University
Leicester LE1 9BH

Question 12: Who will review the study?

West Hertfordshire Hospitals NHS Trust
Local Research Ethics Committee
Mount Vernon Hospital,
Rickmansworth Road
Northwood
Middlesex HA6 2RN

For further information you can contact me on, Tel: 07971 728346 mobile or 01727 830031 alternatively you can write to me at De Montfort University

For an independent point of advice you may wish to contact organisations such as MIND or Service Users' Involvement Groups.

I wish to thank you for taking time to read this.

Everton Bolton

Principal Researcher

PLEASE KEEP THIS INFORMATION SHEET IN A SAFE PLACE. YOU WILL ALSO BE GIVEN A COPY OF YOUR SIGNED CONSENT FORM TO KEEP.

Appendix C

Centre number:

Study Number:

Patient identification Number for this study:

CONSENT FORM

Title of Project:

“A study of the experience of having multiple admissions to psychiatric hospital”

Name of Principal Researcher/s: **Everton Bolton, DipSw, MSc.**

I (name)

of (address)

Please initial box

1. Confirm that I have read and understand the information sheet dated 22 January 2005 for the above study and have had the opportunity to ask questions. ☐
2. Understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and that this will not affect my medical care or legal rights. ☐
3. Understand that sections of any of my medical notes may be looked at by Everton Bolton where it is relevant to my taking part in the research. I give permission for him to have access to my records. ☐
4. I agree to take part in this study and I grant permission for my personal information to be used anonymously by Everton Bolton in the process of completing a PhD degree, including a thesis and any other report or publication necessary. ☐

Name

Date

Signature

Principal Researcher

Date

Signature

Witness to consent (if appropriate)

Date

Signature

Copies: 1 for patient, 1 for researcher, 1 for case notes

Appendix D

Sample Interview Transcript

Andrew Simpson	Told story
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Ok, I would like you to tell me the story of your life, all the events and experiences that were important to you until now, start wherever you want and take all the time you need, I won't interrupt you, but will take some notes for after you have finished telling me about your experiences.

My name is Andrew Simpson erm I was born in 1978, lived a pretty normal life, erm went to school, everything was basically normal until I went into hospital. Erm that's when I suppose getting schizophrenia changed my life in different ways, (4) different parts. I don't know what different parts stick out in my life. I don't know what what I'm going to talk about, like work, work wise was normal, doing work was normal and that was good. When I was at school I had a good time, everything was normal. I had a not bad chil upbringing, (2). Had a few girlfriends in my life, go the pub occasionally, what else, (cough) like enjoying myself. I like doing different things erm (2). The only problem I've got at the moment I suppose is my mental health and about what's happened with that and that's one of the strangest things that's happened to me in my life not being able to understand why I've become ill, why why why it effects people in different ways and what what what it actually is.

I don't understand the mental illness side of it. It's frustrating at times having to take medication being told this is this is going to make you better when you don't hundred percent trust what's what's going on around you erm (3), What else erm?

Its not nice going into hospital or being involved in that environment or being stuck in that environment should I say. It's (cough) it is frustrating and you get told that this is what's wrong with you and you get diagnosed and you don't know whether to trust trust what's being told to you and you know they are professionals and they've done this job for a long time and they are people are qualified qualified to do this job but

erm like I said you don't you don't know whether to trust if you are being told the right things or not and its hard having to learn about mental illness and pick yourself again from when you've when you've had erm a psychotic episode or a breakdown of some sort and erm. That's one of the main things that sticks out in my life and I was thinking would things have been different if I hadn't gone into hospital and would my outlook on life be different. Erm (2) would I be in the same position in that I'm in now if I didn't go into hospital? Would would I be working still? Would I, I ask myself these question all the time. Erm (2) would I have a steady relationship? Erm (2), erm (2) would I be enjoying things more would I be going out with my friends more, these are questions that I constantly ask myself about about myself, being put through, well not put through, but going into an episode does it change your outlook in general in the whole lot as if you have one of these episodes does change your perception on life? Does it do you does does do you go do, do you actually go into hospital and then come out the same or do you change, this is the questions I keep asking myself constantly because I mean, I've lost work because of going into hospital. I am not working at the moment. I'm not doing as many things. I don't sort of like go out with as many friends erm (2) and generally my mood is not as good as it used to be, and I'm not as easy going as I used to be. So, and these are the questions (6) you seem to sort of have, and when you go into hospital you seem to sort of shut yourself out off to reality because a big part of that has been taken away from you like the responsibilities as well. When you have carers coming out to see you it takes your responsibility level down, you start doing, start relying on certain things and that and you are not as strong as you used to be as well so that's another thing about that and its just frustrating, you have no control or say over your life its like being a kid again. It wasn't like it before you went into hospital and that's another hard thing to being being able to let people into your life and have a say in your life. It takes away your part of sort of (3) I dunno, it takes away a part of you because you have to bow down to what people are saying because you know they are right about what what they are doing and how, the medical health team I'm talking about. They are right with the medication they are giving you or telling you what's wrong with you because you've obviously been in hospital for a reason, and you have to let them in and take on board what they are doing and saying and it takes a big part of responsibility out of your life so that's another thing erm.

What else? (8) Uhm, I dunno. With my life I know this talks about anything but what sticks out is the mental health bit. That's the only thing I tend to talk about because like everything seemed normal until I went into hospital and it's the same question I ask myself. What made me go like that? (5) Uhm, I don't think there's an answer to that sort of question. I've asked doctors and they just give you statistics. They just say yeah it can happen to anyone out of so many people and its just one of those things. Yeah, I felt in control of mostly of part from a couple of times and I don't think (cough) that erm the doctors appreciate that enough because I mean uhm, there's a certain amount of control in me. Whereas I've seen people in other institutes or in hospital where they haven't had that control and when the doctors go into my thing I sort of I'm more depressed on my side of things. I sort of like kept going into hospital and had some control. That's what I'm saying what makes people, it effects people in different way obviously, but that control, I mean sort of like, I could make myself better from that control so I've been able to rehabilitate myself but like I said I've never felt the same since I've been in hospital. I mean and erm but it's questions you ask yourself, am I going to get better and am I going to get the stage I was before and you seem to get the same answers from the doctors and these pills will keep you stable and will erm stop you prevent you from relapse but in some ways these pills are then controlling some of your emotions and that that doesn't feel good because its another thing you want full control of your mind and body and I mean fair enough I think that's one of the reasons why people stop taking the pills and go back into (cough) hospital. Because they want more control over themselves and some people can handle that control and some people can't which is fair enough that's when they need the medication but erm, it's like uhm (10) yea control with the doctors, its its sort of like (4) pills take away a part of you as well and I dunno, its like that, its all about control. I think and I mean if you can't control yourself the way you want to I dunno it takes a bit of your pride away. I think and that's another part of trying to rehabilitate yourself as you think I'm not the same person sort of thing. You go outside and you don't feel the same and I dunno there's probably another reason for relapse because you don't know enough about yourself, that's the way sort of that's the way my cycle goes when I've had enough and stop taking my medication. I just shut away, and that's another part sort of what my illness is, other than that I've been in hospital. What I've seen of hospital wasn't too bad. I mean people are generally nice. Uhm I've had different outlooks on life. I mean at one point everybody things

the whole world is against them in some sort of way but that's another thing you learn as you get older or as certain things happen to you. You learn different things about different people, different things and you learn to take more in you know what I mean, and that was one good thing when I went into hospital. Because I learn that there are good people out there and do different things and are actually probably genuine and like most people just want to get along, but when I was ill I thought the whole world against me sort of thing but that's just a natural natural thought (cough) but when I was in hospital I got thought different things met some nice staff in there, nice clients and basically started to see things better than I did before I went into hospital. I think the whole thing about hospital was a good learning experience it helped me out a lot, but its still the same question it doesn't stop people relapsing and why do people relapse at the end of the day, have they had enough, or is it just a thing that's in their head? That's keep happening like an imbalance that's my main thing, is it me doing it to myself or is it an imbalance in my brain so that's another thing, I don't really want to find out about it I don't want to take the time to sit down and think and diagnose myself and think what is it? that's not me, I don't want to sit down and think is it me or is it my brain. Is it me because I'm feeling depressed that's what I think at the time, just start making things up, well doing stupid things, well not stupid but doing things that are not right. Uhm so like I said I'm not going to try to diagnose myself, due to life at the moment I think I'm going to try and get a job and go back to college time spent at the moment I'm just sitting at home doing nothing (cough). Just watching daytime TV. Getting up at about 10 o'clock, watching TV going to bed at about 12 at night. Not doing anything productive not engaging myself in anything hopefully that will change in the future.

I hope to go to college next year or something like that to actually do something get a qualification because I cant stand being at home. At times you need some form of activity in your life, work or work definitely work you need to engage in what you do. You need to engage your mind, otherwise you tend to sit and think about things and that's not good for your mental health.

Erm erm go out and drink at the moment, drink too much and smoke cannabis, smoking too much cannabis still, erm hopefully like to stop that soon, erm I think I think due to becoming ill erm my cannabis level sometimes can go up high to smoking it lot and drinking a lot of alcohol. That's that's another thing that sort of like

concerns me because its not that I don't want to stop it it's a fact that I l've got don't have anything else to do. I get bored easily and I tend to smoke more and then the time tends to pass faster but while that's happening I'm still under the influence of alcohol or cannabis. My brain just seems to be wasting away and I think this is all big factors of why I went to hospital in the first place but I mean it feels like at the moment that nothing is getting better in my life and not until I actually engage in sort of going to college or getting some form of work I don't think any of this will get better. But its not getting to the point where I'm in despair it it its manageable but it is boring. Erm yea so definitely work work and have some sort of structure to your life and I think those are erm good things to keep yourself rehabilitated.

Uhm (2) whereas girlfriends I haven't got any girlfriends at the moment erm (1), er relationships don't seem to last at the moment, which isn't bothering me!, Erm erm (2) friends as far as friends are concerned I've lost a lot of contact with friends over the pass couple of years I don't know whether that's part of my illness, well not my illness but going into hospital and people stigma they have their stigma about the mental health side of things I'm not too sure whether that's the issue or whether its just me or just friends just growing apart but like I said I've lost a lot of contact with friends. I've only got a couple of friends now, but that's not a problem in ways it makes things easier gives me a lot more time in the day to think about myself in some ways that's good and some ways it's not uhm (8). What else?

Uhm (3) seen a couple of friends who are still in hospital, uhm (2) I don't (cough) I don't like seeing people in hospital. Erm seem to sort of er feel that they've had something sort of like done against them. Like this shouldn't be happening to them. Erm I don't know why I feel (cough) like that, even (cough) when I get put in hospital. I feel like this shouldn't be happening erm that's one thing I don't understand. That's one feeling that I don't understand is why I feel that uhm people shouldn't actually be in hospital, but I know they should and erm like if if if if if if you are unwell then you need to be in hospital but that's just one thing I needed to say that uhm I don't understand that why I feel that people don't need to be in hospital but that's one of my crazy thoughts erm (3).

What else is there? Erm (6). Yea, I'm having contact with the outreach team erm which is two times a week. I think that also that's a good part that keeps me uhm sort

of on the level, keeps me sane if you like. I need somebody to speak to, and everybody needs someone to speak to on different on different levels because you talk to you friends and you get the same same input or the same (cough) same sort of like conversation cos its just sort of like about one thing and your friends are not doctors or anything. So they are not going to talk to you in a certain way or are not going to talk to you about certain things like mental health issues or anything. So (cough) having the (house phone rings three times)outreach team around does help to talk to them and have a different input into what's going on and why you react to certain things and why you do certain things and just to see someone like is good. That's a good thing that's happening in my life at the moment it's keeping me out of uhm hospital. Er they help me with a lot of stuff, like I said going back to what I said earlier that that takes a big responsibility out of my life I don't know whether I (cough) like that 100% but I mean I know it's it's a part of what's happened (cough) and what's going on at the moment. So I'm not too bothered about that erm (8).

The main problem (slight chuckle) at the moment is just killing boredom. Boredom! I don't know what to do with my boredom. I know I've got some plans for the future with college and that but I'm bored (bad cough). Sitting at home just seems to be getting worse, but like even when I do go to work it's it's not it's not just the work it's coming home and I'm still going to have the boredom. I think that's one of the main contributing factors why I started to uhm have my mental sort of like mental issues. Uhm because I was so bored and didn't have nothing to do with my time. I know I know like people say there's loads of things I could do and engage myself but I don't I don't know what it is why I get so bored and want to do different things think and why my mind travels and I like think I need to engage myself more in activities as well as work. I mean that's one thing I will be sorting out with myself is to keep myself always occupied and have something to do and get some different interests in the future but and that's another thing that leads me onto this. I mean I've changed now and I don't want to do these things. I'm talking about them and I know I know it's sounding good to do all these things but there's a part of me that doesn't actually want to do anything. I think this is the thing that's always always sort of held me back because there's one big part of me that doesn't want to do anything. I think that's that's what makes me sort of relapse because I don't want to do anything I get depressed and get low, and I dunno, (2) it's just I've got to think of it as I've got so

many years left on this planet and I've got to actually do something otherwise I will end up in hospital again and again. But it's like what do you do to motivate yourself. I mean I'm still lost so I don't know about that. Changing the subject (erm 5),

Uhm (10 lights up a roll up) I want to eat healthy (laugh). I dunno, I want to go to the gym and eat healthily and do the right thing, erm that's it! What shall I talk about erm (3)?

You're doing really well

Hopefully yeah I'm getting a flat soon erm by the council. Hopefully I can move into there. When I start work I want to buy it. That's another thing, I want to buy a house as well. I want some sort of property. Erm being on benefits is not helping me at the moment. I've been on benefits for a few years and it just seems to me that I'm reliant on the government for money. That's another reason why I don't think I've got back to work quickly because I've had money always there since I went into hospital. I was getting benefits getting disability living allowance erm this doesn't help you really. It just makes you sit at home doing nothing. That's another reason why I'm at home still because I want my flat I want a flat off the council, so I can have my own space. Living with people is getting too cramped at the moment. Being around people is not what I want in my life. I mean I've got to a stage now where I'm 27 I need to have my own space. I need somewhere just to, well I need somewhere of my own so can put my feet up and watch what I want on the TV and er just have a little bit of space to myself (erm 6). Living with about four people if you've had a mental illness it just seems everything just seems to be pushed into one space and everybody seems to be living on top of each other uhm and you seem to clash and I mean I can't handle clashing with so many people. That's the main reason why I want my own flat. Erm I want to start work when I get my flat as well. Hopefully when I'm saving in a good few years, maybe 5 years think about buying somewhere (mobile phone goes off). I don't think I don't think I want to live not live I don't think I want to grow up and have nothing to show for what I've lived for. I want something of my own (mobile phone goes off again) er and (2) a flat or something like that is definitely definitely what I want. I don't know if I am going to be able to do it or not but its just one of the things that are in my mind that I want to do within my life. Erm going on holiday I mean at least once a year, is got to be another thing I want to do, definitely have a holiday

once a year. I mean when you get older get older it's definitely something you want to do I want to see different places in the world? Erm what else (12)? Can we stop for a minute?

(Interview and tape stopped after 30 minutes 41 seconds)

A break was taken at Andrew's request. During this time Andrew made a cup of tea and I took the opportunity to write some notes. We resumed the interview after six minutes:

Yea uhm (1) I said about holidays I just wanting to go on holiday anywhere around the world at least one holiday every year. Er these are just things I want to do like something to look forward to if I start work or anything like that. I mean I can't stay where I am at the moment not doing anything because its not productive enough and it's not helping me in any way.

Doing things in my life I mean I haven't that many things. I haven't done that many things. I've I've I've just done normal things in my life just like I've had a few holidays here and there uhm I've been to work. I've done all the normal things and (cough) losing that part of my life to do what I'm doing now is is is a big step and it puts you in such a way that you think that you've lost everything for ever. But it's not like that and it's its just like these little things like holidays and that you look forward to and work and that to sort of build yourself back to er some sort of control over your life.

Erm erm (3) everytime I've been into hospital I've never like it. Erm (2) I've met different people in hospital with different uhm illnesses. Erm (2) its its its its been one those experiences that I mean I would have changed if I could I wouldn't have liked to me in that situation. I would have changed it if I could. It's it's one of those things that erm that that once it's happened to you you no longer feel you are part of society. You're no longer the same person and you no you no long you're not you feel like you're degraded is some way. Like you've done some some outrageous act and everybody is looking at you or everybody is talking about you because you're not the same as them. That's one thing that does happen when you go in hospital but you meet uhm different people and all those different people that I did meet I think that the same has happened to them erm (2).

Once you've in hospital you don't feel the same, and you seem to react to people differently erm (3) erm but the doctors will tell you that's not the case and everything is normal but when you drift away from society its always going to take you a little while to immigrate into it. The doctors normally say it could have been you before you went into hospital before this has happened to you could just have been you and that you probably just imagining it but it does seem very real at the time. And uhm I think that's one of the big things about getting back to reality if you like is is trying to integrate again and it just seems as if everything is going against you and all these things just build up an up an up and up and then you think oh I've had enough of this and then you just start drinking more alcohol or smoking cannabis and all these thoughts about going to work an that go out the window and you just go back to square one again. And it's that what I want to get out of at the moment I want to have something in my life. I want to have go to work and do these things and its its its its its like I will have to do it in a way that I give up doing what I'm doing drinking alcohol and going back to work and think like right, that's it now, and just basically keep keep on the wagon. Uhm uhm cos I've met people in my life and they talk about doing the same thing over and over again and they never seem to do it. And I don't want to be one of them people talking about it now and sort of like being recorded talking about it and not being able to well not not been able to do but not doing anything about it and getting to an age where I'm not been able to do anything about it. So, erm it's it's it's finding a balance and being able to maintain yourself and get back to normal if you like and do the right thing. Well, that's what I think anyway. That's what I believe I think that everybody needs to have work in their life have their own place and just things like that (4).

Going back a little bit uhm (4) I find myself in situations now that uhm I react in different because of being in hospital. I'm no longer like as aggressive as I used to be so which is one good thing. So there are things that helped out from being in hospital so I want to use that to to to my advantage. To to get get something productive going in my life. Uhm (3) erm I have forgeotten what to talk about.

Just whatever comes to mind.

Erm (7) erm (6) (Lights up a roll up) (10) I'm lost, I don't know what to talk about. I'm trying to find something to talk about erm erm (15). I was just trying to think of

something to talk about erm. It's hard to think of something to talk about erm (4). Different things to talk about gardening and the weather or something erm (3). Yes, since I've been on medication in hospital I 've had all these side-effects that happened to me. And uhm I was just weighing up the advantages of taking medication and thinking is medication is medication given in too much of a quantity? Is it given out too freely and does it do the job that it's suppose to do without causing too much distress to the client as well. Uhm this is something that I have a big issue about talking to my doctors all the time. We've been trying to change we've changed medication a couple of times trying to get the right medication for me. Uhm I don't know whether they give too much in one go I don't know whether they are too ready to give this medication. It seems when you take it you are drugged up you have you have you are sedated a lot. You can actually feel it. Whereas doctors actually would say that erm these drugs are quite good and you shouldn't feel that much off of them. And then they contradict themselves saying that if they had taken these tablets then they would feel tired. Like when they had given to them to people if you react well off these medication then they would say well you're not drowsy and that. Erm, so, normally if you give this to people normal people well not normal but if you give this to a person who hasn't got any form of illness then they would feel drowsy or whatever. So they do contradict themselves in ways in one way that pill don't make you drowsy and in another way if you give it someone who hasn't got a mental health oh, it would make them drowsy so I mean like are they too ready to give this drug to you. And do they give you too much medication and do they not care about care about I know I mean the system is there so that you can work with the doctors and you can say look this is making me feel bad or whatever, but they still want to give you. It seems they still want to give you a high dose of medication, and can you function as normally as you would if you wasn't taking that medication? These are all things that build up and obviously the side-effects you get from taking medication is is uhm at the end of the day is it worth taking it?

Erm some people can stay well for a certain amount of time without taking medication then they get ill again and they take the medication and then they won't take it. So In theory they are well for an amount of time without taking this medication so do people or do I need as much as what they are giving me. I tried talking to my doctors about this but its an ongoing battle well not battle its an ongoing procedure at

the moment I'm still working with my doctors to find the right dose so, or the right medication for me. Uhm but I in my mind at the moment I don't know well I'm not hundred percent for what the doctors are giving me because I don't know whether if it's too much or not right medication and with with stuff like that I mean (5) I dunno I have seen stuff on TV and I've I've have heard things on the radio that doctors or mental health service are giving out too strong a dose to people. It's just the little things it's not major it they're not big things have seen on the TV it was just a little debate that I heard on the radio as well it was talked about that do doctors give out too strong a medication or strong dosage and stuff like this an that's one of the things I think about as well do they give me too much or not the right stuff an that.

I've seen people in hospital and I don't know what they was like before but I seen them in the hospital after taking these drugs and I've seen them dribbling and shaking they look like they have been taking crack or something but they haven't they have just been taking medication.

I don't know how people could justify in making someone into a dribbling shaking nervous wreck rather than being like what they was is better for them. But I mean yea obviously there's another side to that because there are other people involved. And, obviously it's about care at the end of the day and there are other people involved so it's about harm to other people as well as yourself. So yea, but it's just a question I ask you is it justified that making someone one way is better than having them like sort of like well. If that person was just looked after and given care instead of given medication after a certain amount of time would he rehabilitate or would he not? I mean I know there is not amount of time given to people's medication or, if he was given a lot care without medication would he rehabilitate or not?

That's the question I ask. Erm and (3) what else? Erm (2). Yea, Acuphase! I've had an acuphase when I was in hospital. I don't know whether like I said that's why I ask this question because I've seen people given acuphase and they have been asleep for three days an that and like that's another thing. How can making someone sleep for three days make them better and stuff like this. I know I know people get unwell and drugs are need at times but I mean still is it hundred percent right or not? Erm (5) yea mixing cannabis with uhm medication anti-psychotics has an adverse affect on you as well. I mean uhm it seems to do things to you like you you you you get a

really heighten perception of things and with alcohol mixing it with anti-psychotics it it affects you twice as much. It's sort of like you can't lead normal life from taking these drugs although it says you can continue a normal life but you can't basically. You can't drink and you can't do the things you were doing before.

There are these things as well. There are loads of things with these tablets you can and you can't do and it's just weighing them up to think is this good for me is this good for everyone. Erm er erm (3) Cos I like to smoke I like to drink but sort of like it's getting to the stage I don't to do these things cos I don't feel so good cos I've got medication to take. And it's mixing and it doesn't make me feel good. And its like that, that's another thing that that the mental health has got over me cos that's playing a big part in my life that's taking away something I like doing. And I can't do it as frequently or as much I used because of different things like this.

I also feel drowsy when I take medication that's what I was talking about it (33) erm, er. I mean it's just funny the different people you meet along the way when you go through life. You said to tell your life story. I mean but a life story can go on for ages uhm. But its funny the different people you meet in your life and and (3) meeting different people and and how you react, If I had never gone into hospital I would never even have known about about what it is. If someone had said to me, schizophrenic I would have just thought uhm nutter, someone whose not well. But I mean its funny how normal people are when you meet like like from like if I was to meet someone from hospital they they they are just as normal they have just got a few issues. But its funny the different people you meet. That's what I was saying earlier. Would I be the same person now as if I didn't go into hospital and have all these things sort of like happen to me and could it have been prevented? Uhm, (4) like but, talking about the funny people you meet, I mean the people who go to (name of hospital) and places like that uhm they have to go there everyday and see these different things and I mean they have to go to work every day and it's it's it's more or less the staff you have to trust when you're in hospital and most of them are genuine people and they're nice and that's what I'm saying there's lots of characters that you meet. I think from having been in that environment and meeting all these different people I think it is hard to to sort of break away from that because cos you meet characters and you feel like drawn to certain situation. And like you remember things and it brings back memories of how things were and different things like that. And I

mean when you get put in that environment is is is that environment actually making you better or is it sort of like bringing you down in one way because You you sort of like becoming institutionalised into into sort of like everything is okay, people people are friendly people well, people should be friendly all the time it's inappropriate to to behave in certain ways.

When you walk down the road people don't act like that. But, when when when you when you when you're in that situation you're been told this is inappropriate and like that you know what I mean. How are people suppose to get back to normal or rehabilitate quick when when you're put in a situation when you're been taught like a child again. It's this, that's like I'm saying I almost took it as a joke when I was in hospital. I took it as a, I just see everyone as a characters but then in that way like I said I got drawn to a situation when I remember things I thought oh that's alright that's alright been in hospital its just a funny experience. When everything is sort of like, when when when staff is telling you this is serious you got clients just having a laugh about a situation they got themselves into. But it's not the situation, it is serious and it just seeing those two sides an that and it's almost as if you're battling between those two sides. But, I mean (4) where do you draw the line? And I mean what is funny and what isn't funny? It just feels like I mean you've got to teach yourself again. And (2) and the people you have met you sort of look up to them in certain ways and you think they can get through it, or I can get through it. But you don't know what's going through peoples mind at the time you don't know what people are thinking. So I'm saying, I met a lot of characters along the way that uhm (lights up a roll up), some tell me its good to behave this way and some tell me it's not good to behave this way. And its finding like I said that balance where to draw the line. I think this is what I got to do, this is how I got to behave, uhm, erm (6).

Yea, is just some of the thoughts I had when I was in hospital as well I mean. I mean it's as almost as if you're closed off from reality. Because when you're in hospital and everything is normal and it seems like a big thing. When you come out of hospital you got all these worries. I get worried about my personal health, physical health, sorry, not my personal health, physical health. And uhm I'm always sort of worried about that. When I was in hospital it sort of shut off everything to me. I'm thinking more now and my brain is working a lot faster. Cos I think my brain is working a lot faster, it worries a lot more. I'm worrying about things more and more and more. And it's like

that, you're not told how to deal with all this. I mean you're not told how to react to it in certain ways. And different things, I mean you're told all this information but not how to use it. How to think to yourself, no I'm alright or, cos everyday you wake up you have a different problem. Like one day it's my leg one day it's my chest. I can't get rid of these feelings because I don't know what it is. Like my brain was used to working one way but as soon as I got out of hospital it's working a lot faster obviously and its worrying about things more. I mean there are things that you could obviously be told to put into good use. We're not told how to use it or put into use bout how to calm yourself down and think about different things or anything like that. All you're told is not to get yourself into stressful situation, I mean what is a stressfull situation? I mean anything could be a stress. Having an argument could be stressful to one person. Having an argument to another person could be relieving stress. One person could be blowing off steam and one person could be getting stressed out from the argument. There are two sides to it. So, you're not told how to put it into use. You're just told not to go into stressful situations. What else? Er, ere r (40).

Yea, I see a fight yesterday and I tried, and that was another thing that's what I said I was reacting differently, I see a fight yesterday and I tried to breaking it up. I see these three people kicking this one person in the head. So I broke it up, well I got all the person's blood over my top. It's like that, normally I wouldn't react like that but I mean. There is a part of me now that that that that sort of like, I dunno, like caring. I don't know what it is. I mean like, I see this person getting beaten up, normally I would have walked pass. But now I just tried to break it up and I stopped it. I'm thinking now why, why am I doing the things like this, cos I could have got myself into trouble anyway. I could have got into the fight and into the situation. Uhm (3) like I said is it the medication or what? Does it make you react differently because I wouldn't have done something like that because I'm thinking that was stupid I shouldn't have got into anyone else business. Erm, that's a part of being in hospital. Fights happen in hospital and I've broken them up. And it's like that, you've told that's inappropriate but you're not told how to use it. And that's what I'm saying how how do do I react back into society after I let myself go down one road and then I'm then I'm trying to get back on my feet and get back to normal. How am I suppose to use all this stuff?

I don't know how to react. I see a fight happen so I try to split it up when really its none of my business. It's the job of the police to do that (sips a cup of tea).

Erm (5) er what else?

I'm going to change the subject. I like going out shopping. I like buying clothes. I like going up London. I like er driving; I haven't got a driving license at the moment, I would have to get a driving licence. That's another thing I am worried about is how to pass my test. I don't know how to pass my test because of the drugs I'm on. I will have to look into that (6). Need to go to the optician to sort out my eyes, don't know what's wrong with my eyes at the moment. They seem to have gone a bit blurred.

Erm, (2) everything seems to be going downhill. Like my physical health I'm worried about erm I don't know whether I worry about things too much and its just making me just ill, well not ill, my mind its just playing tricks on me whereas I just worry about things. Don't want to wear glasses, don't like wearing glasses. Erm, don't want to wear contact either, because I don't like putting things in my eyes. Erm, want to buy loads of clothes but I haven't got any money at the moment cos I'm not working. Go out shopping, but I haven't got any money to do that so I'm walking around with hardly any clothes. That's another bad thing about being on benefits because you never have any money, never have any independence because you're always reliant on other people. Everybody seems to be doing things in their life, like something constructive. All my friends are working, doing, got a family, doing this, got a house. Erm got a job, got a car. Where I am at the moment seems like I'm just on square one. It seems like I'm never going to get off this square one. Cos of being on benefit and everything is being provided for me and I'm going to get a flat or a house, and I've got people around me all the time doing things for me it seems like I'm going to be stuck in this in this situation doing nothing and have nothing. Erm (5) I know people at the age of forty and being in my situation and got to the age of forty and still had nothing and start worrying about life then. And I feel it's a little too late to start worrying about it. I know we think about things like this a lot but it's having the drive or the motivation to do things, like go to work and do things like that erm. Is that alright?

That's fine.

I dunno, I was just talking. I don't know what to talk about. I could talk about when I was young but it doesn't seem too relevant to what we are talking about well, what we talking about. Doesn't seem too relevant for why you are here.

I dunno, because we might under circumstances like under the mental health it just seems like that's what I need to talk about.

When I was younger, everything was normal. I wasn't really a model student. I done my work. I went to school and done what I needed to do. I was a student character and got involved in situations like fighting an that. I could have been a better student but other than that went to (name of school). Got expelled in the third year. Erm then went to another school. Passed my exams. Come out of school. Didn't do much for a couple of years, got work with for my dad for a little bit, when I could a week here and week there. That's when I really started seeing the value of money, understanding the value of money. I then I wanted to work. So I went back to work with my dad. Work for years with him but, I think the stress got too much for me and that's when I went into hospital I think it was 2000. Erm, in between working for my dad I went out uhm to London drinking, normal things (3) uhm, (2) er going out with friends. Use to go to the cinema, bowling, uhm going out to places to eat and er girls. Er had a few girlfriends. Just normal relationships. Didn't really, none of my relationships lasted for very long erm er (6) erm er, that's about it.

(Interview lasted 36 minutes)

This is the 2nd part of the interview. I'm just going to ask a few questions on what you have said already.

You said, 'I was born in 1978, lived a pretty normal life'. Can you give me an example of uhm, what normal life was like?

Doing what boys do, riding around on my BMX as a youngster; playing with others, climbing trees, making tree houses, having games of war, playing manhunt, going to play schemes when I was younger. When I got older, going to Youth Clubs, meeting different people when I got older. When I got to 17 going out drinking; to pubs, just normal things, go swimming with my friends, just normal anything normal day to day activities, anything to occupy my mind in the 6 week holidays or weekends, as long as it wasn't hurting anyone else or hurting myself. That's what I mean my normal, we

just played; bowling, swimming going to cinema, eating burgers and chips, asking my dad for money going to shops for sweets, until I got older and going to work then going down pub with friends at the weekend,

You mentioned your dad, can you tell me more about the relationship you had with him?

Yeah we've got a good relationship had since I was young. I always asked him for money when I was younger. He taught me what was right and wrong, always been there for me. Even when I was caught for stupid things when I was younger, like caught for stealing, he was always there for me and supported me and basically got me my job, showed me how to do electrical work and stuff like that. He has been there for me all my life, and through that we've built up a strong relationship. The only breaking point was when I had my psychotic episode and found out I had schizophrenia. The relationship had a rocky time but its back to as it was. That's another reason why I would like a place of my own because I've lived here for 27 years and it doesn't matter how amount you get on you need a certain amount of your own space. We have had a very good relationship. I was accident prone when I was younger and used to hurt myself and my dad always took me to hospital.

Can you tell me about a particular accident when your dad took cared for you?

Yeah, I jumped off a bridge at the end of the road and broke my leg and he took me to hospital and he didn't have a car so he had to get a taxi up there and we didn't have enough money to get home but we had enough to town. So I had to walk up town with a broken leg and I couldn't so he carried me when I was younger. So that was one incident its just things you remember that your father is always there for you and your family is there. I was quite lucky that me and my dad built up a strong relationship when I was younger.

You spoke about your dad but, you haven't mentioned your mother...?

Yeah my mum and dad split up when I was younger. I was about 4 and don't really remember it. My stepmom I don't really get on with her and never have. And its one of those things that it's uncomfortable being around her so I try not to be around her. Me and my dad, the relationship with my step mother, I don't think she would want

anything to happen to me but we don't talk to each other so we stay out of each others way and it's manageable to me (8).

You said, 'mental health was one of the strangest things that have happened to me, not being able to understand why I've become ill'. Can you give me anymore details about that particular time when you were told you had a mental illness?

Prior to that I had a thought and I knew it wasn't real but I was letting it play on my mind and the more I let it play on my mind the more it was effecting me and then I believed it more and more to the point I had a fight with my dad. He knew there was something wrong and he called the mental health services, (heavy coughing) and that was nothing and they said it was a drug induced psychosis. But came out of hospital and went in hospital and went in hospital 2 more times and was told I had schizophrenia. So what part would you like me to tell you about being told or the build up or both of it?

Whatever part you feel comfortable with.

Well the build up to it was believing something that wasn't real. That's why I think I can rehabiliate quicker because I knew it wasn't real, but to let it go that far it was a horrible feeling to let my mind believe a certain situation that wasn't real, looking back on it it was scary not strange but when it was actually happening it was strange and strange why it was happening. When I was diagnosed that I had schizophrenia I didn't believe it, I thought no no I haven't got schizophrenia it wasn't nice it was just one of those things. I couldn't live with it was like no I haven't got this illness, the build up when I look back with hindsight is why am I letting this happen, it was just I was in autopilot mode and just let the natural flow of what I was doing integrate in my normal life but it wasn't normal, I was thinking something was real and it wasn't real and I know it wasn't real and I was just believing it was real and kept believing it was real then I was taken into hospital and told I had schizophrenia. I didn't believe it and it has just been a struggle since then trying to cope with what I have got and learn about it and try to understand the illness and try to keep myself from relapsing, is that alright?

That's great! You said, 'My first admission was in 2000, and I had admissions after that...'

Yeah nine admissions.

Okay. Can you tell me anymore about those admissions?

To tell you the truth I don't know why it's happened and why I keep letting it happen, I don't know why I was going into hospital, at the time I was just down and depressed I didn't have anything constructive in my life to do and that's one of the main things that starts me off, but the way I feel about it, it shouldn't have happened I can't explain it, it's just horrible the worst feeling going into hospital and to happen nine times is obviously something going on in my mind and I'm too stubborn and I know it's part of the illness. I keep fighting the system that's why I keep relapsing and I've relapsed 9 times. The feeling of it is I can't explain, it happens because I don't think I've got anything better but I don't know if that's me or the imbalance in my mind. I've had a lot of support for it so in a way I feel bad that I keep doing the same thing so I feel guilty as well as I don't know, not right, I feel guilty as well as nauseous feeling sick, I feel that I'm apart from the world this is when I relapse I don't want to speak to anyone, I close off completely, when people are talking to me I ignore them, the feeling is that everything is heightened, everything your perception, seems ten times worse, when someone is speaking to you and you don't like it, it seems the end of the world. Did you say the build up while I was in hospital?

Just your feelings about your admissions.

The feeling about the admission is: Why has this happened? And I feel stupid in a world afterward, but at the time I believed anything that came into my head. I believe the world is against me so that's why you're putting me in there, but afterwards, I feel stupid because I know it's not real and I feel guilty and upset.

Is there any one particular admission that stands out in your mind?

They all stand out and that's the worst thing because I can remember them all, it makes me feel sick and I get all emotions from it. I laugh at a funny situation that happens and I try to look on the lighter side but it's not it's a serious thing but you get all the other feelings afterwards. The guilty feeling because you've let people down you've let yourself down you feel upset because you let yourself get into that

situation. At the time what you're feeling about the admission is totally different when you come out of the hospital. When you go in there the admission is irrelevant, it's, this isn't right. You feel you can't do this to me, bla bla bla. You're not doing this to me, but when you come out of hospital then what you feel about the admission is that this shouldn't have happened, feel upset because you've let it happen to yourself you've let others down because they've been giving you support, keep thinking why do I keep doing this to myself, feel sick sometimes because you think I couldn't have let myself get this way without asking for help, without going to people asking for support, all these emotions you feel after you come out. But if you ask someone when they've just been admitted you will get a different answer but afterwards you don't feel good about yourself. That's one thing you try to shut off from.

You said, 'I worry about things more...'

Yeah that's what I said, that's the only problem when you go into hospital. You could not like someone talking to you but you could feel like its ten times worse than it is but when you come out of hospital but you're thinking on the level thinking about normal things on the level like work, everything seems like ten times worse like I haven't got a job what am I going to do, instead of taking a deep breath it builds up and gets on top of you. It feels ten times worse, like everyday things, like having a bath doing your washing, trying to get a job, filling out forms for the social, everything seem worse than it is, because you think I've been a certain way for so long I've let myself go for say months before I was given any help. It feels like I'm struggling to keep myself normal and normal everyday things build up, but as you say if you take a deep breath you've got a little support and can talk about it you can get through it. That's about it.

That's great!

Cool man.

(Second interview lasted 18 minutes 25 seconds)

Appendix E

Example of Thematic Field Analysis

Michelle Walton's Told Story	
Told story	Thematic Field Analysis / Microanalysis
Ok, I would like you to tell me the story of your life, all the events and experiences that were important to you until now, start when you want and take all the time you need, (2) I won't interrupt you but will take some notes for afterwards.	
I came from a very privileged background both my parents were quite wealthy.	<p>Not so wealthy now Telling us she is respectable Checking out interviewers values Delusional statement Did social situation change because of parent's wealth? Qualification / Explanation Waiting for my response Aware of wealth - theme Well establish financially Illness got in the way of social future Sense of loss – no parents Relationship with parents monetary Driven out of native land</p>
I remember fighting a lot with my brothers and sisters but all children do that (1). My mum was quite neurotic and a lot of the time she couldn't cope.	<p>Chaotic life Lack of discipline Where does this person fit in the family? Looking for way out Unlikely to marry Different father Expectations of parents War makes fighting ok History of aggression will follow Incompetent mother How many siblings? Where is the father / role model? Not coping emotionally or practically Father is away in the Navy or is a business man.</p>
My dad was always working he was a high flying business man he used to get very aggressive (4) they weren't always nice to me but I don't want to go into that.	<p>What type of aggression and to whom? Aggressive - theme Really wants to talk about parents – checking out whether it is safe to. Stress</p>

	<p>Who are they</p> <p>Why not go into it – still emotionally painful.</p> <p>Father is an alcoholic or has a personality disorder.</p>
<p>We lived in a beautiful Edwardian house had own swimming pool and own pony and very spoilt and very happy until I took my A levels.</p>	<p>What does happiness mean?</p> <p>Chaos v beautiful house</p> <p>Materialistic</p> <p>Lots of luxury, but no love in the family</p> <p>No discipline</p> <p>Interviewee is female</p> <p>Parents have separated / divorced</p> <p>Trauma loss or bereavement</p>
<p>My parents went away when I was doing my 'A' levels and I basically had a nervous breakdown</p>	<p>Went to a boarding school</p> <p>Parents gave space to finish 'A' levels</p> <p>High expectations from parents.</p> <p>Must be the youngest child</p> <p>Grown up too quickly</p>
<p>I was doing too much and I realised I needed to grow up but, (3) I didn't want to grow up I wanted to do music and drama when I left school.</p>	<p>'I want' phenomenon</p> <p>Enjoys been spoilt</p> <p>Didn't want listen to parents</p> <p>Rebelled against parents</p>
<p>I was doing 3 'A' levels, 'A' level music, asked to take a lead part in a school play and looking after a horse. (3) I was taking grade 1 flute it all got a bit much and I was working too hard and I felt a bit dizzy and sick and I crashed my car I just didn't feel well.</p>	<p>Ambitious</p> <p>Popular at school</p> <p>Artistic</p> <p>Perhaps all these things were distractions from home life.</p> <p>Suffered a nervous breakdown</p>
<p>I wasn't particularly depressed or anything (2) I just felt everything was all coming in on me and my parents went away to Canada to see my other sister and they weren't around when I took my 'A' levels and I completely went berserk.</p>	<p>Protesting against her parents going away.</p> <p>Feels parents shouldn't have left her during her 'A' levels.</p> <p>Always had her own way, now parents weren't around couldn't cope.</p>
<p>I was just crazy mad. I thought I could start a revolution, and I thought I was Jesus Christ. And I saw the water, and I thought I could walk across the water. So, I took all my clothes off, and I sunk, so I had to swim, and of course, it's a three mile distance across the river. How I did it I will never know. I was drowning. It was freezing (loud laugh). I couldn't help myself.</p>	<p>Manic behaviour</p> <p>Michelle is being rebellious</p> <p>Will be sectioned</p> <p>Michelle knows she was unwell</p> <p>Michelle losing control of herself</p>
<p>I was raped by a psychiatric nurse. I don't know how he got away with it. It's such a cheek, isn't it? Such a nerve! I was in the observation room (loud laugh), but</p>	<p>Out of the blue disclosure</p> <p>Feeling vulnerable</p> <p>Fear of consequence of talking about it</p> <p>Low self –esteem</p>

it's not funny, really, it was horrible, but I didn't dare tell anyone.	Emotional pain Still very painful, emotionally Feeling shame and loss of dignity
After that, other admissions weren't too bad, because after that I kept going high. It was different because I'm bipolar. I'm manic depressive.	Sense of sadness Now used to the mental health system Loss of identity Now a label, 'bipolar' 'manic depressive'
I kept going (3) I took myself off of drugs. I didn't like what they were doing to me, I didn't like the feeling they gave me. They were horrible. I was on depixol and largactil, horrible drugs, don't know if you know them?	Don't know who I am anymore I want to be me I am free but drugs have taken over my life. I don't like these drugs
Yeah (5), can't really say though because it's going to put my parents in the shit (10), it's a long time ago.	Was she sexually abused? Father sexually abused her Really wants to talk about it, just testing the water.
They thought I was drunk and I gate crashed a doctors party at the (name of hospital), it was a BBQ I took a flagon of cider they thought I was drunk my parents had to pick me up because they thought I was drunk... I said I'm not high I'm not ill I'm not high I'm just drunk and they believed me, but I was going high but my parents had to give me a lift because I had to leave my car there because I couldn't drive and be drunk obviously, and when I got in, my father tried to strangle me...	Who are they? Drunken behaviour Narration Michelle getting her own back on the doctors Michelle play acting Michelle is spoilt and is attention seeking This will lead to her being readmitted Michelle has a personality disorder
And my mother and father poured cold tap water all over me to try and sober me up. It was really frightening and my father tried to choke me... and I ran away, I ended up in a home for the homeless called (name of home), do you remember (name of home), it was horrible, a very horrid place (3), but I refused to go into hospital. You see, I get like that, I can be real awkward (loud laugh)...	Nervous laugh Genuine story Negative and violent themes Won't be believed Tormented Running away from parents Parents were abusing her
Well, the Doctor came round (1) they called an ambulance, I went absolutely crazy and screaming I started screaming, I	Negative and violent themes Narration Her word against their

told him that my father had tried to strangle me , me he thought I was making it up or hallucinating or something, he didn't believe me (laugh), my father really did try to strangle me..!	She is mentally ill, it's her illness Even now she is still feels she is not believed. Wants to convince me that her father tried to strangle her.
The ambulance took me to the hospital and I managed to con the psychiatrist that I was ok -I'm quite an actress -then went up the (name of home) the home for homeless (2) then after that my father felt so sorry for me for what he had done and everything he bought me a house in Devon I was very happy in it for a while (2).	Embarrassment to family Narration Able to trick her way out of the situation She has learnt how to manage the system.
My parents brought me a house when I got married when I was 26 and things went well for a while.	Wants children Problems with husband Couldn't have children Still dependent on parents Husband was having an affair Husband abuses her Parents still believing money is all that matters Matter of fact about being married Sounds disappointed with life/husband
Well I had to have an abortion because of the Lithium. I wasn't allowed to keep that baby because of the Lithium, I was on Lithium, Lithium can harm the baby so I wasn't allowed to keep that baby, but I put that behind me.	Unresolved grief Unplanned pregnancy Period of depression after abortion Matter of fact talk Lacks emotion Might be hiding real emotion May have dealt with the devastating loss
I worked for a while I worked four years and then I came of the Lithium very slowly, very very slowly. you can go so high and low and I got pregnant in 1984 no! 1988 I got married in 1984 and got pregnant in 1988.	Responsibly Planned pregnancy Determined to have another baby Dream come true – home, husband and baby
I really wanted a baby and that is why he is so beautiful. I really worked hard for him; did all the right things ate yoghurt and fish and milk I stopped smoking and I tried so hard for him I really desperately wanted a baby. When you have lost one it makes you want one more (he really is beautiful), he is stunning.	'I want' phenomenon Wanted a baby Wanted to be a mother The 'I want phenomenon' Motivated Self-belief Strong sense of identity
he was 9 months old when he was christened and it was Jack's birthday and	Turning point Happy period

my mum threw a party and I was so happy.	Son brought the family closer together Now has a real purpose in life
then Jack fell out with his boss so he started up a business in an estate agency and we started to argue about money and things and we didn't get on at all and that was effecting our mental health and I got ill.	Partner had mental health problems Negative and violent themes Rocky relationship Stress Financial problems
I thought he was having an affair because he wasn't giving me very much attention.	Marriage break-up Feeling unloved Frustrated Hospital admission may follow Will be strong and see things through
I got very paranoid about him I ended up going into (name of hospital) a few times not for long though and then it all came to a head and one night he attacked me.	Pattern of violence Hospital used to get her out of the way Identity as an abused wife Hospital admissions placed a strain on marriage.
He hit me and kept hitting me in fact he beat me up so I was admitted to hospital to keep him away from me I nearly prosecuted him but I didn't and nearly got a divorce.	Negative and violent themes Hospital used as a refuge Nearly? Still loves her husband despite of how he treats how.
Uhm, well I don't really want to go into it it's a bit personal (4). I've been abused a lot really by other people, when I'm on a high people can't understand why I'm like that and they take it out on me but I can't help going high it's something I've got inside of me.	Vulnerable to abuse Probably self-respect has been eroded Self blame It's not others it's me. I can't help the way I am
Can you tell me what happened? Well they end up hitting me or hurting me which I think is wrong they shouldn't do that.	Was she sexually or physically abused? Trying to console herself Negative and violent themes
Who hit you? (4) My parents and my husband have done that, I think its totally wrong they shouldn't do that, they don't understand me (3) they see it as Michelle as going high and Michelle cant help it and Michelle is ill they see it as Michelle as being naughty that she is not behaving herself (2).	Inappropriate interruption of story (who hit you) question. Child like talk Viewing herself as a child (naughty and not behaving herself) Parents treat her as a child Immature Does not feel that people understand her.
But I haven't gone high or low, but I haven't gone high or low for 2.5 years now,	Medication is helping Giving up

so touch wood I'm doing alright maybe it's the end of the illness hopefully, whilst I keep taking my medication. The medication does help (2) I'm not pooing the medication.	Wishful thinking Trying to convince me she is taking her medication. Wants reassurance that medication works.
(3) I suppose when you go into hospital they put you on medication don't they? So therefore it is a help, isn't it? It's a way of controlling the illness (3), otherwise I don't know where I would be. (8)	Not really sure about where she would be without hospital. No thoughts about life as a whole Sounds unsure whether hospital and medication really helps. Wants me to comment on the use of medication. Long period of silence (thinking)
I used to like horse riding, cycling, swimming and that sort of thing but I won't do it because I'm so big (loud laugh) I get comments all the time from people (3) they are so rude especially men, men are really rude to me, "you ought to go on a diet love!" (loud laugh) (2) I've been on a diet!	Cut from the things she once enjoyed Feelings of loneliness Feels unloved Feels undesirable Unkind remarks makes her feel angry Uses humour to cover feelings of shame / Embarrassment.
My marriage? Well basically he took me for a ride, because I had inherited some money he got me to buy a car, house and business, ok I was going to benefit from these things but he walked off with another woman.	Husband married because of wealth Loss of inheritance Feels cheated Taken advantage of Resentful angry
He has married her (4), imagine how I feel (2), I couldn't help being ill (2), I thought marriage was meant to be in health (2) what's the saying in sickness and in health but I thought marriage was in sickness in health but he divorced me anyway he found someone else, very hurtful.	Questions whether husband was after her inheritance Serious exploitation Married for money Unloved by parents and husband
I feel a bit bitter but I am determined to enjoy my life even though I have got this horrible illness and I kept having to go in and out of hospital but I am determined to enjoy and I am determined to keep out of there too.	Revolving door attachment Resolve – strength of character Resilient Self-determined Illness or just Michelle not being able to cope
I think as long as I keep taking my medication and doing things properly I won't have to go in there again at least I hope not unless there is another crisis in my life.	Self critical Abuse of the system Refuge really
Life is what you make of it, isn't it? I have	Philosophical

definitely changed. I'm much more placid, I accept things more. I accept what happens to me.	Resolve Trying to be positive
I've been well for one and a half years and I have been taking my medication to the book. I've got into a routine now; I treat myself as if I was in (name of hospital)...	Institutionalised On the road to recovery No more admissions
I've got exactly the same routine as they gave me in (name of hospital). I take my tablets dead on time and I have regular blood test.	Institutionalised even though in the community. Broken spirit Has no choice, but to do as told
My parents have been wonderful but have been upset by it all. Couldn't have more supportive parents (3) I bet they get a fed up with me. I try not to pester them too much; they seem to want to help (3) they want to help.	Trying to convince herself of her parents love Where are her siblings? No mention of siblings 'I want' phenomenon
They still think it's their fault, but it's not their fault at all. It's just something I've got, can't help it. I rebelled against them when I was young, but most teenagers do (3)	Defensive of parents Blaming self Justifying her childhood behaviour Perhaps feeling guilty
I wanted to leave home, kept running away . Wasn't the right way to go about it was it?	'I want' phenomenon Overall theme of story, trying to leave home. Reflective Now believes she may have gone about things the wrong way
I wanted to go on stage (5). All together really my life has been a bit of a mess (4). Nothing I can do about, its all pass now anyway, can't change the pass can you?	'I want' phenomenon Despondent Feelings of regret/sadness
Sometimes I'm joggling along alright and I think I'm doing fine, then I think I'm not going to be ill again, I've combated this illness. I'll keep taking my medication. I'm not going to be ill again. Then something happens, and it comes back, it's quite frightening it really is. It's horrible!	Feelings of disillusion Living with bipolar disorder is a constant battle. I am always going to be ill I need to be always taking my medication. I cannot prevent hospital admissions.

<p>Can you think of anything more you want to talk about?</p> <p>Nothing I can think of (coughing excessively), except I wanted to do music and drama and I wanted to be a star, that's all.</p>	<p>Summed up her dream of wanting to be on stage.</p> <p>'I want' phenomenon</p> <p>Feels resentful that dreams weren't fulfilled</p> <p>Feels angry</p> <p>Feelings of life being a waste</p>
<p>Well, you've been a star today, thank you.</p>	

Colour chart for coding themes

	I want phenomenon
	Themes of violence
	Reflective themes
The ambulance took me to the hospital and I managed to con the psychiatrist	Narrative Segments/Extracts

Appendix F

Published works

Bolton, E., Vorajee, Z., and Jones, K., 2004. *The Verismo of the Quotidian: A Biographic Narrative Interpretive Approach to Two Diverse Research Topics*. In N. Kelly, C. Horrocks, K. Milnes, B. Roberts, & D. Robinson (eds.), *Narrative, Memory & Everyday Life*. (pp. 9 – 17) Huddersfield: University of Huddersfield.

Bolton, E. (2005). *An Investigation into the Experience of Having Multiple Admissions to Psychiatric Hospital*. In K. Milnes, C. Horrocks, N. Kelly, B. Roberts, & D. Robinson (eds.), *Narrative, Memory & Knowledge: Representations, Aesthetics & Contexts*. (pp. 165 – 172) Huddersfield: University of Huddersfield.

2 *The Verismo of the Quotidian:* A Biographic Narrative Interpretive Approach to Two Diverse Research Topics

EVERTON BOLTON, ZAHEERA VORAJEE (née ESSAT) AND
KIP JONES

Background

The turn to narrative enquiry shifts the very presence of the researcher from knowledge-privileged investigator to a reflective position of passive participant/audience member in the storytelling process. The interviewer as writer/storyteller then emerges later in the process through her/his retelling of the story as a weaver of tales, a collage-maker or a narrator of the narrations. Recent times have seen the development of myriad methods of narrative inquiry; one such method and the practicalities of its interview protocol will be discussed in this chapter.

The Biographic Narrative Interpretive Method (“the Method”) (Chamberlayne, Bornat and Wengraf, 2000; Wengraf, 2001; Rosenthal, 2004; Jones, 2004) is built upon biographic work developed in Germany in the early 90s by Rosenthal and others and evolving from Shuetze’s (1976) method of story and text analysis and Oevermann’s (1980) objective hermeneutical case reconstruction (Rosenthal and Bar-On, 1992: 109). The Method uses an interview technique in the form of a single, initial narrative-inducing question (minimalist-passive), for example, “Tell me the story of your life”, to elicit an extensive, uninterrupted narration. This shift encompasses willingness on the part of the researcher to cede “control” of the interview scene to the interviewee and assume the posture of active listener/audience participant. A follow-up sub-session can then be used to ask additional questions, but based only on what the interviewee has said in the first interview and using her/his words and phrases in the same order.

This dynamic and interpretive method, with its emphasis on action and latent meaning, distinguishes it within the broad and rich range of life history, oral history and narrative approaches. The Gestalt of the participant’s story using a minimal passive interview technique is maintained by this method of non-interruption. Gestalt has been defined by Hollway and Jefferson (2000: 34) as ‘a whole which is more than the sum of its parts, an order or hidden

agenda informing each person's life'. Gestalt represents the constructed shape of a story, through theme, motif and/or various agendas – hidden or otherwise.

Asking for Story: The Narratives of Two Studies

Two PhD candidates from De Montfort University present outlines of their research projects explaining how they arrived at the use of the Method to discover meaning in their two very different research topics. The process of choosing a narrative method for a PhD project is highlighted in their recounting. Both are at different stages in training and use of the method.

First, Everton Bolton describes his proposed exploration of the narratives of people with severe and enduring mental illness. He suggests that much of the insight of these individuals is relatively private and that by excluding their stories we, in effect, omit a large and essential body of information. He argues a need for qualitative research, placing emphasis on phenomenological inquiry and the storied life, and explores how this approach can help researchers to gain special insight into the unique experiences of the individual. He describes his journey to a biographic interpretive method – first considering, then discarding, other methods along the way and his present anxieties as he is about to embark on biographic narrative interviews with mental health services clients in the UK.

Secondly, Zaheera Essat describes her use of the Method to elicit stories from ethnic minority women who have given birth. How birth stories rely on women's memories of their past and their connections to everyday life is explained as well as how the shape of the story is maintained through narration. Her experience of working with the biographic narrative method is shared and how the method is beginning to reveal birth stories and their connections to the quotidian at the midpoint in her interview process.

Finally, Kip Jones sums up working with the biographic narrative interview process and outlines the Methods' use of interpretation for analysis through self-reflection and reflective teams.

Everton Bolton

There is no doubt that quantitative research methods have been traditionally the methods of choice in health care research. However qualitative methods are increasingly becoming important methods in both health and social care research. My on-going PhD research: "*A study of the experience of having multiple readmissions to psychiatric hospital*", is based on qualitative methodology, using open-ended biographic narrative interviews according to the protocol of the Biographic Narrative Interpretive Method. I was introduced

to the Method at a workshop conducted by Dr Kip Jones at the University of, Wales – Swansea. It was there that I realised the potential of this data collection tool for this particular research.

Of interest to my study is how individuals with mental illness construct personal identities in relation to their lived experiences of the ‘revolving door’ phenomenon, a phrase often used by mental health professionals to describe a pattern where a patient is frequently readmitted to psychiatric hospital. By making an integrated analysis of the experiences of these patients and of the objective social structure that form the necessary conditions for the experiences, I hope to contribute to a greater understanding of how these experiences are incorporated (or not) in their life stories/senses-of-identity and how they attach meaning to these experiences. So far, in their attempts to understand this phenomenon, researchers in this area have tended to rely on quantitative and positivist research, rather than qualitative and idiographic research methods. Despite these attempts, the problem of the ‘revolving door’ phenomenon remains. Because much of my work as a mental health social worker involves listening to service users problems and their stories concerning their everyday experience of living with mental illness, I chose the Method to further explore these experiences in a more systematic and meaningful way.

For the study, the Method was chosen to elicit the lived experience of ‘revolving door’ patients and is theoretically grounded in hermeneutic phenomenology and social constructionism. Narratives will be obtained through dialogues that are reflexive and reflective, considering the social position of the participant, the participant and researcher (micro), and the participant and society (macro). The challenge is to articulate these different levels of analysis, giving voice to the rich, meaningful, and unique experiences of narrators.

The rationale for adopting the Method hinges on the fact that it uses a single, initial narrative-inducing open question to generate an extensive uninterrupted narration (Wengraf, 2002: 119). Alternatively, but still remaining within the Method, responses may be more targeted by a single narrative question that is directed at a thematic or temporal area of the participant life story (Wengraf, 2002: 122), for example, ‘Tell me the story of your life, beginning when you were admitted to a psychiatric hospital for the first time’. Both these approaches can be useful as the storyteller determines what is told, what is important and what is unspoken. At the same time, this is different from semi-structured or structured interviews that try to elicit facts particular to a researcher’s own interests. Furthermore, this method has relevance in this study because this research population has a tradition of not having their experience of living with mental illness explored in any meaningful way. Moreover, the choice of qualitative methodology is inextricably linked to phenomenology, social constructionism, symbolic interactionism and

ethnographic theoretical perspectives, thus providing the framework for thinking about the phenomenon of ‘revolving door’ patients in the widest possible ways.

My journey to the Method began by first considering other narrative research approaches, the number of which has seen rapid growth in recent years. A range of areas in health and social psychology has greatly influenced my thinking. Only three narrative methods will be briefly mentioned here: the work of Crossley (2000) in narrative analysis; Smith’s (1996) Interpretative Phenomenological Analysis (IPA) and its application using narratives as a way of exploring the lives; and McAdams’ (1993) work and its concept of ‘generativity’ based upon the earlier work of Erikson. It was the methodology of McAdams (1993) and his interest in narrative psychology and identity that led the way to the consideration of the Method as the data collection tool for this particular study. McAdams (1993) proposes an interview protocol for collecting narratives and argues that semi-structured interviews can be used to explore personal narratives (1993: 254). The use of semi-structured interviews and the limitations to data collection that these approaches offer were, however, deciding factors in not choosing them as the method of data collection in my study. These approaches were, nonetheless, helpful in conceptualising my use of narrative for eliciting patient’s stories.

Whereas structured or semi-structured interview formats aim to capture precise data of a codable nature in order to explain behaviour with pre-established categories, the Method makes an attempt to understand the complex lives of members of society without imposing any assumptions that may limit the field of inquiry (Wengraf, 2002). The Method’s interview protocol has the advantage of keeping the researcher’s preconceptions in the background and giving priority to the participants’ own conceptions of their experiences.

Not having used this method yet – in any real sense – one can imagine my fears and anxieties about using it for the first time! Will I be able to suspend my compulsion to ask questions and not let my social work professionalism disrupt the participant’s gestalt? Will inviting patients with a mental illness (considered by mental health professionals as a vulnerable group) to tell their story be asking too much of them? At the same time, I am already encouraged by the keenness of patients eager to take part in the study. From the initial interest shown by patients, I anticipate that their narrations will underline the importance of “story” in human research. This will yield valuable data and insight into the private world of patients living with mental illness who experience frequent and repeated admissions to psychiatric hospital.

Zaheera Essat

I am currently using the Biographic Narrative Interpretive Method in my PhD investigation of the life stories of ethnic minority women who have given birth

in order to gain insight into the meaning of childbearing for these women. At present, I am in the midst of doing interviews using the method and hope to share with you my personal experience of using the method for the first time.

Initially, I was apprehensive about whether the Method would provide insights into people's lives because of minimal intervention from the researcher during the interview. It was only when I carried out an interview for myself that I fully understood how the Method works and my doubts about it were abated. During the interview, a single narrative-inducing question about childbirth was asked, giving the woman space to tell her story with no interruptions. I strongly believe that the woman gave a rich story as a direct result of minimal intervention and because room was provided for her to explore as she wished. Allowing people to tell their story without interruption was initially difficult for me, but, in actual fact, proved vital to the interview process. The woman often paused whilst she was talking and, initially, my interpretation was that she was stuck for words; it was very tempting to nudge her along, but she did not need direction and was probably taking time to reflect, commonplace during narrative interviews.

Prior to the interview, I did have assumptions about the structure of the story that would be told, but, in reality, the story that was told refuted my predictions. I expected a basic chronological order of events, but she discussed a variety of events in no particular lifespan order – moving from marriage to birth, to puberty then to her childhood. At a glance, it may seem extraordinary that a story would be told in this way, but, looking closely, many of the experiences held similarities; for her, grouping them together was important because the emotions felt through these experiences were comparable. Words such as 'fear', 'scared', 'loneliness', etc. were used a number of times when describing past events in her life. What may seem like a confused story is actually a personal account of past experiences and how she saw her life. Stories are dependant upon memories of the past, but the fact that they are remembered and shared describes a personal and particular gestalt.

Although childbirth was an important aspect of her story, it was not told in isolation from other events in her everyday life. Birth is a physiological event experienced by the woman alone; nonetheless, it led the woman to constantly talk about her family and friends who were around her at the time. The strong influence of other women who could relate to her experience of childbirth and the significance of this support in shaping the woman's own birth experience were made apparent in her story. For me the initial open interview question takes this into account and, therefore, should not be too focused on a particular life event. There is an inclination for participants to concentrate on a specific event alone if the question itself is too narrow in focus.

Keeping a reflective diary is also vital as it can allow pre and post interview thoughts and ideas to be recorded, which can be a learning source and play an important role during analysis. For me, the most important aspect

of using the Method is to learn from each interview and consequently to improve on my interviewing technique. Whilst preparing for other interviews, I am constantly reflecting back to my first interview using the Method and reminding myself to go into the interview with an open mind and appreciate each woman as an individual with her own story, even though many birth stories may be similar. The participant may reveal distressing issues that have never been addressed before and, consequently, may need referral to support networks which should be in place before the interview. Childbirth can be a deeply traumatic occasion for women and an interview addressing personal birth experiences may be the first time the woman has reflected openly on her birthing experience. During my first interview, I noticed that the woman was at ease talking to me, which most likely contributed to the richness in her life story. Just as the interviewer is nervous prior to an interview, the participant will also be experiencing similar emotions and so it is vital to commence by building mutual trust. The style of questioning with this method may be difficult for the participant to assimilate and so building rapport with the participant at an early stage is essential.

Although childbirth is a universal event, the way various societies manage childbirth and attach meaning to it are not (Priya, 1992). This allows me to appreciate the concept of diversity in the structure of the birth stories told by women. Childbirth may seem like an independent event but it is not and to appreciate this is to allow women the freedom to explore what is important to them. Giving people the space to tell their life story rarely occurs in everyday life, let alone in most research studies. The Method, therefore, opens up a space for people to give rich accounts of their lives. It is imperative not to have assumptions or agendas prior to the interview as this can cause the interviewer to listen only for the story that s/he wants to hear and ignore what is being shared that could be vitally important. "What interviewees have to say about their lives and self-concepts are much more illuminating than any specific research assumptions or questions could be" (Jones, 2003: 61). As with all methods, there may be times when interviews do not progress smoothly or as expected and situations arise that were not anticipated. Nonetheless, these experiences have provided me with important learning points, strengthening my interviewing technique.

Kip Jones

What does it mean when we seek to know a person? (Jones, 2000) In "truth" seeking, are we merely comparing and contrasting our own everyday world with the worlds of others? Within the individual's world and her/his tendency of 'revealing/concealing', 'knowing/not knowing' (Heidegger in Krell, 1993), by exploring the terrain, are we simply only portraying the process itself, its

dialectical underpinnings – its thesis and antithesis? Or, in fact, do we, in our attempts at some sort of a dramatic “truth” (Verismo) stumble on to a synthesis after all, a moment of revelation that truly is wrenched by the individual in her/his self-knowing and revealed to us?

Asking a person to tell us about her/his life is just a beginning. By doing this, in a less than perfect way, we are at least starting by participating in the storytelling of the person in her/his world, her/his expectations, successes, failures and dreams. Next comes interpretation and, indeed, the Biographic Narrative *Interpretive* Method has much to say about this second process (see Wengraf, 2001; Jones 2004).

In brief, microanalysis of the narrative of the reconstructed life follows the interview stage, using a reflective team approach to data analysis. The ‘*Lived Life*’, or chronological chain of events as narrated, is constructed then analysed sequentially and separately. The ‘*Told Story*’, or thematic ordering of the narration, is then analysed using thematic field analysis, involving reconstructing the participants’ system of knowledge, their interpretations of their lives and their classification of experiences into thematic fields (Rosenthal, 1993: 61). Rosenthal defines the thematic field as: ‘the sum of events or situations presented in connection with the themes that form the background or horizon against which the theme stands out as the central focus’ (1993: 64).

Still, it is important to emphasise that interpretation on the part of the researcher begins early, even within the interview process.¹ During the interview, the researcher is often making and dealing with subconscious observations whilst maintaining a position of active listener. These subconscious thoughts are brought into the interpretive process through thorough note taking and self-debriefing following the interview sessions. Through the use of this note taking in the first subsession of the interview, the interviewer is participating in a process of interpretation, making choices about which areas of the story should be explored further in the second subsession. Post-interview debriefing (ideally with supervisor[s] or other researchers) is inherently interpretive. Later, when the interviewer (preferably) types the transcript of the interview, further reflection and note taking takes place. Further hearings of the tape recorded interview produce additional insights and are diaried by the researcher as well. When constructing the Lived Life and selecting passages of the Told Story for team analysis, again, the interpretative skills of the researcher come into play. It is at the level of the reflective team analyses of data that the researcher, finally, is able to put her/his interpretive skills aside and present the data to a group unfamiliar with the interview material, acting as only a facilitator for group level interpretive analyses.

Through hypothesising how the Lived Life informs the Told Story, the case history is then finally constructed from the two separate threads of the Lived Life and the Told Story. A case structure is then formulated that

validates more than one event based upon the actions of the interviewee. Freeman (1997: 395) sums up thusly: 'The project at hand is therefore ultimately a reconstructive one; it is a project of exploring lives in their various modes of integration and dis-integration, formation and de-formation, and, on the basis of what is observed, piecing together images of the whole'. This whole becomes the imaginative subjective drama of an everyday life: the *Verismo* of the quotidian. Without an initial, unstructured and open-ended request for story, however, this would not be possible.

Endnotes

1. For an example of an interview where interpretation by the interviewer is consciously restricted to these early reflective stages of the Method and then becomes apparent through presentation, see K. Jones (2004) "Thoroughly Post-Modern Mary" [A Biographic Narrative Interview with Mary Gergen]. *Forum: Qualitative Social Research* [On-line Journal], 5(3), September 2004. Available at: <http://www.qualitative-research.net/fqs-texte/a5b6c7/04-3-18-e.htm>

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16 An Investigation into the Experience of Having Multiple Readmissions to Psychiatric Hospital

EVERTON BOLTON

Introduction

This paper is drawn from a wider project focusing on the stories of psychiatric patients elicited from collective case studies. The stories are biographically constructed from the patients' narratives of their experience of the 'revolving door' phenomenon. This is a phrase often used in psychiatric discourse to refer to multiple readmissions to psychiatric hospital. Given that the quest for meaning in the social world is firmly embedded within its various institutional structures (and that these structures influence the resulting stories), there is a conceptual concern regarding the potential identities embodied in each patient and how they are interpreted and accommodated by the social environment.

By carrying out an integrated analysis of the experience of these patients and of the objective social structures that provide the necessary conditions for the experience, I hope to contribute to a greater understanding of how they are incorporated (or not) in their life story/sense-of-identity and how they are perceived. So far, researchers attempting to understand this phenomenon have tended to rely on quantitative and positivist research, rather than qualitative and idiographic research methods. Despite these attempts, there is still no adequate explanation for the 'revolving door' phenomenon.

In this chapter, I will focus directly on the methodological approaches involved in researching the phenomenon. I will discuss the notion that people with mental illness are too damaged by their condition to recognize what might help them with their recovery. Further, I will argue that using a positivistic approach when researching the 'revolving door' phenomenon does not provide us with enough information to fully understand the problem or the person. I will also argue that it is only when we offer patients the opportunity to tell their own stories through the use of qualitative methodologies that we begin to discern the nature of the person. I will try to show that the use of the Biographical Narrative Interpretive Method (BNIM) (Wengraf, 2001) offers a deeper understanding of a patient's personal experience. Indeed, this data

collection and analysis tool provides the means for obtaining valuable information and a unique viewpoint from which to interpret the patient's life story as it is remembered and recounted. Before embarking on this task, a brief history of the 'revolving door' problem is presented.

Historical Context of the 'Revolving Door' Problem

Over the past five decades, Western psychiatry has witnessed the deinstitutionalisation of the mentally ill (Pilgrim and Rogers, 1999). However, this period has also seen an increase in the percentage of patients being readmitted to hospital (Goodwin, 1997, p.117). Today, in accordance with the 1990 NHS and Community Care Act (Department of Health, 1990), many of the services for people with severe and enduring mental illness are provided within the community. Whilst most of these people manage to live in the community without major disruption to their lives, some experience repeat admissions to psychiatric hospital. These individuals have come to be referred to as 'revolving door' patients (Haywood, 1995, p.856).

Any crisis requiring admission to a psychiatric hospital (whether voluntary or involuntary) is more often than not followed by a period of stability of varying duration, discharge, exacerbation of the illness and then relapse, leading to re-admission (Goodwin, 1997, p.117). Not surprisingly, the revolving door phenomenon has raised many questions about the effectiveness of community care (DoH, 1994) and particularly the way that the mentally ill are regarded by society in general (Perkins and Repper, 1996; Barlett and Wright, 1999, p.vii). Certain high profile cases (DoH, 1994) have added to the debate on whether the closure of several large hospitals was indeed of any benefit to the patients themselves (Reith, 1998), particularly since stigma remains a prominent element of a patient's everyday life (Bean, 1993).

In my own research, emphasis is placed on hermeneutic inquiry, or expressed differently, the process of interpretation and the understanding (*verstehen*), of the significance or meaning that is attributed to the stories being interpreted. In biographical work, this approach can help researchers gain special insight into the unique experience of each individual (Cooper, 1990). The storied life is of particular relevance as the ideas that people construct of themselves - their image of who they are and where they fit - are, according to both Bruner (1990, p.56) and Plummer (2001, pp.233-234), based upon memories gathered from years of personal experience.

Paradoxically, revolving door patients have more often been studied in the context of medical ideology, which focuses on biological and environmental factors that account for the aetiology or maintenance of severe mental illness (Birchwood, Hallett and Pretson, 1988; Hirsch and Weinberger, 1995). They

have also been portrayed as objects of the clinical gaze of mental health professionals (Pilgrim and Rogers, 1999, p.193; Foucault, 1977; 1997) as well as the government (DoH, 1999) in The National Service Framework for Mental Health in accordance with the concept of Clinical Governance (DoH, 1998).

In reviewing the literature on psychiatric patients' experience of repeat admission to hospital it emerges that, whilst there are historical accounts of the changes in services and the treatment for mental illness, very little is recorded about the personal experience of the patients themselves (Beveridge, 1998, p.117; Canvin, Bartlett and Pinfold, 2002, p.362). Moreover, although medical researchers and pharmaceutical companies have written on the effects of medication on mental illness itself, there are no reports from the perspective of patients' lives. This adds to the view of Dahlberg, Drew and Nystrom (2002, p.212) that much of the insight of individuals with a severe and enduring mental illness remains relatively private and that, by excluding their stories, we are, in effect, omitting a large and essential body of information. Pilgrim and Rogers (1999, p.193) also argue that clinical research in the area of mental health has tended to exclude the views of patients or to portray them as passive objects of study.

At the same time, a number of reasons have been given to explain this scarcity of representation of people with mental health problems within mental health care research, such as:

- The assumption that the views expressed by psychiatric patients will be irrational or unreliable because of the state of their minds (Dworkin, 1992, pp.59, 62, 69; Rogers, A., Pilgrim, D. and Lacey, R., 1993, pp.6 -10).
- The assumption that the very fact that those receiving psychiatric treatment may have been given a diagnosis of 'mental illness' means that they will be incapable of expressing a rational opinion (Dworkin, 1992, pp.59, 62).
- The assumption that research involving mental health users may cause distress by encouraging them to recall unhappy events or experiences that they may prefer to forget (McIver, 1991, p.31).

McIver (1991, pp.8-9) identifies the vulnerability of people with mental health problems, the difficulties in achieving a representative sample and the importance of asking the right questions in an appropriate manner. However, McIver (1991) also believes that researchers can overcome these problems. He states that, by using qualitative research methods, such as unstructured interviews, research can establish the service user's agenda of importance

(McIver, 1991, p.12). In fact, the use of interviews gives a voice to services users who are not able to read or write, or who feel unhappy about questionnaires.

Method of Analysis

Having collected data from seven in-depth biographical interviews using the protocol of the Biographical Narrative Interpretive Method (Wengraf, 2001), I am now in the analysis phase of the research. A brief introduction to the analytical approach I am using to interpret the data from the interviews follows.

I decided to use an inductive approach to analysis, based on 'objective hermeneutics' and still within the protocol of the Biographical Narrative Interpretive Method, which, in essence, allows research findings to emerge from the frequent, dominant themes inherent in raw data without the restraints imposed by structured methodologies (Thomas, 2003, p.2). My aim is to understand the subjective understandings that patients have of their lived experiences and how these understandings inform personal constructs used for making sense of themselves.

According to in-depth hermeneutics, subjective expression is not only taken for granted, but is also allowed in order to look for meanings and implications beyond the knowledge or intent of the acting, knowing or speaking subject. Further, it conceives reality as contradictory and repressive and assumes that critical interpretations should always be an attempt to develop the underlying or repressed possible actions of the subject. From this follows a double attempt to deconstruct the meanings and actions and to 'construct' other possible meanings and actions (Schwandt, 1997).

A unique and interesting element of the Biographical Narrative Interpretive Method analysis process is the use of the reflecting team approach. This approach to data analysis facilitates the introduction of multiple voices and the opening up of interpretation possibilities, rather than relying solely on the principal researchers' interpretation of the interview. A prerequisite for the participants of the reflecting team is openness and creative imagination rather than knowledge of specific research methods (Jones, 2003, pp.60-71). In his initial work with the technique, Jones (2001) used reflective teams comprised of academics from diverse backgrounds to analyse interviews, incorporating team members' experiences to bring understanding to the interview material.

The reflective team approach to data analysis can be used to facilitate distancing and openness, which Ricoeur (1991) suggests as a way for researchers to critically examine their methods and uses. Denzin, (2003)

encapsulates the importance of using multiple perspectives to interpret a single set of data in what he calls triangulation (2003, pp.66-67). In the broad context of this method, triangulation refers to the play between the interviewee, the interviewer and the reflecting team. As the team can consist of three or more members from diverse backgrounds and perspectives, another opportunity for triangulation takes place at this micro level. These triangulated, reflective processes represent an attempt to secure an in-depth and broad understanding of the phenomenon in question.

Interpretations

I will start this final section by reflecting upon my own interpretive process which I have been engaged in from the very beginning of the study and have found instructive, in that it is not only helping me to understand others but myself as well. I will then continue by examining conclusions so far drawn from the interviews conducted and I end with some thoughts about the journey ahead, in particular, working with reflective teams and the challenges and opportunities this is likely to offer.

I originally started my metaphorical journey in many ways like a true explorer with apprehension and anxieties simultaneously exciting and daunting, not knowing what lay before me in terms of possibilities for discoveries. But being motivated largely by a desire to understand more of the processes that make individuals and society in general work, and by an aspiration to make the world more intelligible by adding something to the field of knowledge.

Notably, the human aspect of listening to patients' stories has made the interviewing most fascinating and often, emotionally touching. A common theme that emerged from the narratives was that admission to psychiatric hospital is an emotional event. What Pillemer (1998) refers to as 'personal event memories'. The concept of 'personal event memory' is described by Pillemer as having five distinct features. The personal event memory must:

- Be a specific event that took place at a particular time and place.
- Contain a detailed account of the person's personal circumstances at the time of the event.
- Evoke a feeling of re-experiencing or reliving the event.
- Link its details and images to a particular moment or moments of phenomenal experience; and

- Be believed to be a truthful representation of what actually transpired (1998, pp.48-51).

According to Pillemer (1998) analogous events or episodes that are readily compared with similar other events to suggest a pattern or theme that runs through the person's life story are seen to be most instrumental in self-definition.

McAdams (2001) suggests that, 'when a person experiences emotion in a given life scene, he or she has already made an implicit appraisal of the scene's meaning in terms of its causes and probable consequences and the extent to which goal attainment may be furthered or frustrated' (2001, p.109). As a mental health social worker I am aware that I have pre-conceived socially constructed ideas based on what admission to psychiatric hospital represents for patients. For example, conceptualising that frequent and repeated admission to hospital is a process that can bring with it periods of change and discontinuities. And that these periods have the potential for identity to become fragmented and fragile as a consequence of the disruption of biographies. Indeed, many of the stories told in the interviews reflected this understanding. However, being always open to fresh interpretation through questioning and not necessarily relying on my own perspective not only allows me to exercise my critical voice, but also gain insight into the differences between interpretations and how they are arrived at.

Finally, I regard the use of reflective teams in the analytical phase of the study as an important next step, the strength of which, I envisage will offer a wider perspective to view the phenomena under investigation, bringing different interpretations to the interview material. For the reflective teams I plan to use professionals from multi-disciplinary teams (ie. doctors, psychologists, nurses) and lay members as it would be interesting to find out their perspective on what was going on in each of the chosen cases to be analysed.

Conclusion

In this chapter, I have demonstrated the fact that the experience of having multiple readmissions to psychiatric hospital has not been addressed in-depth and in a meaningful way within medical and sociological research spheres. Quantitative and positivistic approaches have been criticised and I have tried to highlight the need for qualitative methodological approaches to help us understand the experiences of a disparate group of people such as those suffering from mental illness.

I have also shown that the Biographical Narrative Interpretive Method belongs to a growing branch of qualitative methods that focus on the story, its composition and its telling, and is a useful data collection and analysis tool for understanding the psychology/subjectivity of the individual. While there are some barriers to interviewing this particular research group - such as the possible difficulties of narrating a coherent story in times of crises when personal identity is necessarily in a state of confusion and flux - I argue that the Biographical Narrative Interview Method is a means by which people can relate experiences from everyday life and, in this way, provide opportunities for us to come to a modicum of understanding of what those experiences mean.

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