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Whose Madness Is It Anyway: Perspectives From the Voice Of Unreason

Brian Murray

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Declaration

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Section A: Preface

This portfolio comprises three sections: an empirical research project, a case study, and a publishable paper. Each piece was completed during my training at City University London and together demonstrates my competence as a counselling psychologist. This portfolio provides evidence of my knowledge and skills within research and practice, demonstrating critical and independent working, to the standard of a professional doctorate.

Overall these sections provide an indication of the development of my identity as a counselling psychologist with a growing social constructionist epistemological viewpoint. Through the research element, my epistemology refines to that of the critical realist, whilst maintaining a deconstructive underpinning and critical lens in understanding and presenting the findings. The process of planning the research component inspired the publishable paper section through the struggles met maintaining epistemological identity within a traditionalist or realist/empiricist environment. Instead of resting my case in the ethics boardroom, I decided to produce a paper that might provide some reference-based support for budding counselling psychologists. Prior to the research element being considered, the pre-disposition for engaging in difficult work was spotted by my NHS clinical supervisor. He supported me in completing work with a woman who was living with an identity as 'a mad woman', which left her presenting as physically disabled and housebound. In working with this colleague who aligned himself with a systemic school of thought, my social constructionist epistemology was able to extend into the therapy room, through the use of the psychodynamic model. Being encouraged to follow my social constructionist thirst for thinking and working creatively helped me to challenge a variety of ways of thinking, from therapy room to the multidisciplinary clinical team meeting room.

Having a positive experience early in my training helped cement my de-constructive ideology and gave me the confidence to choose a difficult research project, inspired by my clinical work. This engagement in research that was service-user inspired provided the fuel to continue with the project despite major challenges. In identifying with the position of 'the other', and challenging ideas of the status quo, the various sections of this portfolio provide a range of windows into the way in which I have worked as a trainee counselling psychologist and endeavor to continue to work as a counselling psychologist.

The first section of the portfolio is the empirical research project. As briefly mentioned, this was inspired by a service user on one of my placements. Being told that a nod and a smile from a psychiatrist was interpreted as a dismissal into the identity and language of a mad person caused me to re-think my notions of what is perceived as madness. It also provoked me to question how mental health professionals believe they are seen versus how they are actually received by service users. After realizing the frequent change in mental health terminology, yet a lasting reaction against a range of terms, I decided to explore the term *madness*. A literature review revealed that service user perspectives are largely included as part of the diagnostic formulation only. This echoed the client's view that her voice was translated into the language of *madness*. Current research discussed the history of the term and focuses on the anti-psychiatry movement, moving away from who it matter most to – those who are labelled. As such, I recruited service users to explore the construction of the term and the function of those constructs. Following the use of semi-structured interviews (3 individual and 1 group), the interviews were transcribed and a discourse analysis formed the analytic procedure. The results described the use of the term *madness* in a light minded manner to be used in everyday language (with possibility to offend), as an offensive term with negative connotations, as a description of an actual experience, or as claimed identity that is positive. The consequences of being deemed *mad* as well as the media impact of foregrounding *madness* was outlined. It appeared the process of re-claiming *madness* as a term to describe an experience or as a positive celebration of difference. The consequences for counselling psychologists appeared clear – we need to encourage the deconstruction of mental health terminology and not be afraid to allow words that sit outside of official terminology to be discussed. The idea of 'normalising' was also challenged as it encourages the divide of 'us and them'. Instead, I proposed the idea of encouraging counselling psychologists and other professionals to look at the individual's own experiences and making sense of them within their context, providing informed, individualized formulations and solutions.

The next section of this portfolio demonstrates my professional practice through the inclusion of an in-depth case study. This case study represents my developing interest in working psychodynamically, informed by systemic thinking. The adaptive perspective lends itself to this marriage of models and retains my social constructionist epistemological grounding. In working as a trainee psychologist, this case provided an incredibly interesting opportunity to attempt to engage with a woman who presented as what would previously be

called a 'hysteric'. The client described how she became incredibly dizzy after a confrontation with a family member. This symptom increased to the point where she felt the 'world fell apart' and left her unable to walk, bathe, and dress unaided. It also left her unable to read or write. In working reflectively, I was able to challenge the constructions held by the client as well as the build an awareness of the subtle emotional/transferential impact of working against a long-standing identity of illness. Historic presentations of anxiety, PTSD, and agoraphobia had been managed in the past, though unresolved. However, the continued access to physical health services sustained the idea that there was a 'cause' and the cause could be found by an expert and cured. After some time the client was able to hold the idea that anxiety was present, as a result of early trauma, and was impacting her physical health problem. Overall my focus on identifying and de-constructing the client's years of defense mechanisms helped to widen my lens to see the function of those defenses. This left her husband as the centre of her world and positioned as her carer. The 'sick role' also deflected any blame for missing years of her childrens' life through her agoraphobia and ignored any potential for both husband and wife to question difficulties in their marriage. As the sessions continued, the function of her role in the family also proved to be difficult to change. In order for the client to 're-surface', her husband would have to re-position himself in a less dependent role. Through supervision and personal therapy, the impact of projected emotional material became clear and I was more able to identify my role in maintaining the client's sick role. Towards the end of the work, I was able to maintain my ability to 'hold' the client without fearing to go beneath the surface that was presented. The client responded well and enjoyed reclaiming her identity of a forgotten past. This work was extremely challenging but reaffirmed my choice to work with cases that other deem unfixable. In maintaining my social constructionist identity through therapeutic models that encourage de-constructive thinking, I was able to challenge the wider world of the client, outside of the therapy room, as well as realize the impact of myself as both part of the problem and the solution.

The last section of the portfolio demonstrates the end-point of my time on the doctoral course. Following the challenges faced in the production of the research project, I was determined to produce a publishable paper that stood up for counselling psychology and encourages research projects that can provoke social change to break through bureaucratic and epistemological barriers. The paper forms the necessary requirements for submission to the *Counselling Psychology Review*. It is hoped that counselling psychologist reading the paper will use some of the examples of why counselling psychologists are suited to research

and supports the use of qualitative methodologies that are congruent with non-realist epistemologies. An awareness of the identity crisis within the clinical and research world of the counselling psychologist was also integrated into the paper. The challenges faced in my own research were outlined, as well as recommendations for how to approach similar resistance in for future projects. My own experience delayed my research significantly. However, in maintaining my passion for the subject, and reminding myself of the inspiration for the research, I learned how to take on the challenges a counselling psychologist faces in their multi-faceted portfolio careers, in order to encourage meaningful social change.

These pieces of work are presented in order to demonstrate my competencies within counselling psychology in terms of research, clinical practice and service delivery. However, I also hope they present my passion for trying to engage in community and societal roles of the counselling psychologist. Throughout the doctorate course, we have been encouraged to take part in the field of psychology 'beyond the therapy room'. I hope the development of my skills in research, practice, consultation and teaching will facilitate my ambition of encouraging social change from the therapy room to the board room. Through my personal underpinning in social constructionism, I am able to make use of therapy models that encourage a process of deconstruction, research that challenges thinking whilst engaging those who need to be heard, and consulting other professionals in a way that encourages creative thinking without appearing threatening. I sincerely hope this passion continues within my own person and spreads to other professionals, policy makers and beyond.

What Do We Mean By Madness: How And Where Is It Used Today?

Supervised by Dr Jessica Jones Nielsen

Abstract

Overview: Currently service users views are included as part of the diagnostic construction. The impact of mental health language is difficult to explore as terminology is shifting through the decades. The term madness has survived. Therefore constructions of this term and its societal and subjective consequences can be investigated. **Objectives:** The objective of the study was to investigate what constructions are held in regards the term 'madness', as well as the perceived 'function' of those constructions from the perspective of mental health service users. **Design:** A qualitative methodological approach was used to deconstruct the term 'madness' using Discourse Analysis. The term was chosen as it represents a long-standing construct that has not changed over time unlike current mental health terminology. Service users were asked to share their constructions of the term as current literature on the topic is lacking from the mental health service user perspective. **Method:** Following NHS Ethics approval, participants were selected from Service User Involvement Forums in West London using opportunistic sampling. Individual (n=3) and Group (n=4) semi-structured interviews were used. Discourse Analysis methodology formed the analytic procedure. **Results:** The term 'madness' can be placed within a continuum of similar terminology such as insane or crazy but the use of the term has varied functions: 1) Flippant, non-offensive, non-labelling term; 2) Labelling and harmful, with or without intention to do so; 3) An accurate description of 'an experience'; and 4) Labelling but positive, indicating creativity/uniqueness. **Conclusions:** The term 'madness' is not clinical, though clinical terms may be translated as 'madness'. The term can be harmful when misused (e.g. through the media). The term is most helpfully re-claimed and re-constructed by service users, in order to encourage acceptance. A change in clinical philosophy, re-thinking the use of clinical language as well as re-considering normalising, and suggesting opportunities to encourage transparent working are promoted.

Keywords: *Madness, Mental Health, Mental Wellbeing, Mental Illness, Discourse Analysis*

Chapter 1 – The Introduction

Unless we are to diagnose entire cultures as psychotic, we have to rethink the question of what counts as mad, locating it in social and cultural definitions rather than assuming a trans-historical identity of the insane. (Hodgkin, 2007, p.4)

1.1 Overview

In this chapter, the author seeks to enlist the help of recent literature in uncovering what constructions society holds about the term 'madness' today. How these meanings serve to *do something* in the contexts where the term is used will also be explored. What is clear from the published material is that the general view of madness is not clear. The central tenants of 'madness' in major literature appears to be in the form of historical explanations, citing the 'rise of psychiatric power' and 'mechanistic/reductionist views' that do not satisfy professionals in the mental health field or those designated as 'mad'. A political and philosophical debate then seems to be the motivation behind the published material. Uncovering why madness as a term has been maintained throughout this time appears to be less reported, lost instead to the political debate. As a result, the perceived function(s) of madness usage today is over-intellectualized and therefore inaccessible to those who are associated with 'madness'.

However, more recent papers show a growing trend towards the publication of patient's narratives in the search for meaning (e.g., Allen, 2005; Adams, 2003; Barnes, 2008; Campbell, 2009; Fearne 2010). In terms of how this information is used clinically, Barrett (1996) argues that patients' narratives currently are only included as part of the diagnostic construction. After reviewing the main literature, which is dense in the book volumes but limited in the form of research articles, the author will attempt to look at some of the recent directions in published articles which may give further insight on the meaning(s) of madness today and on the perceived function of these different meanings. This will be explored with application to counselling psychology and the aims of the current study.

1.2 Assumptions on madness

Whilst one would normally begin by searching for a range of definitions of a term, this will not be the case here. The quote from Hodgkin (2007) at the beginning of this chapter serves as a more pertinent attempt to position the *constructions* sought by this paper, as opposed to definitions. The function or functions of a particular construction is the topic of interest in this research paper. The methodology chapter includes a current 'definition',

sourced at the time of writing, in order to 'check-in' with what 'official' terms are currently offered in society, in contrast the authors own assumptions.

The overwhelming literature response to meaning(s) of madness has been from the field of psychiatry, with particular attention to the establishment of the mental health system in the USA. Some recent readings on the history of madness include Gracefully Insane: The Rise and Fall of America's Premier Mental Hospital (Beam, 2009); Creating Mental Illness (Horowitz, 2002); Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill (Whitaker, 2002) and Madness: A Brief History (Porter, 2002). The last example traces theoretical routes throughout Europe as opposed to foregrounding the USA, as per the evident choice of the other authors. Overall, at the times of each era of madness cited, the professionals at each point would offer explanations of madness, rather than assumptions. The functions of these 'explanations' appear to have altered only a moderate degree throughout history, generally serving to inform 'treatments' of various guises.

In the 18th century, madness supposedly 'advertised itself in a proliferation of symptoms, in gait, in physiognomy, in weird demeanor, and habits. It was synonymous with behaving crazy, looking crazy, talking crazy. Villagers, churchwardens and doctors alike – all could spot "antic dispositions"' (Porter, 2002, p.35). These assumptions therefore had a function of being able to identify madness without necessarily having any 'expertise'. In the 'clinical world' of today, the debate on mental health terminology and the supposed function of each particular mental health 'phrase' continues (see Muijen below). Conversely, if the view of Psychiatrist and Academic, Thomas Szasz (e.g., 1961) were taken, the actual existence of madness or mentally illness would be dismissed entirely. Clearly, there are many 'experts' in the mental health field who have their assumptions of how madness can be defined (or dismissed entirely). However, historically, we see the term madness extended to philosophy, art, political – and even spiritual – understandings.

1.3 Why explore madness today?

The meaning of madness has been explored throughout history, from references to the 'Golden Age' of Greece to the writings of Shakespeare (e.g., King Lear), to the more contemporary medium of film (e.g., One Flew Over the Cuckoo's Nest). As per Porter's (2002) picture of the 18th century noted above, the last example from the world of film hints at a more general view of madness. A knowledge and diagnostic ability is held without a person being exposed or trained in the supposed 'phenomenon'. Currently, treatment plans

for those deemed not to be sane are decided upon by mental health professionals, which suggests that there is an expert knowledge and definition of what it is to be sane, insane or indeed 'mad'. However, in 2006, Dr. Matt Muijen, Regional Advisor for Mental Health at the European Region of the World Health Organisation, highlighted the problems associated with (mis)understandings of umbrella terminology, arguing that:

… 'mental health', 'mental ill health', 'mental wellbeing', 'mental illness', 'lack of mental wellbeing' are all being used, and we all assume that we are talking about the same group and the same concepts. It is very dangerous. In the Helsinki Declaration we consistently used either 'mental wellbeing' to talk about positive mental health, or 'mental health problems' to talk about negative mental health, and already this could lead to debates about the meaning of those concepts. We cluster together a whole group of disorders and a whole group of people who actually have nothing in common. We talk about people with, let us say, relatively minor anxiety states and people with very major forms of schizophrenia as part of the same group. It is unhelpful because they need very different interventions leading to different outcomes. (Great Britain, 2007, p.92).

Therefore, there appears to be a core misunderstanding of what different people mean when they use these labels. In the above statement, Muijen goes so far as to suggest that people with different diagnoses should be group-labeled differently, and that it is 'dangerous' to call them or think of groups as the same. This suggests that the constructed taxonomies of mental health should be segregated, perhaps into 'mild mental health' and 'real mental health' catgories. It does not question assumptions behind these taxonomies but instead creates a fear in the audience that positions schizophrenia at the extreme end of some imagined scale. The result is that these ideas are further cemented rather than deconstructed and questioned. If positioning individuals at the 'extreme end' is interpreted as modern-day madness, would his statement have a different impact on the audience? Does mental health versus. mental illness mean anything different to the lay public? Where does the concept of madness fit into this equation?

The author of the present study has chosen to look at how 'madness' is constructed today, as it is a term that remains relatively persistent throughout time. It is a word that stands up to what Bahktin (1971) calls 'great-time', whereby all significant words, although fluctuating to some extent, continue to have importance beyond their immediate context (Lindsey, 1993). The novelist image of what madness is has endured throughout the citations

of the word madness. The opposing phrase 'small-time' may relate to mental illness, or mental health, which are only present in our current time, and their meanings continue to vary and alter (Lindsey, 1993), as Muijen's terminology debate (Great Britain, 2007) seems to suggest.

Moreover, the recent labels may be used when the individual using them is actually referring to their own or others' idea of madness. This highlights how language is constantly creating and recreating meaning with varying functions, within different contexts. The functional consequence of this term to an individual may be detrimental to engagement with services. In a recent article, Williams (2010) describes how, historically, the emergence of constructions of madness or insanity, "coincided with ways in which relations of order and power were administered in a newly industrializing world", and that "these influences have had tremendous impact on the ways individuals are viewed and treated" (p.111). Williams strongly suggests that this continues to be the case today, in terms of how such individuals are viewed, treated and managed. In the field of counselling psychology, one of the key components of a National Health Service (NHS) psychologist role is multidisciplinary team working (MDT). Being involved, from initial assessment to end treatment with an individual, positions the MDT as decision makers. Therefore, their own constructions may be pertinent in deciding how to manage patients. As an active part of that team, counselling psychologists could play a role in understanding, and possibly deconstructing and challenging these assumptions at both an MDT and patient level.

1.3.1 Clinical terminology

In recent years, there has been a strong focus on de-pathologizing terminology within the mental health sector. For example, we now talk about psychosis rather than schizophrenia. In addition we currently have proposals of 'Attenuated Psychosis Syndrome' being brought into the new *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; APA, 2013), with schizophrenia being only one of 11 labels within the diagnostic category of Schizophrenia Spectrum and Other Psychotic Disorders. Shifting language can also be seen from National Institute of Mental Health (NIMH) Director Thomas Insel's neurogenetically orientated article, *Rethinking Schizophrenia.* The work states that we can now think of schizophrenia as a syndrome that can be re-positioned as a neurodevelopmental disorder. He goes on to say that, like other mental illnesses, we can position psychosis as the late stage of a neurodevelopmental trajectory, where the end-symptoms are observed in the form of psychosis (Insel, 2010). This theory extends to other mental health disorders in his earlier article on re-thinking mental illness (Insel & Wang, 1970).

Clinically, we talk about 'mental illness' rather than 'insanity', though the terms are used interchangeably in the media. One example is from Dr. Wessely (Institute of Psychiatry, London, UK) on the Norway massacre in 2011, who argues that the media and the public's first assumption is that the perpetrator, Breivik, must be mad specifically because he has committed such atrocities (Wessely, 2012). The same article quotes terms such as being 'insane' and having 'mental health problems' as a means of explaining Breivik's behaviour. The use of these different terms highlights the varied terminology that exists in the psyche of the lay public. In this case, Wessely reports the publically perceived function of associating a mental health label with Breivik as a means to provide a legal device to exonerate him from responsibility. If so, it would appear that the public's reaction to portrayals of madness, and the consequences of association to madness, is viewed as negative. The idea of a stigma is not present in this example but rather, the notion of the consequences of labelling are unsatisfactory in relation to the public's idea of justice.

The association of stigma, and consequences of it, are present in current literature. These follow the ideas of 'labelling theory', which came into popularity following sociologist Thomas Scheff's seminal book, *Being Mentally Ill* (Scheff, 1966). The overall idea of the ensuing debate was that being labelled mentally ill causes one to be mentally ill; similar to the public's reaction to Breivik's labelling, Scheff's 1966 original theory foregrounded the act of the labelling through institutional measures. At the height of its popularity, labelling theory itself was contested (e.g., Davis, 1976; Gibbs, 1972; Gove, 1970). However, following Lewis's (1971) analysis of therapy transcripts, it was updated in 1989 and 1999 to include the emotional impact of labelling, to include the chain reactions of shame and anger, resulting in poor outcomes for individuals and their families.

Recent studies show that the development of 'insight' into a range of mental health conditions, particularly psychosis, lead to an increase in depression and suicide (Lewis, 2004; Drake et al., 2004). Furthermore, another study found that after 4 years, individuals who were more aware that they suffered from 'mental illness' were likely to become more depressed, with a greater likelihood of attempted suicide' (Crumlish et al., 2005). More recently, Barrett and colleagues (2010) reported similar findings but put forward the explanation that the individual's negative beliefs about psychosis were the important factor for developing depression and increasing the risk of suicide. This is particularly pertinent for the current study as it suggests that the individual's construction of modern-day madness, when perceived to apply to them, has a negative impact, and possibly to an injurious degree.

Equally, the construction of madness that a person holds, in relation to him/herself, might also lend itself to a lighter or more positive function. In thinking about how terms may be used in language, phrases such as 'I have lost my marbles', rather than, 'I'm suffering with a chronic mental illness called schizophrenia, which I will live with for the rest of my life' seems to suggest a different type of label that a person is identifying with, and what they are suggesting to the outside world in relation to this chosen identity. As noted earlier from Muijen (2007), the meaning of certain phrases appears to have very different consequences.

Conversely, Weinstein (1983) suggested that, when legitimately thought of as mental illness, the patient's 'insight' that he or she suffers from such a label may be conducive to improvement. In this view, the application of a mental illness label, where appropriate, can be therapeutic for the client. Illness in this context was however not a diagnostic 'imposed' label. Historically, an individual would undergo an assessment by their G.P. and then have a psychiatric assessment to be allocated a diagnostic label and receive treatment accordingly. However, with the emergence of Wellbeing Centres in the UK, as part of the Improving Access to Psychological Therapies (IAPT) agenda, a person can self-refer, forgoing the attachment of a psychiatric label. However, they may be 'stepped-up' to secondary care services if scoring too high on depression and anxiety scales. This gives rise to the question as to whether new constructions of madness have emerged.

The debate on labeling is ongoing and as yet does not appear to have impacted on clinical treatment or in media representations of labels such as mentally ill, mad, or insane. Therefore, there is a need to continue the debate, at a more deconstructive level, so that the consequences of re-thinking madness reach beyond the level of textbook lectures. The reason for this shift not occurring sooner is debatable, though it is evident that the terminology surrounding madness and its consequences are not new to the world.

1.3.2 Madness through the ages.

Throughout history, madness has had many names and associations, interpreted across cultures with negative connotations. For the purposes of this review, the words 'lunacy', 'insane', and 'deranged' will be assumed to equate to the common language that comprises 'madness'. Casey and Long (2003) compiled terminology on madness from a literature review and listed labels as: 'possession by evil spirits', 'punishment for past wrongs', 'mystical experiences', 'biochemical imbalances', 'faulty genes', 'feeble mindedness', 'social-deviance', 'the product of damaging interpersonal/social environment', 'faulty thinking' or 'the result of past traumatic experiences' (Casey & Long, 2003, p.92). Spread throughout

history, these associations extend beyond the views of western culture, though it seems only with the emergence of psychiatry that the language of madness has since expelled spiritual or mystical explanations. The rise of psychiatry will be discussed later in this review. At this point the reader will find that some of the (mis)understandings of what madness means will seem familiar. However, it may create unease as one realises that the past views of what madness is still resonate in today's society.

According to a timeline created by Roberts (1981), at the turn of the last century, people with mental health difficulties were referred to as 'defective', 'lunatics', and 'insane' and believed to be prone to committing homicide, and attempting to murder and maim (Roberts, 1981). In 1890, the meaning of madness was dismissed and was thought to be caused by an erroneous nervous system and believed to be incurable (Roberts, 1981). In 1900 the mad were incarcerated in large, overcrowded, under-resourced 'madhouses' or 'asylums' to protect them from exploitation and protect society from them (Roberts, 1981). Furthermore, in 1904 the Eugenics Movement called for compulsory sterilization of the insane to prevent racial degeneration (Roberts,1981).

Later in the 1980s, the UK Mental Health Act (1983) used the term 'mental disorder', defining it as 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder of the mind'. It emphasized reception, care, and treatment of mentally disordered patients, and placed legal controls on medical treatments, particularly surgery, electro-convulsive therapy, and mood-altering medications.

Today, Mental Health Law allows for compulsorily hospitalization of those individuals with an approved social worker or the next of kin for assessment (Section 2), or emergency treatment (Section 4) lasting a maximum of 28 days or 72 hours, respectively (Mental Health Act, 2007). The reason for admission must be that the person needs assessment and possible treatment for the protection of themselves or others. Previously it was the case that a woman may be detained into a hospital at "the request of the husband of the woman", "without the evidence of insanity" (Szasz 1973, p.55). Furthermore, in Russia, individuals were detained for political reasons; revolution itself was thought to trigger an epidemic of "latent deviance in apparently normal people" (Beer, 2008). In brief, if you are seen to be decenting, you will be 'classed' as insane, and 'treated' as such. Currently, the psychiatry profession has been appointed the designator of those who are sane or insane. Therefore, does the contemporary definition of madness lie with them?

1.3.3 Psychiatrists – the deemers of madness

Thomas Szasz is a well-known author on the topic of madness and has numerous books, including, *The Myth of Mental Illness* (1961), *Ideology and Insanity* (1970), *The Manufacture of Madness* (1970), and *The Second Sin* (1974). In his books, Szasz (1961, 1973) famously put forward the idea that there was 'no such thing as mental illness' and that it is in fact a man-made myth! Indeed, Szasz's name is usually associated with the anti-psychiatry movement that emerged in response to the medicalization of matters of the mind and the treatment that followed from these medical-models. In his book, *The Age of Madness – The History of Involuntary Mental Hospitalisation,* Szasz (1973) explores the rise of psychiatric power over those deemed insane.

More recently, Szasz (2001) has argued there is no meaning of madness for psychiatrists as practices such as detaining, drugging and invalidating their experiences, by translating content into 'lack of insight' or 'delusional states' continue. However, it is worth noting that Szasz himself is a psychiatrist by designation; later in this review we will see that not all psychiatrists are the same.

Another name in the defending of the mad (referred to as 'voice of unreason') against psychiatry (referred to as the 'voice of reason') is Michael Foucault. In *Madness and Civilization* (1965) and, more recently, *History of Madness and Madness* (2006), Foucault presents a history of the division between madness and reason, a history of institutions, and a history of power between us/them. In this way, it is the general narrative that has been accepted by society that allows psychiatry to determine polarized view of sane/insane to exist by consent. However, although this leads us to an understanding of what madness means for society, it perhaps objectifies 'the mad' as those who are the subject of academic and philosophical debate. Therefore, it further creates an 'us/them' way of thinking that sustains a power divide to which society subscribes towards. Furthermore, it does not add to any progress into the understanding of what madness means today in terms of clinical application. The only solution would be to refer to the opening quote in this review (Hodgkin, 2007), though this may prove untenable. With the development of access to therapy outside psychiatric ministrations (for some), it may be that it means something entirely different to those who would otherwise be seen as experiencing madness. Furthermore, what if madness is experienced in another form, a meaningful one of being touched by the hand of a mystical/supreme being?

1.3.4 Explorations of the myth of madness

In recent years, Richard Bentall has been a popularized figure within the realm of mental illness study. Here, the term madness is used only as it is Bentall's chosen word – the most recent term for separating the mad from the sane. In his book *Madness Explained,* Bentall (2004) looks at what he describes as the most severe types of mental disorder – the psychoses. Bentall's book is similar to that of Szasz in its description of the rise of the psychiatric movement, and the emerging attempts to understand mental illness through mechanistic biological framing. It differs in its focus on the development of the tools by which psychiatry now diagnoses someone based on a classification manual (e.g., ICD and DSM). The beginning of classification originated – according to Bentall – with German psychiatrist Emil Kraepelin. This seems to have begun the metaphorical medical ball rolling towards further redefining insanity. What was then termed dementia praecox is now more universally known as schizophrenia. However, as Bentall points out, the method of diagnosing people in this way can never be an absolute measure of the barrier between sanity and insanity. This runs contrary to 'the giants of psychiatry', such as Kraepelin who had suggested that people either suffered with mental illness or they did not, quashing the belief that one might be able to interpret madness as eccentricity (Bentall, 2004).

1.4 Boundaries of madness

Where Bentall brings together historical and modern understandings of madness is in reported studies that show the 'first-rank' or 'positive' symptoms of schizophrenia seen in all people. The first study Bentall cites was conducted at the end of the 19th century, and focused on hallucinations. It found that in interviews of 14,000 men and women in the UK, 8% men and 12% women reported at least one experience of vivid hallucination (Sidgewick, 1894, in Bentall, 2004).

Bentall reports that modern surveys have continued to provide evidence that hallucinations are experienced by people who, importantly, appear otherwise 'normal' and who have felt the need to seek psychiatric treatment. The recent studies have not had random distribution of participants, who had been taken mainly from student populations. Therefore, its generalizability is somewhat limited. However, Bentall cites a survey in the USA, which comprises 18,000 participants. This study by Allen Tien (1991, in Bentall, 2004) cited between 11% and 13% of participants reporting experiences of hallucinations. However, these studies differ not only in time and location but in their results: the former reported the experience of hallucinations at ages 20–29 and the latter in old age. Furthermore, the latter,

US study, reported fewer incidents of visual hallucinations. This suggests that there is not a clear divide between madness and sanity. However, the difference in the two studies shows that cross-cultural and historical variation play a role in what constitutes symptoms of madness in those otherwise considered to be sane.

1.4.1 Madness in the sane

Evidently, the lines of madness can be blurred further, as there have been exceptions allowed in psychiatry to allow for hallucinations in the sane, despite it being seen as one of the defining points of separation from reality. In 1925, at the height of the 'classification' era of Kraepelin – his 'clinical manifestations of mental illness' book having been published 5 years previously (Bentall, 2004) – an article was published in the *British Medical Journal*, reporting the case of visual hallucinations in a patient (Ormond, 1925). The case study was explained by the author, an ophthalmic surgeon, and compared with Galton's earlier work that suggested a 'sane and healthy person' could have 'visual presentations' that could reach the level of hallucination. This was attributed to some neurological origin in the occipital region of the brain. However, if the person was distressed by this and saw a psychiatrist, would they therefore be diagnosed as mad?

Current developments in general medicine have led to the 'discovery' of Charles Bonnet syndrome (CBS). However, there is disagreement in the medical world as to how this actually occurs. It is believed that loss of sight leads to some form of compensation in the brain. An article titled *Visual Hallucinations in Sane People* (Rosenbaum, 1987) and a later review by Gold and Rabins (1989) noted the phenomenon being reported for several hundred years without consensus on whether these hallucinations should be considered a separate syndrome, CBS, or whether eye disease or brain disease is a necessary or exclusionary criterion for diagnosing this syndrome. Overall, it was understood to occur in elderly people with decreased visual acuity; the article concluded with recommendations for diagnostic criteria. However, the literature, published in psychiatric journals, still seeks this categorization rather than exploring the difference of having hallucinations that are distressing, leading to diagnosis of psychosis and antipsychotic medication, and someone who has a hallucination and is deemed to have CBS. This may mean that those otherwise deemed 'mad' could perhaps pass for sane and vice versa, depending on which doctor they see. This leads us to consider the personal account of people who experience hallucinations.

1.4.2 Personal accounts of hallucinations from the sane.

The personal accounts of those who experience hallucinations have been noted in case reports from psychiatric journals with view to explain their presentations within a diagnostic framework. However, there are individuals who have the academic reporting means and ability to position their experiences outside of madness. One such study is from Goldstein (1976), who reports "several highly organized visual, auditory, and kinaesthetic hallucinations" (Goldstein, 1976, p.423) that he experienced for three days before undergoing spinal disc surgery. Of particular interest to this review, Goldstein asserts that if he was identified as 'psychotic' before the experience; his article would be "nothing more than a report of a very common, trivial experience" (Goldstein, 1976, p.423). He then continues to state evidence for his sanity due to his employment background and the temporary nature of the occurrence. However, this ability to self-diagnose and self-determine how one is viewed after such an experience is rare. Later in this review, the experience of madness by those deemed mad by others will be explored.

1.4.3 On being sane in insane places

In a famous experiment, Rosenhan (1973) described a case whereby eight individuals reported unusual auditory experiences at US psychiatric hospitals. They were subsequently admitted and given a diagnosis of schizophrenia. The study is from a psychology platform as opposed to medicine or psychiatry, yet it supposes that there is an amount of leniency the can be allowed in misdiagnosis. Subsequent studies of a similar time also criticized the methods used in the 1973 study, though it is cited widely in the field of psychology as an example of the importance of context and diagnosis in psychiatry. Crown (1975) rebutted that, "psychiatric diagnosis, particularly of schizophrenia, is culture bound rather than absolute and depends on the interaction between the symptoms presented by a patient (or pseudo-patient) and the background and training of the psychiatrist" (Crown, 1975, p.453). Importantly, when admitted, the pseudo-patients dropped any symptomology but "were not detectably sane" (Rosenhan, 1973, p.252) in the environment of a psychiatric hospital. Furthermore, the original 1973 study reported that at the end of the pseudo-patient's admission, each of the pseudo-patients who had been diagnosed schizophrenic was classed as having schizophrenia 'in remission'.

This is arguably the most important consequence of a diagnosis of modern-day madness; people diagnosed with any other disorder can seemingly return to sanity, though

individuals who are given a diagnosis of schizophrenia or psychosis can only ever have their status updated to 'in remission'.

In 2001, Scribner revisited Rosenhan's work in order to evaluate whether any progress had occurred in the mental health field over the past several decades. Conversely, these were individuals with a history of psychiatric illness and in the midst of an acute exacerbation of their respective 'illness' (Scribner, 2001). It was found that these individuals did not gain admission to their desired facilities. Scribner concludes that this shows a shift in psychiatric services that forces individuals to "maintain a level of dysfunction that is neither too mild nor too severe, ensuring that he or she squeezes into that ever-shrinking range of disturbance that is deemed to be suitable for treatment" (Scribner, 2001, p.258).

This controvertibly proposes that the meaning of madness today might be influenced by the services that provide provision to treat them, and that the mad are able to modify what the meaning of madness is to the service providers in order to seek treatment.

1.5 Whose madness is it anyway?

The ambiguity over what counts as mad begs the question: how can madness be portrayed so that it fits into a general understanding and renders services receptive to that construct? It also suggests that, to the professional, the idea of how 'ill' is 'ill enough' to provide acute services? It also links to Muijen's (2007) mental health versus mental illness debate, whereby there may be a move toward mild mental health versus 'real' mental health – modern-day madness – in determining service provision. Perhaps the term madness now has its meaning embedded as a great-time word from something accessible in different forms throughout history – the media.

1.5.1 Media's madness

The literature accounts of madness on behalf of psychiatry – and its emerging counterpart, the individuals deemed mad – may not quite fill the overall (mis)understanding of what madness means today. Although there appears to be a raft of viewpoints from psychiatrists and the affected individuals, people in general have an idea of what madness is – apparently, without having being exposed to it. This can be seen to have occurred throughout history in various guises of media portrayals. Whether from Shakespeare, Edgar Allen Poe to films such as *One Flew Over the Cuckoo's Nest* (1975), the exposure of media portrayal of madness has been the debate of research publications.

According to a recent review by Nairn (2007), English-speaking societies have a considerable store of images of the mad, which are embedded in known narratives and official practices. Using a social constructionist viewpoint, Nairn supposes that these notions "rely upon recycled vocabulary, metaphors and other tropes, and narrative fragments that have accumulated over hundreds of years" (Nairn, 2007, p.139). This perspective allows the recipients of such knowledge to be familiar with biomedical cornerstones such as 'schizophrenia', 'psychosis' and both 'mental illness' and 'mental health', as seen throughout this review, dating back to the 18th century. Nairn has published works on media depictions of mental illnesses over the last decade and has come to categorize clusters within the bank of images available as: 'animal(ity)', 'damaged goods', 'incomplete', 'out of control' and 'possessed' (Nairn, 2007, p.139). These do not categorize the mad as per the method in mental health services, though gives a picture as to the meaning of madness to the general population.

Importantly, such narratives available through media are evidently open to the general population, which therefore includes both those deemed mad and those who 'do the deeming'. This may therefore be an important means to answering the question of what the meaning of madness is today, and to understand why some will go to great lengths to avoid the usual 'route of diagnosis', preferring to opt for psychotherapeutic treatment.

However, as Nairn (2007) states, the data collected had some exclusions that leave the results to be reviewed with caution. The samples taken were from newspapers, television documentaries, soaps, and dramas in the UK, USA, Australia, and New Zealand. Nairn's work on madness in the media spans 10 years, therefore the ideas can be taken as a snapshot of the discourses of specific types of media at a given point in time. However, Nairn's work neither indicates the impact on the meaning of madness from media to the individuals most sensitive to the portrayal, those deemed mad; nor does it show its impact on the general public, or the clinicians who diagnose or give treatment to people entering the mental health system. It would be illuminating to examine works of the past literature and media, and its effect on the meaning of madness and therefore on service provision.

There are a number of works that seek to link psychoanalytic understandings (both pre- and post-Freud) the works of Shakespeare (See Edgar, 1970; Feder, 1980; Sakeld, 1993) in order to understand the meaning of madness in the characters. Although historically of

interest, this does not fully explore the meaning and consequences of understanding(s) of madness today.

However, Liam Clarke's (2009) Fiction's Madness book provides an initial look into how this might be done. In the form of essays rather than an academic work, he takes 12 works of 'classical literature', from Shakespeare to Kafka to Kingsley Amis, exploring mental illness and proposes how understandings can be rendered from stories. The result is that some recommendations are given to address the reductionist nature of diagnostic teachings and look at the context of both the authors and the protagonists in understanding the meaning of madness.

This is further supported by Crawford and Backer (2009) who suggest that parallels of psychiatric teachings can be found, perhaps to a more rich and experiential degree, by writers of fiction. It is hoped that through the discourse of fiction, the psychiatrist-in-training can examine the human experiences, emotional responses and behaviors of both patients (fiction's protagonists) and their carers (secondary characters). This opens up a debate on the meaning of madness 'for whom', which as discussed later might be particularly important for clinical practice.

1.5.2 Media's madness in therapy

Whilst we may not know every impact of media's portrayal of madness, we can see some attempts to see its influence on pockets of society. Perhaps most pertinent to counselling psychology, is its impact on therapy itself. Tutter (2009) looked at the reaction of clients when they presented with the proposition of taking medication in its activation of 'romantic fantasies of madness'. Tutter explores what she calls a "defense analysis' of their objections, which may be feared and concealed as a source of shame, destruction, and loss, and also cherished and revered as a source of power, inspiration, and mystery" (Tutter, 2009, p.631). According to Tutter, the romanticized texts are also known to the therapist and, therefore, inadvertently lead to the therapist colluding with the idea that medication may quash inner wishes and desires – taking the meaning from madness.

Moreover, recent attention has been given to delusions themselves that might change the attitudes of both client and service provider towards the function of 'the madness of today'. The discussion here focuses on delusions, which Roberts (1991) suggests are 'a means of sense-making'. He argues that delusions themselves may help the individual attribute meaning to "unaccountable, unpredictable, anomalous experience" (Roberts, 1991,

p.19). This theory fits with the Foucauldian constructionist approach towards the meaning of mental illness. It also supports earlier assertions from Lansky (1977) that a delusion is restitutive in "ameliorating anxieties by altering the construction of reality" (Lansky, 1977, p.160). This has intriguing applications for the acknowledgement of the importance of the content in the narrative of people deemed mad. However, the application of these theories to practice may remain with the therapist, and not be translated to the end-user – the client. Furthermore, how might it be conveyed through psychiatry's end-users – the patients? Could this change the meaning of madness for them?

1.5.3 Madness for the 'deemers of madness'

A recent paper looks at the meaning of madness today through an interview with a psychiatrist. The psychiatrist's name is not used, though he has quite clear views on the meaning of madness for him, which he calls "the abyss". Furthermore, the interviewee states that there is a not-so-clear delineation separating the sane from the insane. For him, "sanity is sustained by the network of validating, affirming connections that exist in a person's life, connections to other beings" and "if those links fail, one falls" (Atwood, 2010, p.344). His definition neither creates a generalizable idea of the meaning of madness for all, nor does it necessarily represent the views of all psychiatrists. However, this seems especially interesting as a new means by which to examine the meaning is of madness today in a novel way. Furthermore, in terms of its application for further analysis it lends to the possibility that the interview itself might be qualitatively interpreted to draw out themes of the experience of the psychiatrist (phenomenological). It may also be used to understand the processes emerging from the language (or discourse) used, and the positioning of the interviewer, the interviewee and the target audience.

A possible new direction in the journey towards understanding what the meaning of madness is today might first be achieved by first exploring what it means for whom – the subjective meaning(s) of madness for those on both sides of the mental health front.. Subsequently, it might be possible to explore the meaning of madness in a more general way. To achieve this, one might be able to begin with the grounded theory approach, using interviews for example, and then later testing this at various presentations and focus groups. If starting at the point of the question 'what is the meaning of madness, for whom', this would begin with 'the client' and 'the people who work with the client'. The latter would be a vast array of individuals ranging from G.P.s, student professionals to therapists (both public

and private). Importantly, the 'meaning of madness for the system of the client' might be the overall aim. This would therefore include family and friends.

Earlier, it was noted that these individuals were historically the ones who decided if a person was 'mad'; today, once a person is deemed mad in the modern sense, such individuals are the ones whose consent is required, for the patient's detention under a section of the Mental Health Act.

1.5.4 Meaning of madness from the (ex)mad

An article from *Madness Strikes Back* (Rose, 2008) brings the meaning of madness today into the context of this review, and has applications for both research and service provision. Particularly pertinent is the clarification in the article where Rose elucidates 'who are we talking about?' Rose points to the gaze of the World Health Organization (2005) and the economic impact of on mental health services of the increasing incidence of depression (WHO, 2005, in Rose, 2008). However, Rose then states that these individuals will perhaps have voluntarily seen their routine family doctor and never see a psychiatrist. This is in stark contrast to someone who is "subject to compulsory psychiatric treatment, or given a stigmatizing diagnosis such as paranoid schizophrenia" (Rose, 2008, p.639). Furthermore, when thinking about what – or how the medical-model world – constitutes severe symptomology, Rose suggests that voice-hearing might be meaningful to those who experience it. The aim for the article is to promote service-user involvement in research to redress the power imbalance between psychiatry and service users. In allowing their views to be heard by means of systematically collecting 'user testimonies' it is hoped that the emergence of a new type of researcher is introduced as 'user researcher' that is, 'someone who is both a researcher and has experience of psychiatric services'. In the Rose article, 'patient-centred systematic reviews' are named as a new type of movement, which was created to match traditional medical systematic reviews that measure the effects of treatments.

At first sight this may entice the reader to believing that this is the new direction for research that captures the meaning of madness from the experiences of those historically deemed mad. However, it is worth noting ethical considerations, as well as applicability. If the aim is to create a nomothetic knowledge, then the researcher's inevitable bias will need to be elucidated as underlying assumptions and personal acknowledgements at the outset, before interpreting the data. This seems to be a pertinent factor of note in the Rose (2008) article. Indeed, Rose, reveals herself as a service user, without clarifying her own assumptions and

'bracketing' them before conducting the study. This may however have been done, though it is not made explicit in the article. For this emerging and potentially rich area of research to fulfil its aim, this aspect needs to be addressed in order for this type of research to be accepted alongside the predominant medical literature.

The danger of maintaining the current imbalance might lead us to believe that society has not moved on from Foucault's suppression of the voice of unreason (replaced by psychiatry as the voice of reason?). The supposed silencing of the views of those who have experienced 'madness' in its varied forms has been noted by Barrett (1996), in an anthropological study of a schizophrenia facility, patients' narratives are only included as part of the diagnostic construction (Barrett, 1996). Indeed it may be that 'testimonies' might be extended to service providers, as well as services users. We must consider that both sides of the power divide are potential providers of data into 'personal experience'.

Overall, the literature appears to associate madness with a lifelong label which, if associated with negative beliefs about the label's consequences, predicts a negative outlook. However, for some groups, madness is now a term that is re-positioned as positive and even celebrated. The most renowned example of this movement is perhaps Mad Pride (Curtis, 2000). Through associations such as MindFreedom, Mad Pride is now an international movement that describes itself as providing "an opportunity to empower psychiatric survivors and raise public consciousness about human rights through various activities such as art, theatre, music, poetry, protests, vigils, and more" (see www.mindfreedom.org). The use of language previously connoted as being negative is also used in groups such as Friends of East End Loonies (F.E.E.L.) in London, formed by service users, carers, and professionals.

Therefore, Mad Pride celebrates the term madness, reclaiming it as a sense of uniqueness and difference, in a similar way to minorities such as the L.G.B.T. (Lesbian Gay Bisexual Transgender) and black community have reclaimed previously derogatory terms (e.g., the term 'queer' reclaimed by the L.G.B.T. community). This embodies the modern movement of identity politics, which Anspach (1979) describes as "activists attempt to create an identity for themselves and to propagate this newly created sense of self to others" (Anspach ,1979, p.675). These examples point to a less polarized us–them understanding of the word madness within certain contexts, in the present day.

However, as can be seen from the review overall, there are pockets of individuals who have their own (mis)understandings of the term madness, which do not appear to be

changing. Therefore, for there to be any lasting impact from deconstructing and reconstructing madness, we must surely build our understanding from the people who are affected most by the current (mis)understandings – that is, those who identify with having a mental health concern. The other sources of knowledge on madness, whether from media or mental health professionals, can then reconstruct a more helpful idea of the contemporary term from those who are most affected by it.

1.6 Aims of current research

The aim of the current research is to seek a deeper understanding of what constructions of madness are held by NHS service users. The study will use discourse analysis to explore the service users' constructions of madness through the use of language, and examine the function of different interpretive repertoires on their subjective world (behaviour, thoughts, and feelings). Current literature fails to allow a process of deconstruction and reconstruction from the perspectives of the service user. Therefore, the current study is particularly warranted in order to impact service provision from a client-centered level, rather than imposed from 'expert' understanding.

In exploring the research question, the objective of the study will be to enlist service users who identify with having a mental health difficulty. It is hoped that they will be able to understand the following:

- what is meant by madness, from a number of different sources;
- how the term is used in different contexts, and explore what impact (if any) this has on their subjective world; and
- where the term is used within society today from contexts the service user mentions.

1.7 Personal reflexivity

When thinking of the topic of 'madness', the reader of this review might have a different perspective from that of the author. Therefore to put the work into the context of the author, it should be explained that the inspiration for this research stemmed from an NHS placement at what was once known as the County Lunatic Asylum – current 'patients', 'clients', or 'service users' still refer to it as such. It had been suggested in service-user meetings that those who do not attend appointments, or fail to engage with the service, do so because of its association with 'madness'. the review author's personal view is that this

'association' brings about thoughts of asylums, the shameful past of psychiatric practice, and the inhuman treatment of others who are deemed to be suffering from a total break from normality.

The need to answer this issue of perceptions of madness and its treatments was brought about from the new establishment of psychological 'well-being centers' that cater for individuals who present with anxiety of depression, yet do not necessarily need a referral from the G.P. Therefore, the person may receive a short intervention and then be discharged. One might question whether words like 'depression' and 'anxiety' have themselves been circulated so much into our western language that they no longer resonate with the de-humanizing label of 'madness'. Does the term exist in these new contexts of mental health/wellbeing? This prompts the question of what it means to be mad in a world where the sufferer does not have to be first diagnosed as such in order to in order to receive support.

Two personal events also impacted on the choice of the term madness as the subject of study and provided motivation to pursue this for a doctoral length piece of enquiry. The first was a client with whom I was working for over a year. The client stated that the psychiatrist who reviewed her weekly thought she was mad. She stated that whenever he asked how she was, once she started to tell him how she was truly feeling, his nodding smile indicated to her that he was now listening to the language of a mad person. The psychiatrist no doubt felt they were showing empathy, though to the end-user, a smile and a nod was interpreted as deeming madness. The second event was when questioning whether the word madness still evoked a strong reaction in society. The author of this study was struck by a response from a colleague who exclaimed, "Are we even allowed to use that word anymore?" Combined with the response from this client, this suggested that the term has endured in its power and therefore is the 'great-time' word needed for the current study.

Chapter 2 - Methodology

2.1 Overview

This chapter provides an outline of the route from research question to the chosen methodology. This includes the researcher's views towards ontology and epistemological positioning, feeding into the methodological approach adopted to explore the research question. This is followed by a detailed description of the method used. This includes sub-topics of sampling, participant recruitment and ethical considerations, data collection, transcription and the approach to analysis. The assumptions of the researcher will also be outlined as this will be pertinent to the chosen methodology and ontological assumptions.

2.2 Methodological rationale

The aim of this paper is to try and explore the research question within the context that it is being studied. As such, the study will firstly try to capture constructions of the term 'madness' through the use of language, from the perspective of mental health service users. This includes the 'how and when' for those being interviewed at the time and context of the study. In doing so, the study aims to explore the possible function(s) of the different discourses that emerge in the interviews. Through this initial piece of investigation, it is hoped the findings will have implications for the existing discourses and practices in the field of counselling psychology. As such, the anticipated outcome would be a promotion of future exploratory work, whether this be in a research or clinical format.

The reader must take note that the research is not trying to 'answer' the research question but rather to 'explore' it. The reasons for this become clear when the ontological and epistemological assumptions held by the researcher are illuminated in the next section. This has directly informed the choice of methodology. The study does not aim to measure, compare or predict quantifiable variables by trying to 'control' the research environment. Using, Silverman's (1993) distinction of terminology terms, in order to explain the method – 'a specific research technique'- one must first look at the underlying methodology – 'a general approach to studying research topics'. Generally speaking, Willig (2008) argues that 'not *all* research methods are compatible with *all* methodologies' (Willig, 2008, p8). Fortunately, in this study the researcher's 'general approach' to research flows from their general view of the world. This provides a study which is harmonious with what knowledge can be found in the study, based on the researcher's critical stance on what knowledge can be found in the word in general. This epistemological position fits with what has come to be

known as the Social Constructionism (see 'Philosophical Underpinnings' below for overview).

According to Silverman (2013) a researcher's concern for an 'in-depth' focus on people's activities (or representations of those activities) is best facilitated by using qualitative methods. In order to explore the research question, a quantitative approach would not allow this focus and would be out-of-synch with the researcher's epistemological commitments. This is what Ricoeur (1970) calls 'the hermeneutics of suspicion', aiming to discover something beyond the initial aspect of analysis, to allow a deeper interpretation to be made which can 'challenge the surface account' (Smith, 2008, p.18).

Potter (2003) asserts that methods and analytic perspectives are typically underpinned by broader philosophical principles and assumptions. Bryman (2004) supports this notion and goes further to argue that because ontological assumptions and epistemological commitments feed into the way questions are formulated and research is carried out, decisions about methodology in research are based on how the phenomenon investigated is ontologically viewed, from which the underlying epistemology which then informs the given research methodology. Therefore these assumptions will be elucidated first, in order to identify the natural choice of research method chosen – Discourse Analysis, hereafter referred to as DA.

2.2.1 Discursive Analysis (DA) and Discursive Psychology (DP): An Overview of Philosophical Underpinnings

Instead of beginning by explaining the variant of DA chosen for this project, is important to firstly explicate the background to the emergence to DA and the philosophical underpinnings that necessitated its creation. This includes views around ontology and epistemic commitments.

2.2.2 On matters of Ontology and Epistemology

According to Madill and colleagues (2000), epistemological positions commonly adopted within qualitative psychology range from the opposing standpoints of 'radical relativist' to 'naïve realist' (Madill, Jordon, & Shirley, 2000). Along this continuum, there are few researchers who would place themselves at either extreme (Breakwell, Smith, & Wright, 2012). The naïve realist view of the world asserts that the world is 'knowable and is just as it appears to be' (Madill, Jordon, & Shirley, 2000, p.3). This sits well with the positivist view of the world in which the natural sciences, and to some degree, areas of psychology still closely ally themselves with.

To put this into a psychological context, we would look at existing discourses such as the scientist-practitioner role used in applied psychology and notions of evidence based practice. From this viewpoint the naïve realist would have the belief that their work is informed by research that acquires knowledge from what is already 'out there', in the same way that is found reported in the natural sciences. The evidence-based practice would also therefore be based on this tangible view on the acquisition of knowledge.

At the opposite end of this view of what we can say about the world, we find the **radical relativist**. This stance asserts that there are multiple and competing views of the world, and that these 'knowledges' are socially constructed purely from available **linguistic** and **discursive resources** (Breakwell, Smith, & Wright, 2012). Already we see language that would suggest the basis for this study. However, using the same example from the psychological perspective, the radical relativist would question the available existence of the role of a scientist-practitioner as a term socially constructed, and therefore any evidence-based practice that results from this as a construction based on dominant views from established institutions (e.g. BPS, NHS, educational bodies). Therefore the view of the researcher here is one of '**critical realist**'. This can stance can be seen as a middle ground between the two extremes on the epistemological continuum. From the critical realist perspective, one acknowledges the existence of an objective and real world, though argues that our access to this world is mediated though a lens of social, cultural and historical practices. According the Breakwell and colleagues, this also includes the linguistic and discursive practices which we are brought into from the outset of our existence (Breakwell, Smith, & Wright, 2012).

Using this perspective on the previous example from psychology, one would now suggest that the 'scientist-practitioner' role is one that can exist, though through existing discourses that are available within a socially constructed context of psychology. However, the critical realist would also view the knowledge acquired from the scientist-practitioner role, as one of many types of knowledge, all acquired through the lens of the afore mentioned social, historical and cultural practices. Therefore any 'evidence based base practice', would also be viewed as subject to the same conditional view of the world.

The researcher's view of knowledge comes from a Social Constructionist rather than objectivist or positivist ontological understanding of the nature of the world. The study is therefore held by the belief that knowledge is produced through social interaction and cannot be understood as external realities with built-in essences that act on and constrain people, but rather as emergent realities in a continuous state of construction and reconstruction in which

meaning is generated through interaction (Bryman, 2004). It is the researcher's view that knowledge thus derives from understanding individuals' subjective interpretations and meanings in the social construction of their reality (Bryman, 2004). The current study aims to unpick how people use or do not use their constructs of the term madness from within their own realities at a given point in time.

It is hoped that this piece of work will provide some initial understanding on the meaning and usage of the word madness and the functions of those meanings within the context of the individuals interviewed. Further studies may then seek to explore this topic within a wider context to enable services to address the beliefs held within the current zeitgeist.

2.2.3 Validity and quality: scientific rigor

In reading this current study, one must be familiar with the aforementioned views on what kind of knowledge the researcher believes can be looked at (epistemology), informed by their view of how the world can be seen (ontology). By trying to explore the research question from a critical realist position, the research does not hope to 'generalize the findings' in the way empiricist or hypothetico-deductivism approaches aim to achieve (Willig, 2008).

However, this does not make it less 'empirical'. Qualitative researchers are not interested in the identification of cause and effect relationships but are instead interested in the meanings attributed to events by the research participants themselves (Willig, 2008). They offer a unique contextual richness not seen in quantitative methodologies. However, one is still able to question the efficacy of such an approach in terms of its reliability and validity. Qualitative studies address these issues in the following ways (adapted from Willig, 2008). Links to the current study are outlined below:

A. *Participant validation* – allowing participants to challenge or correct the researcher's assumptions about the meanings investigated in the research *(e.g. allowing interviewers questions to be questioned and encouraging de-construction of all terminology).*

B. *Ecological validity* – often attempting to see participants in natural settings rather than artificially 'controlled' environments *(e.g. in a centre already used by most of the service users).*

C. *Reflexivity[1]* – By continuously reviewing their own assumption and role in the research, the researcher discourages impositions of meaning, thereby promoting validity *(e.g. outlining assumptions throughout the study and foregrounding them in the interview as well as in the write up).*

D. *Deliberate limited reliability* – qualitative researchers look at specific, particular phenomenon in great detail, in order to capture (one of many available) participants' frame of reference or view of the world at that moment. It therefore does not aim to test a hypothesis that can be applied to a larger population *(e.g. the current study highlights the context of the study as the only source of exploration, and analysis of what the research is able to examine via the limitations of the research).*

Some argue that the view on reliability is a matter of choice for the qualitative researcher, as when methods are applied rigorously and appropriately, the results generated should be reliable (Silverman, 1993). In addition, if the aim was to achieve some generalizability, one could attempt to use accumulative techniques (Willig, 2008). In this way, a particular observation made in one text is checked against related observations in other contexts in order that some overall view or wider conclusions may be drawn. The latter approach fits with the objective of the current study. However, this piece of work will employ the use of 'as natural as practically possible' setting and using participants who are familiar with one another and feel able to challenge the assumptions of the researcher, in order that the study has merit if seen only from within the time and context it was investigated.

The current research took account of some of the criticisms of scientific rigor in qualitative studies by working through the methodology outlined by Potter and Whetherell (1987) with particular attention to 'stage 8: validation'. The areas to keep addressing were outlined as '(a) coherence (b) participants orientation (c) new problems and (d) fruitfulness' (Potter & Whetherell, 1987, p.169). Following these guidelines also allowed a greater reliability as it means that the same approach could be repeated by another researcher interested in the same question.

Already the theoretical underpinnings, and philosophy of the chosen methodology, DA, can be seen to emerge. This foundation to DA is an approach to thinking about knowledge, the world around us, and how we might come to understand one another, is not limited to DA but extends to become the foundation to 'deconstructionism', post-

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[1] See reflexivity section for more information on the importance and use of reflexivity in research.

structuralism and 'critical psychology' (Burr, 2003). How the researcher arrived and the chosen methodology will therefore have been informed by the history of this approach and it's attachment to the study of psychological phenomena.

2.2.4 Social constructionism and the turn to language

Social constructionism has with roots in linguistics, sociology and the broader humanities (Burr, 2003). The foundations of social constructionism can be philosophically traced to the works of Ludwig Wittgenstein, and John Austin (e.g. Wittgenstein, 1953; Austin 1962). This came as a reaction to the other approaches of the time which focused on trying to either hypothesizing what goes on 'inside someone' (psychodynamic) or opposing view of examining observable behaviour to infer internal states (behaviourism). Wittgenstein argued that terms such as 'emotions' or 'thoughts' are not inner events which occur only within the head of the person who is said to have the emotion, or though, but are related to social activities. However, this way of thinking did not materialize fully within psychology until the 1970s, accompanying a 'crisis' in social psychology, with Gergen in the US and Harré and Secord in the UK arguing for a new vision of psychology with an emphasis on language (Burr, 2003). Social Constructionism became a means to debate 'constructions', brought into social existence through language.

According to Burr (2003) and Potter (1996) there is no single way of defining social constructionism. Therefore, instead of trying to define social constructionism - which in by essence would not be able to be singly defined – we can instead, we might loosely think of as social constructionist any approach which has at its foundation one or more of the following key assumptions[2] based on the work of Gergen (1985):

1. A critical stance towards 'taken-for-granted knowledge'. Knowledge of the world (and ourselves) should be looked at through a critical lens. This critical stance would be taken when confronted with the traditional notions such as our notion that our 'objective observations' on the world are *able* to gain answers on the world. This positioning would go further to question whether we even can be 'objective' and 'unbiased' in our observations. This way of viewing the world runs in direct contrast to notions of positivism and empiricism which continue to exist in the natural sciences, and to a certain extent, in certain fields of experimental and applied psychology. This opposing viewpoint supports the ability of the observer to gain the answers of the world, and that what exists is what we perceive to exist.

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[2] See Burr (2003) for a broader look at Gergen's (1985) assumptions and overview of Social Constructionism.

Social constructionism cautions us to be ever-suspicious of our assumptions on how the world 'appears to be'.

  2. *Historical and cultural specificity.* From this position, one would assert that what we believe to know about the world, 'the categories and concepts we use, are historically and culturally specific' (Burr, 2003, p.3). This suggests that one understands the world depends upon where and when in the world that person lives within. For instance, when looking at that commonly held psychological ideas such as having a 'self-concept', we (in the western world) more commonly associate this through our western psychological filter, using constructed concepts of 'independent' and 'autonomous selves' (Markus & Kitayama, 1991). Heine (2005) asserts that 'different cultural environments provide different contingencies for specific thoughts and behaviours and, as such, render different kinds of thoughts and behaviors as functional for fulfilling similar underlying motivations (Heine, 2005, p.536). Indeed our current notion of what constitutes 'psychology' was previously (and perhaps currently in some contexts) seen as being encompassed within the field of 'philosophy' (Weiner, 2012).

  3. *Knowledge is sustained by social processes.* Social constructionists propose that our understanding of the world comes from ideas that constructed between people. According to Burr (2003), through our daily interactions between people, and by use of the tool of language, that our versions of reality are invented. The use of language in the creation of these 'ideas' or 'constructions' are particularly important for the social constructionist. Our notion of what we currently believe to be true is thought to be created and bound by social processes and interaction in which people are constantly engaged with one-another. This suggests that our version of knowledge can also change through the same process.

  4. *Knowledge and social action go together.* As mentioned in the last section, our understanding of the world can become 'understandings' of the world, through social action. According to Hayes (1997) this negotiated process creating and re-creating ideas of the world through social interaction and use of language, mean we are able to have 'knowledges rather than knowledge' of the world (Hayes, 1997, p.7). Furthermore, Burr (2003) asserts that different constructions also bring with them, or 'invite', a different kind of action from human beings. A possible example may be how people view someone who is homeless. If seen to be 'dangerous', 'unpredictable' and a 'social drain', the responding social action may be *to avoid*. However, if they are to be seen as 'victim of circumstance' and with a history of 'mental health', they may be position under the mental health umbrella, and thought of as 'in need', inviting 'mental health professionals' *to approach* them to address 'their need'.

2.2.5 The 'Turn to Language' and emergence of Discourse Analysis

Although there may be other ideas on what constitutes social constructionism, the principles above provide the main areas of agreement between social researchers. From the areas already covered, one may sense a theme of 'reaction against' something that existed before the emergence of social constructionism. In brief, the movement began in the 1950s, from philosophers, communications theorists, and sociologists as a reaction against established individualist, essentialist notions of the world. These established views asserted that language could be used provide 'a set of unambiguous signs with which to label internal states and with which to describe external reality' (Willig, 2008, p.92).

Language, which was previously positioned as the passive vehicle for our thoughts and emotions, was to become viewed as an active process (Burr, 2003), seen to 'construct' versions of social reality and achieve social objectives (Willig, 2008). The key works of this time can be found with Wittgenstein (e.g.1953), Austin (e.g.1962) and Foucault ((Foucault, 1965). However, it was not until the 1970s that social psychologists began to take a stand (e.g. Gergen, 1973, 1989) again of the prominent school of choice at the time – cognitivism. The 'turn to language' became more established in the 1980s, with seminal works such as Potter and Whetherell's (1987) *Discourse and Social Psychology; Beyond Attitudes and Behaviour*, providing not only a critique of cognitivism but also a means to challenge the existing methodology of producing social research. Their means to produce a viable alternative centred on social constructionist underpinnings, providing a detailed analysis of interview transcripts using a **Discourse Analysis (DA)** approach.

The philosophies, research interests, and assumptions as to how DA should be defined also vary and different analytic interests, schools of thought, and understandings of 'discourse' can easily be identified both within and across disciplines (e.g. Parker 2005, Burr, 2003, Wodak & Meyer, 2006). However, broadly speaking, DA researchers find that the study of language is important. Furthermore, DA suggests that when people state a belief, opinion or express a position, they are taking part in a dynamic process, a conversation in which has a purpose and in which each person within that interactional communication has a *stake* (Willig, 2001). In taking into account the social context, the DA researcher will be mindful the participant has a number of possible discourses available to them, though will *orient towards* a particular way of responding in order to perform certain social actions or functions (Breakwell, Smith, & Wright, 2012).

The discourse researcher is interested in identifying recurrent patterns in language use. In exploring the dynamics and dilemmas of people's active sense making, the detail of people's practices of categorisation, accounting and explaining all lie at the heart of this analytic task (Potter and Whetherell, 1987). As a result, and in keeping with its social constructionist epistemology, the focus of DA is on how versions of our social realities are achieved within/through language (Willig, 2001).

2.2.6 Discursive Psychology (DP) and Foucauldian Discourse Analysis (FDA)

Since Potter and Whetherell's (1987) initial publication, the applied field of Discourse Analysis (DA) has continued to develop. Whetherell (2001) identifies up to six variants of how discourse analysis may be done, however, this paper will focus on the two major branches currently reported: **Discursive Psychology** (e.g. Potter, 2003) and **Foucauldian Discourse Analysis** (e.g. Parker, 1992: Willig, 2001). Broadly speaking, each can be described for their respective focus on micro and macro features of discourse (Burr, 2003).

2.2.7 Discursive Psychology (DP)

DP is rooted within ethnomedology[3] sociology and conversation analysis[4] (see Wiggins and Potter, 2008 for full history of DP). Indeed this tradition of being influenced by the principles of conversation analysis continues within DP (Willig, 2001), more recently placing particular emphasis on examining naturally occurring text and talk (Hepburn and Wiggins, 2005; Potter and Hepburn, 2005). This approach focuses on the micro, or fine-grained aspects of discourse in order to explore psychological phenomena. Therefore, the *psychology* of DP lies within its interest in psychological phenomena, with investigations in to memory, attribution and identity. Within this approach, these concepts are rejected as cognitive processes and instead viewed as *discursive* actions (Willig, 2001). The *action orientation* of discourse refers to the notion that people *do things with words* (Austin 1962), they account for, explain, blame, make excuses, construct facts, use cultural categories, and present themselves to others in specific ways taking the interpretive context into account. The discourse researcher is interested in identifying recurrent patterns in language use DP aims to get a better understanding of the micro-mechanisms of the production and re-production of practices.

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[3] Ethnomethodology was founded by Harold Garfinkel (1967).
[4] Conversation Analysis (CA) commonly cited as being developed by Harvey Sacks (e.g. 1989, 1992).

2.2.8 Foucauldian Discourse Analysis (FDA)

FDA is arguably[5] based upon the work of social theorist and philosopher, Michel Foucault. Instead of looking at discourse within the micro, fine grain filter, FDA rather than viewing language as an individual action and creation, FDA widens the focus to consider the larger macro structures that influence available discourses (Willig, 2008). The common areas of interest include historical, institutional and cultural influences on knowledge, and the relationship between knowledge, social action and power relations (Hook, 2001; Burr, 2003).

As Willig (2008) clarifies, 'while discursive psychology is primarily concerned with *how* people *use* discursive resources in order to achieve interpersonal objectives in social interaction, Foucauldian discourse analysis focuses upon *what kind of* **objects** and **subjects** are constructed through discourses and *what kinds of* ways-of-being these objects and subjects make available to people' (Willig, 2008, p.96).

2.2.9 The best of both worlds?

According to Willig (2008), although there is a growing attempt to 'differentiate' between the two main types of DA (as above), most researchers emphasize the overlap and 'cross fertilization' between the two versions. Certainly the view from Parker (1997) and Potter (1997) that the two versions come from different theoretical and disciplinary positions (CA, ethnomethodology, sociology vs. post-structuralism, philosophy) are valid. However, Wetherell (1998) presented a paper that suggested 'a synthesis' of the two versions, encompassing a 'twin focus', would 'allow for the reader to pay attention to both the situated and shifting discursive constructions as well as the wider social and institutional frameworks within which they are produced' (Willig, 2008, p110). Therefore an integration of the two discursive methods may not only be possible but also beneficial.

2.2.10 Criticism of Discourse Analysis and Discursive Psychology

One of the main criticisms of both Discourse Analysis and Discursive Psychology research is that there are limitations incurred as a consequence to using interviews as a data collection method. Instead, there is a move to trying to observe naturally occurring conversations (e.g. Potter & Mulkay, 1985; Potter & Hepburn, 2005). The debate of the

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[5] Hook (2001) argues that a Foucauldian discursive method never truly existed, though attempt to look at how it may have looked had there not been mis-applications of his original ideas.

usefulness of such data analysis are that it creates an 'unnatural' type of interaction, and therefore should not be used as a substitution for more 'naturally occurring' talk. However, the topic being studied and the 'answers' to be found are assumed be co-constructed locally occasioned research interactions, and designed to be open-ended and conversational. In terms of applicability, a conversational, co-constructed interaction is seen by Counselling Psychologists and their clients in their everyday therapeutic environment. In addition, group settings, such as the service user group recruited for this study, are environments in which the participants are well versed in the co-constructed interactional style seen in this research study. Therefore although the data is locally occasioned (and perhaps limited to), the environment is familiar to the participants, and therefore replicable to some degree, whether in a research or clinical setting.

2.2.11 Rationale for Discursive Psychology

The methodological options available to the researcher are thus far filtered by the epistemic commitments to Social Constructionism, informed by a critical realist view of ontology. The research question could be read from both a DP or FDA perspective. However, the reason for choosing DP is in the emphasis within the context of the work. Although it is assumed that broader historical, cultural and institutional factors may influence the discursive positions available, being able to examine this fully may neglect form the micro-mechanisms of *talk-in-interaction* that occurs between the participants and myself. As the research hopes to have implications for health professionals and particularly counselling psychologists, it was felt that focusing on the discourse practices between mental health service users and a (trainee) counselling psychologist (the researcher) would be more appropriate. In the next section, which will elucidate the researcher's individual reflexivity, one should be aware of assumptions of the researcher as well as the role they may be seen to serve within the interviews. Whilst thinking about the exploration of meaning(s) of the term madness and its contextual usage, the researcher will be able to use the DP approach to focus on the management of *stake* and *interest*, whilst acknowledging their role within the talk. In-keeping with the aim of DP, the researcher will be interested in how people display sensitivities about, and manage the potential interactional consequences of, inferences that other people (including the researcher as a trainee counselling psychologist) might draw about themselves in virtue of what they have said (McKinley & McVittie, 2011).

However, given the overlap between some of the procedures for doing analysis (e.g. Potter & Wetherell, 1987; Willig, 2008) the researcher is aware that the analysis may change as the reflexive journey through the piece of work, which may evolve and change in emphasis. Indeed it has been contended that the key to the analysis of discourse be the development of an analytic mentality rather than stark adherence to a rigorous methodology (Billig, 1988). Therefore a blended approach between Potter & Wetherell (1987) and Willig (2008) will be used, being mindful of Antaki, Billig, Edwards and Potter's (2003) guidance regarding the practicalities of doing DP research.

According to Hayes (1997) one of the main aims of any discourse analysis is to reveal the act-action structure of a sequence of actions constitutive of an episode of human interaction. This *includes* the special case of reflexive interactions when the other is oneself – the researcher definitely counts himself as a fellow human and therefore agrees that reflective accounts are needed throughout the study.

2.2.12 Critical language awareness

The researcher notes the awareness of the language used with the study and how asking a question in a certain way then invokes a response from that category of language. The researcher is aware that although the responses may differ between individuals, the language used in their reply stems from the language used in the question posed by the researcher. This was an important part in choosing the word madness, as opposed to mental health, mental illness or wellbeing. An awareness of the researcher's own assumptions before interviewing and analysis was therefore fundamental to the study in being able to capture the constructions of the participants within their specific context.

2.2.13 Personal reflexivity

The study involves participants recruited from a community in which the location of secondary care was once referred to as the County Lunatic Asylum. As such I thought that language around local area may refer to locally available discourses surrounding an iconic building and it's infamous history. My choice of using the term madness for the study was brought about following a period of personal thresholds infinitely raised (to the point of questioning the existence) on what is considered to be 'madness', though without the explicit term being brought to mind. My own understanding of the term was not fully formed, perhaps something to do with some kind of break from reality. My half formed ideas had not

come from any training but from movies, derogatory terms used in social groups, playful descriptions of eccentric people and in ways to describe management or political decisions that were perceived as reckless. In searching for a definition and trying to employ a means of searching I would use for other words – Google. From dictionary.com I was presented with the following:

1. the state of being mad; insanity.

2. senseless folly: It is sheer madness to speak as you do.

3. frenzy; rage.

4. intense excitement or enthusiasm.

Working with patients with psychosis and who psychiatrics would describe as 'floridly psychotic' initially seemed to fit my half formed idea of the term, matching the dictionary term of 'insanity', which although I would previously thought to be an out-dated term, it appears as no.1 at this time of writing[6]. However, I then found that the meaning behind the client's narrative within the majority of cases and the function of the 'delusion' became apparent. The perception of having to attend an appointment based at 'an asylum' then became part of my contextual understanding of such narratives. I then became aware of situation which were previously routine in my clinical setting; being contacted by a staff member from a 'mental health service', was sometimes met with resistance by people, who would 'become' service users by the mere act of a phone call, sometimes resulting in a breakdown in service provision. The need to explore assumptions, expectations and functions of mental health discourses was therefore motivated by such examples. As explained the in the introduction, the choice of the word madness being used was due to the fact it seems to have stuck around, though ideas around it from the service users perspective have not stuck to anything I was able to find in the empirical sense. Certainly, throughout the duration of the study, the term seemed to appear on television, newspapers and other media, for a variety of reasons/functions.

Other assumptions/reflections from the researcher:

- *People hold an idea of what madness means for them, even if thought not to exist.*

- *The term madness is familiar though the origins perhaps not knowingly sourced.*

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[6] Madness. (n.d.). Dictionary.com Unabridged. Retrieved August 02, 2013, from *Dictionary.com* website: http://dictionary.reference.com/browse/madness

- *Although in his late 20s the researcher is sometimes described by others as notably young looking.*

- *The researcher coming from a western, British, psychology background, though with a critical viewpoint of each of these institutions*

- *The researcher assumes no psychologically mindedness necessary for the study.*

- *Participants will have the capacity to understand the purpose of the study and share their experiences.*

- *Patients may limit the totality of their experiences if it is seem to reflect an image of them that may have repercussion for their career or mental health status.*

- *The researcher has an idea of what the answer to the study question is from his own experiences (in personal reflexivity section) which does not need to be 'bracketed' before interviewing but aware of beforehand and especially when beginning analysis of the data.*

2.3 Methods

2.3.1 Research Questions

The aim of the paper is to explore the construction of madness, and the function of those constructions from the perspective of mental health service users. In order that the interviewer does not restrict the diversity of participants accounting practices, a themes interview schedule was constructed, based on the research question. This enabled a systematic range of topics to be explored within an open-ended framework. A pilot interview was conducted with a colleague who identifies with having a past experience of mental health problems. The pilot enabled any issues not foreseen in the proposal to be addressed before the actual study and ensured the research questions are suitable for exploration within the context of the participants. Based on the initial themes for discussion on pilot interview the following ideas were proposed for the actual study:

1. How is the word madness defined today?
2. In what way is the word used?
3. In what context does it have meaning?
4. What are the implications of these meanings?
5. What effects may they have?

The final version of the interview themes can be found in the Interview Schedule in Appendix D.

2.3.2 Ethics

The participants will be given an information sheet beforehand[7] (read to them to confirm), detailing the research and providing sufficient information to inform their decision to participate or decline. At this point they will be informed about how their data will be used, how it will be stored and destroyed (on successful completion of the thesis). From the outset, it will be made clear that the participants have the right to withdraw from the study and their data removed, should they wish to. Contact details of local support service will be made available should any participant require it.

Following the interview process the participants will be de-briefed on the study in order that they can have any queries answered and given the opportunity to withdraw their consent for their data to be used if they wish. They will also be given a de-brief letter[8] to keep, with the contact details of the researcher's department. An opportunity for the findings of the research to be forwarded to participants will also be made available.

However minimal, there is also a risk of the term madness bringing up negative associations for the participant and causing some distress. Although unlikely given the focus is on language rather than experience, I planned to address this by informing the individual's care coordinator and follow the local department's procedures on need for review or referral to specific services**.**

Ethical approval was gained from the City University Ethics Committee[9]. Ethical approval was also obtained from National Research Ethics Service (NRES) -Camden and Islington NHS Trust Ethical Board: REC reference number 12/LO/1390), due to the use of NHS participants.

2.3.3 Sampling and Participants

As mentioned in the introduction, the current research into the exploration of the understandings of the term madness is limited to the view from 'the expert'. Accounts from service users are limited to case descriptions. Therefore service users of mental health services were targeted for recruitment. The researcher would not be so patronising as to suggest he is giving 'a voice' to the service users by inviting them to be participants, but rather opening up the platform for the voices to be heard. It is the researcher's view that the

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[7] See Appendix B
[8] See Appendix F
[9] See appendix E

process of the study itself will have an empowering effect in opening up currently closed or limited discourses.

An opportunistic sampling method was used in order to select those who were able to fit the minimum criteria at the time of recruitment. The current study recruited participants who matched the following inclusion criteria: 1) Aged over 18 years at the time of recruitment; 2) Identified themselves as a service user of mental health services.   The two exclusion criteria were: (A) participants who feel they may not be sit for up to 60 minutes to discuss mental health terminology without undue distress; and (B) anyone who feels they do not have a good enough level of English language proficiency to engage in an interview/focus group for up to 60 minutes.

2.3.4 Recruitment.
Facilitators of local service-user involvement forums were contacted with a general letter outlining the purpose of the study, along with a flyer (Appendix A), and information sheet (Appendix B), proposed interview questions (Appendix D) and the university letter of support (Appendix E). The researcher attended a local meeting with Loud and Clear, to provide more information and to explain the details of participation and consent. Formal consent (Appendix C) was taken prior to the actual participation of the study.
The researcher joined a West London based Service User Involvement forum in order to advertise the study. It was thought that as these potential recruits were used to talking with each other on various topics surrounding the local mental health services and terminology used in the local NHS literature (e.g. Old Age Psychiatry Service versus Older Adults Service).   The service users volunteer to attend such meetings for 2-3 hours and therefore some degree of caution was reduced when contemplating risk associated with discussing potentially emotive topics.

The total number of participants was 3 for individual interviews and then approximately 4 individuals for a group discussion/interview. Although not noted as an area of exploration for the study, the following demographics were obtained[10]:

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[10] N.B. The age ranges have purposefully spanned 20 years in order to further protect identifiable features of the participants.

Table B1

Participant Demographics

Individual interview
x1 Caucasian British Male, aged 60-80
x1 Caucasian British Male, aged 20-40
x1 Causation Northern Irish Female, aged 50-70

Group Discussion
x1 Caucasian British Female, aged, 30-50
x1 Caucasian British Female, aged, 50-70
x1 Caucasian British Male, aged 50-70
x1 Asian British Male, aged 50-70.

2.3.5 Procedure.

After gaining formal written consent, the individual interviews were conducted before the group due to availability of participants. The interviews were held in a meeting room which the participants sometimes use for forum discussions. The interviews were semi-structures and recorded on a digital recording device. The interview schedule (Appendix D) was used as a guide to the topics to be discussed. The interviews lasted between 50 minutes to just over an hour. The participants were made aware that the session would last from around 20 – 60 minutes, as per the flyer (Appendix A). In the group session, one of participants voiced their feeling of fatigue and the group mutually agreed we had reached a conclusion. All participants were then given a de-brief sheet (Appendix F), followed by a verbal explanation of the study purpose and possible outcome, and were encouraged ask any further questions.

2.3.6 Data handling, coding and analysis.

Data handling. Maintaining confidentiality throughout the study was considered at every part of the research process. Documents relating to the participants were kept in a secure place, accessible only to the researcher. The recordings were moved from the digital recorder to a password-protected folder on the researcher's personal computer alongside a second back-up copy. There was no need to keep identifiable information on participants

outside of the consent form, therefore all other documents (e.g. transcript) used a short code (e.g. R1, or GR1) to indicate order of interview, rather than to identify participants.

Transcription /coding. The recordings were then transcribed using Jefferson Lite (Parker 2005). A full account of the transcription convention used can be found in Appendix G. A sample of the transcript itself can be found in Appendix H. This convention facilitated readability whilst also allowing me to capture more fine-grained features of the talk-in-interaction, such as overlap, emphasis, pauses, and contextual information. All identifying details were altered or omitted to ensure anonymity and confidentiality.

The transcription process required a substantial period of time to reach completion. For a usual 'script' Potter and Wetherell (1987) suggest a ratio of 1:10, which corresponds to a one-hour session requiring 10 hours to undertake. They add that the ratio increases to 1:20 for full Jefferson style conventions. As the researcher was new to this formatting, although using the Jefferson Lite style (Parker, 2005), the time requires an approximate ration of 1:15. The analytic procedure follows the recommendations of Willig (2008, p.98-106) as they take account of how to undertake a discourse analysis, remaining true to the traditions of discursive psychology, rather than following a rigid recipe. There is overlap with some of the 10 stage recommendations from Potter and Whetherell (1987, p,160-176), and thus an immersion in both texts facilitated the current analytic procedure for the current study:

Working through the transcript. This loosely follows stage 5 of Potter and Wetherell's (1987) 10-stage procedure. As such the researcher was aware of the role to make clear decisions about what was actually being said from the interviews and to attempt to capture the environment through the inclusion of non-verbal clues. This stage involved a re-immersion in the interview itself from the viewpoint of the researcher and thus forms the initial stage of the analytic procedure.

Intermission. A brief period of sitting and reflecting on the data was taken as encouraged by stage 6 of Potter and Whetherell. This would facilitate the coding stage to follow.

Coding. Before coding, a full read-though of the transcripts was taken as Willig (2008) suggests. As recommended by Potter and Wetherell, the first 'sift' of coding was as inclusive as possible, including any reference to the term madness, similar terms or implicit constructions of either. The researcher highlighted every reference within the transcripts. Re-reading through these passages, the researcher then used a notebook to log the included points so that the analysis could take account of each reference point in the next stage.

Analysis of coded data. As Potter and Wetherell (1987) state 'there is no mechanical procedure for producing findings from an archive of transcript' (p.168). As such, the notebook logs were expanded to include the added suggestion from Potter and Wetherell (1987) to question 'why am I reading a passage in this way? What features produce this reading?' (p.168). This helped to produce patterns in the data in terms of variability[11], consistency[12] and identification of interpretative repertoires[13]. The use of different repertoires was then outlined within the the context in which the speaker was deploying the action. This includes the interviewer as well as the participants.

A list of interpretive themes were then created, looking back through Potter and Wetherell's (1987) recommendations in regard to validation, especially in taking stock of the particpants orientations, the use of language to perform social actions and problems arising in the discourse.

Ending the analysis. Potter and Wetherell (1987) call the final stage of validation 'fruitfulness'. It was this criteria that helped to indicate the end point to the analytic procedure. In practical terms, the researcher was able to identify a point at which no new problems or interpretative themes were generated. In re-engaging in the validation process, this also indicated whether certain themes were evidenced enough within the transcript to be included on their own, to integrate into another repertoire or to be left out of the analysis.

2.3.7 Limitations to generalizability.

As summarised in earlier sections regarding qualitative research in general, the current study does not aim to be able to generalise from the recruited participants. The main assumption within this method is that individuals use their language to 'construct' versions of their social world. For Potter and Wetherell, 'the principle tenant of discourse analysis is that function involves construction of versions, and is dominated by language variation' (Potter and Wetherell, 1987, p.33). Using this method, the researcher acknowledges that the data collected cannot reflect an unbiased account of opinions/beliefs of service users in terms of it being an 'accurate' reflection of similar individuals within society in general or even accurate of the participants at the time of interview. Instead, and in-keeping with social constructionism epistemology, the study aims to be able to provide a way of exploring the constructed discourses rather than simply reflecting true realities. However, it is hoped that

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[11] Variablity: 'differences in the content of form of accounts' (Potter & Wetherell, 1987, p.168)
[12] Consistency: 'the identification of features by shared accounts' (Potter & Wetherell, 1987, p.168)
[13] Interpretative repertoires are 'recurrently used systems of terms used for characterizing and evaluating actions, events and other phenomena' (Potter and Wetherell, 1987, p.149)

the 'active participant' role of the interviewer will allow diversity in the discourse in order that participants' variations within the context are allowed to emerge as they try to make sense of the 'phenomena' of study – what do we mean by madness; how and where is it used today?

Chapter 3 - Analysis

3.1 Setting the scene

The use of the transcript in this analysis is to facilitate the reader in seeing the discursive themes and constructions and how they emerge in the text. The researcher has included extracts that show both common interpretive repertoires and discursive positions, as well as ones that are somehow the exception. The researcher's speech has been included and not shortened in any way. This allows for the researcher's influence to be considered as part of the analysis.

The style of this analysis section reflects some deliberate choices from the researcher, intended to aid the reader in digesting the overall breadth of the analysis whilst attempting keeping the context of the interview intact, enabling a deeper, yet still readable look into the underlying discourses between all parties. The first of these choices is to refer to the researcher in the first person. This is to allow my own part in the dynamic interplay of the discourse to be acknowledged and analysed. I also refer to the participants as 'respondents' and acknowledge whether they were male or female. This decision was not made to suggest there is any significance to their sex or gender, but to preserve the humanness of the interaction whilst allowing the reader to have a male or female voice in mind, all the while preserving the respondent's anonymity.

3.1.2: Summary Findings

The analysis overall indicates that the term 'madness' can be placed within a continuum of similar terminology such as insane or crazy but the use of the term has varied functions: 1) Flippant non-offensive or labelling term; 2) Labelling and harmful, with or without intention to do so; 3) An accurate description of 'an experience' and; 4) Something labelling but positive, indicating creativity and uniqueness.

The analysis will undoubtedly be filtered by context as seen by the researcher, before going into the overall themes that could be seen. Therefore some time will be taken to explain the context, as seen by the researcher. Furthermore, as with any Doctoral Thesis, the list of themes do not represent the entirety of what could potentially be analysed. However, opportunities for further exploration will be suggested in the discussion section.

Transcription Key: I=Interviewer; R1=Respondent 1; GR1=Group Respondent 1

Text in *italics* = emphasize particular words within a quote.

.. = continued speech/Extract taken part-way through a speech extract.

3.2 Orientating to the subject positions

As stated within the methodology section, the use of Discourse Analysis does not provide a record from the participants that are generalizable to the wider population. The data and interpretations thereafter are situated - and limited to - the context of the interviews themselves. Furthermore, I would like to acknowledge that this is not the only possible reading of the data collected. There may be other ways in which these discourses could be interpreted. As a result, in order to allow the reader to understand why the data is being read in this particular way, I will go beyond the methodology level of context description and attempt to explicate the context perceived within the discourse itself. This includes the different subject positions taken on by the respondents (e.g. expert, learner, (ex) mental health patient, member of public, voice of reason versus voice of unreason), as well as the positions taken on by myself (eg. Expert, knowledge facilitator, the neutral researcher, the mental health professional in-training and even a comrade-in-arms). I will also attempt to give extracts of the discursive manoeuvres which may lead different speakers to be positioned in these different roles, rather than freely choosing them. The hope is that this will make the micro-dynamics within the discourse easier to refer to, whilst keeping the theme of the overall discourses explored, in reference to the research question. Again this is to highlight the lens through which this data has been read by this researcher, at the time of the analysis.

In order to find a place to begin, the supposed roles identified were 'interviewer' and 'interviewee'. The assumption here is that the interviewee would know something about the topic being proposed and be able to draw from their internal resources to give a response. Initially, this appears to be the case and there were different positions the interviewee took in relaying this information. However, at times, I was met with a denial of any knowledge on the topic.

To understand the use of different subject positions, I have used titles that describe the function of the positions taken. This also indicates the stake the individual holds in the context of the interview. The two main positions that appeared to be taken by the respondents were that of the knowledge denier, the other or the expert. The knowledge denier role enabled respondents to relinquish identity, responsibility, opinion or attribution to all things mentally ill. The expert position could be seen to serve a number of functions, which are outlined in detail below (3.2.2). This expert position was enabled through talk as a veteran or survivor of mental health services. On initial reading, I believed these roles presented only from the respondents. However, I could see that I also took on both roles:

The knowledge denier in order to maintain a neutral researcher position; the expert role was one I then became positioned as by the respondents, perhaps due to my attempt at maintaining neutrality.

The analysis begins by highlighting these various subject positions in their most obvious form, so that their function in later contexts can be better understood. The uses of the titles in the extracts facilitate the reader in identifying the discursive patterns at play. These may be in the form of interpretive repertoires, highlighting discursive manoeuvres, discursive themes or conflicts of construction.

3.2.1: I know nothing – The knowledge denier.

In order for the process of what is being done with the use of discourse, the analysis begins by demonstrating the subject positions taken by all the speakers. The first is the aforementioned role of the knowledge denier.

Extract 1 <lines 1200-1208>

R2   <u>Mad</u>ness is a very-old term isn't it?=

I: =Okay.

R2   It goes back a long:: long:: time, I THINK!

I: Yeah.

R2   I've seen films where=>old old old< films .h set-back centuries ago:, where they
           used the term madness, .h you know sort of a (.) <u>prob</u>ably   the term insanity is
           NEWER than what the term <u>MAD</u>ness is.

I: Okay.=

R2   =>I think< I THINK so, but I don't know that.

Respondent 2 showed the strongest manoeuvring into the role of what I have come to call the 'knowledge denier'. Extract 1 shows this position emerge in a subtle, yet rapid manner. Following my lack of explicit agreement, instead offering an acknowledgement in the second line, he disclaims his presumption that the origins madness has roots in the distant past. 'I THINK' serves as a disclaimer to this aspect of knowledge, despite painting a picture of where this assumption comes from. Therefore he occupies both a position of knowledge holder and knowledge denier. His use of volume and lack of pause between our exchanges allows him to emphasize the latter position, over the former.

Extract 2 <line 1286>

R2   Mad hatter, (that's a) it's a bit silly ((smiling)) wasn't it?

In Extract 2 the clarification used by the participant was felt to represent a 'checking-in' with me as a fellow member of the public. My own positioning, attempting to be neutral meant that I tried to deflect knowledge, even if it was something I may know as a member of the public , in order to refrain from leading and being the expert, so in a sense I refuted public knowledge in the same way the participant refuted expert knowledge with him being a client. I did not want to give knowledge but instead encourage available discourses from the participant.

In my attempt to assume the position of the neutral interviewer, it is possible that I in fact also produced a discourse that limited my openness about my own access to knowledge. Extract 3 indicates that the respondent may deny my ability to be neutral, and instead positions me as the expert, within the mental health field:

Extract 3 <lines 1368-1385>	
R2	I says, (.) well I don't- I <u>don</u>'t <u>know</u> how it fee::ls to be mentally ill, <u>REA::LLY</u>=
I:	=Yeah.
R2	..I I DON'T,(0.1) consider myself to be <u>MEN</u>tal.
I:	Yeah.
R2	But <u>whether</u> YOU: do or not, >I don't know<.
I:	<u>Oh-o</u>kay.
R2	Because IT IS officially a mental ILLness.
I:	So depression is a mental illness?
R2	<u>Is</u> it or <u>isn't</u> it, I'm <u>ask</u>ing you now.
I:	So: (0.2) it's a <u>descripti</u>on perhaps of a mental illness (.) to <u>label</u> perhaps?
R2	Yes, but IS IT A- <u>It is</u> a mental <u>ill</u>ness isn't it? Mental illness, depression.
I:	Depression?
R2	Yes=
I:	=It's a <u>diagnostic</u> label
R2	Yes, yes yes ((whisper into a mutter))

There are instances within the context of the interview that show the positioning and re-positioning of the respondent based on their discursive manoeuvres. In the first instance, the respondent positions themselves *away* from knowledge of how it could actually feel to '*be* mentally ill', and yet identifies themselves within a mental health label of depression.

The tension in Extract 3 is not seen in other interviews, nor in the group discussion. The intensity is magnified by the choice of phrases which evoke strong connotations. Distancing himself from the word '*mental*'*,* whilst querying my own, mental health expert judgement upon him led to his confrontation with my neutral positioning, forcing me to take a pseudo-expert position and vocalise it. My response also appeared to deflect my own opinion and instead appeared to succeed in deferring to an established psychiatric/medical discourse to which the respondent appeared to be drawing his suggestions from. However, the discursive manoeuvre of either asking for my opinion directly or assuming that certain, otherwise 'neutral' statements, or absence of response, appeared to be *received* by the respondent as 'the voice of a mental health professional'.

When referring to the themes of the overall discursive themes in this analysis, it should be in the reader's view that my analysis in reference to this respondent was with this discursive dynamic in mind.

Although the rest of the interview with respondent 2 was able to explore a range of areas, the use of discursive manoeuvres to position himself as the 'knowledge denier' and myself as the 'expert' persisted. As seen in Extract 3, this carefulness to remove himself from being seen as even guessing what mental health professionals might discuss shows he may be drawing upon specific interpretive repertoires, due to how he positioned me. From this understanding it may be the case that he may offer a different view (or repertoire) with someone else:

Extract 4 <lines 1796-1808>
I: SO: (.) em::- For <u>some</u> reason in-in TV and fil:m, (.) when we look   <u>back</u>, it seems to have been- in THAT <u>context</u>- that it was <u>used</u> >to describe< s-s:evere mental illness- like <u>you</u> sa:y. (0.1) Em:, do you   think that it WAS used, (.) in
the   em TRUE WAY? Em:: (.) at that   <u>ti:me</u>, as well? (0.1) SO do you think-
R2   OH yes::. They have used it in the <u>true</u> way as well.
I: Okay.
R2   But I <u>don't</u> know if they still DO.
I: Yeah.
R2   I DON'T know the workings of the mental health service.
I: Yeah.
R2   <u>Mental</u> health professionals or what terms they use. I have >NO idea<.

3.2.2: Experts in the field.

Contrary to this not-knowing discursive position, other respondents would explain that they **did** have an idea, to varying degrees. The following Extract shows the contrast to the previous Extracts, in that the respondent states his opinion as 'fact-like'. His arguments are succinct and offer number of seemingly informed statements as opposed to a suggestive style offered by others. The style of discourse offered by this respondent (GR3) matched other respondents in terms of taking the position of a veteran and or comrade (in the group discussion), though with little or no room to be challenged:

Extract 5 <lines 3216-3241>

GR3:   It is essentially a negative term.=

GR4:   =YES!

I   <u>O</u>kay.

GR3:   ..And EVEN >for people who< would be DEEMED to be ma::d (.) to <u>use</u> the word
        <u>about</u> themselves is kind of negative.

G: >YEah<.

GR3:   ..I mean if you <u>wanted</u> to be more positive or more light-<u>hearted</u> >you'd say
        "You're bonkers"< or:, er:, <u>poss</u>ibly CRAZ:zy,

I: <u>Oka:y.</u>

GR3:   ..but because >madness is< (.) sort-of <u>linked</u> very closely with   <u>craziness and</u>

SO   are >the abnormalities we talked about<, of-of   be<u>haviour</u>,(0.1) er- they
        wouldn't– they're <u>not</u> necessarily uh-er   logical (.) and-and, um, THOUGHT
        OUT,

I: Yeah.

GR3:   ..-thought out actions and things you <u>sa::y</u> when-when you <u>ARE</u>-ma:d or   (.)
        >whatever you want to call it<, erm (.), and therefore <u>that</u>   would, that would

thro:w other people who em:: (.) >DON'T suffer in the same wa:y< because they wouldn't

be   able to under<u>STAND</u> you (.) an:d they wouldn't be able to follow what you– what-
        what you're <u>on</u>   about, and you might go off in (.) <u>won</u>derful flights of fancy
        about   >one thing or another< and-and (.) ACTUALLY be perfectly <u>SA::NE</u> but,
        um,   (.) >because other people wouldn't be able to< (.) <u>follow</u> your train of

thought,

I: <u>Ye</u>:ah.

GR3:   ..em:: you'd (.) be <u>deemed</u> to be 'bonkers', 'ma:d', 'crazy'-whatever.

Extract 5 above, summarises some of the general assumptions initially held by other respondents, that the term madness is negative, no matter who uses it. The role of my own speech here seems to be to serve as a source of facilitation and encouragement. However, the action orientation of GR3's speech appeared strong, taking an expert position against those who '*deem*' people as '*mad*'. This enabled statements that would inform the listener of how a person would be judged/misjudged by the deemers of madness. This matched some of the discourses conveyed in varying degrees by other respondents, though the style of GR3's discourse, orientating himself as the expert against the deemers of madness, at times served as a barrier to certain constructions being de-constructed and re-constructed by the group. However, as can be seen in the later sections of the analysis, the attempts to rebel, and de-construct established discourses are still attempted by the other members of the group. Some of these attempts re-position the term madness out of its previously negative-only space.

3.2.3 Individual versus Group Discourses.

The discursive resources differed between each respondent, whether interviewed individually or as part of the of the group discussion. Some took on the position of a veteran, some as *comrades* or as *experts*. The respondent GR3 appeared employ similar expert-like discursive practices to R1 in the individual interviews. The major difference was that GR3 appeared to promote the idea that there '*are*' answers to be had if '*reason*' is used, from established discourses. This differed to R1 and other respondents who shared their own personal experiences, interweaved into their comments on how societal ideas of madness could be perceived in the present as well as changed in the future. This provided the ability to shift between expert-veteran-comrade positions. R1 was the only respondent who felt he had experienced madness himself. This provided a unique subjective position and the use of interpretive repertoire(s) not seen in other interviews.

Overall the respondents differed in the degree to which they found more room for curiosity and re-evaluation after hearing each other's opinions and personal stories. The positioning of the respondents in the group interview also appeared to be able to change throughout the discussion which was noticed less in the individual interviews. This does not provide 'evidence' that the respondents in the individual setting were stifled in their responses due to my presence but rather it does show that within the context of this piece of research, that a broader range of different discursive resources and positions were able to be

observed in the group setting as opposed to the individual. As a result, there will inevitably be more Extracts from the group discussion in this analysis.

3.3 Types of Madness: From Wonderland to the Unimaginable

The first theme begins to explore the extent to which the term madness could be seen as something positive, from a 'land of fantasy', in order to be frivolous, out of the ordinary and purposefully exert 'difference' on the one hand, whilst seen as something terrifying, ominous and something to distance oneself from, on the other.

3.3.1 Wonderland.

For some the term madness was described in a number of guises. One of the constructions that persisted was from a broad social discourse, understood by all, that madness could be used in reference to something light, non-offensive. The individuals interviewed made reference   to The Mad Hatter from Alice in Wonderland. The phrase 'mad as a hatter' was used in individual interviews (R2 and R3) and came out by one of the speakers during the group discussion (GR2).

The function of these discourses appeared to be different in the way they were used in each context. For one respondent, this particular phrase appeared to be one of many ways in which to evidence that the term madness is used today in a light and flippant way:

Extract 6 <lines 1284-1292>

R2   -Mad as a hatter.

I: <u>O</u>K:ay.

R2   Mad hatter, (that's a) it's a bit si<u>lly</u> *((smiling))* wasn't it.

I: Okay ((smiling back)). SO-

R2   -The <u>hatter</u> in Alice In Wonderland, <u>he was</u> the silliest person <u>Ever</u> you know? And
        that's why the called him the <u>mad hatter</u> you know? ((croaky towards end

I: Yeah.

R2   You know? *((whisper quiet))*

As can be seen from the choice of transcription format, there are details revealed about my interpretation of what the respondent is trying to say and the position I am attempting to take, as the 'un-knower', the source of no knowledge. The respondent asks 'wasn't it', and I decided on the a full stop as opposed to question mark as I felt this was

rhetorical, though my smile in response to his perhaps communicated an acknowledgement at some level. However, on line 1284 and 1287 he re-attempts to confirm that I know what he is describing using the 'you know?' action.

My own dispreference utterances that would otherwise serve to confirm the respondent's knowledge appeared to have two different discursive effects. The first appears to have the consequence of the respondent refusing to have any further knowledge and asking for his discourses to be 'qualified by me'.

The second, shown below appears to have the converse function, serving as a means to encourage further information to be revealed, attempting to position myself as the learner and the respondent as the veteran of such knowledge:

Extract 7 <lines 1299-1309>

R2:   [YES! (.) Yes yes] yes, and ALSO   of course (.) there was also in Hollywood in the   1920's and 30's one   of the the biggest critics >of FILMS<, all the stars were in .hh   (.)   real FEAR of her, was a woman called hhHedda Harper=she had columns in   all the (.) film magazines and that, they (called) Hedda Harper,   the Mad Hatter, because [she wore] insane hats.=

I: [Okay]   =OH right.

R2   These outrageous hats (.) and her nickname was the:: The Mad Hatter I: So in   THAT wa::y (.) it's almost like the objects could be:: (.)   'insane hats' >it's like an   object< could be this thing as well?

R2:   Yes, of COURSE! Yeah yeah yeah ((becoming quieter))
       ((laughs)).

I: ((smiling))>And her nickname was the Mad Hatter and it was because of   the
       description of::< as you said 'in-insane hats'?

R2:   Yeah that's right.

Here the function of encouraging 'veteran'-talk can be seen in the breadth of information given by the respondent and by the ease of which this information flowed, without any caution or 'self-disqualification' seen elsewhere. In this particular passage, the respondent offered an example to show the idea of madness as a '*descriptive* term' spreading to an object '*worn*'. This object, in this case a hat, was labelled as '*insane*' itself, which the respondent suggests then endowed the wearer with the label 'mad', in the form of a *given* title. The suggestion from the respondent was that this public figure had a position of power, provoking fear in her professional field. In the way the respondent appears to position this

person, it suggests that although the title 'mad' was given, this public figure chose to exude a type of identity that others would see as different and feared, as well and a commanding respect. This extract of a person **choosing** to embody an object that exudes difference and perhaps encourages a title of 'Mad' to their own advantage, is the **only** one mentioned in any of the interviews. In this sense the person being spoken about chose to *wear* the title. There are further examples of attempts to change the meaning of madness into a positive, self-determined meaning that will be explicated in the 're-claiming madness' section of this analysis.

3.3.2 Madness is (not) Mental Health.

The use of the term today appears to vary from its actual use in the context of everyday social language versus what it is thought to actually mean. In Extract 8 (below), with the idea that 'anybody can be a bit mad' being stated, rather than proposed or questioned, R1 assumes that this is something that I, as the interviewer, would know to be true also:

Extract 8 <lines 58-62>
R1:   =as mad as a kind of (er) >anyone could be a bit mad you know today I'm feeling a bit <u>mad</u> or was a <u>bit mad</u> about you know it works in language< in (0.1) in it's context it doesn't .h describe somebody with a difficulty you know having had problems with their mental health.

The respondent draws his statement from his understanding of discourses in within social language. Stating that 'it works in language', seems to allow him to make these assumptions. By using Extracts that are prefaced using the pronoun 'bit' it suggests an informal, small amount of the proceeding term madness. Both Extracts given suggests 'a bit of madness' can be used in everyday language, without referring to mental health. However, this assumption was not overtly verified by myself as the Interviewer (see Extract 9 below). Whether I was being positioned as a peer (general member of the public) or as a mental health professional, is unclear. However, with lack of verification from my side, following these general assumptions on language usage led to the inclusion of madness in context of mental health patients:

Extract 9 <lines 63-69>
I: Ok ((tone shift to curiosity))

> R1:   So I think y-you worried that you know that an initially somebody (0.2) who would
>   single you out <u>or</u> set you apart
> I: mkay=
> R1:   =From the rest of (0.2) <u>us</u> because you have "mental health issues" because you're
>   "mentally ill", I think madness perhaps conjures a different image of that, illness.

The consequences of this connection to mental health, for those with a mental health label, appears to be perceived as being met with negative attention and isolation from general society. The idea of how madness fits into this association appears somehow different, although the term 'conjures' is particularly interesting as we will see throughout the analysis that perceived meaning and consequence of madness does indeed have to be 'conjured' or constructed. However, for other respondents, the **modern day** usage of the term of madness is not connected with mental illness:

> Extract 10 <lines 1774-1777>
> R2   No:: (.)>I think< that the term madness these days: (.), it's just SO: (.) fa:r away from
>   (.)- everyday use- its SO fa:r away from (.) mental illness. That: (.) it doesn't really
>   MEAN (.) >severe mental illness< anymore:e.

Unlike previous statements that appeared to be in relation to the use of the term by 'general society' or mental health professionals, this blanket declaration seems to contradict the accounts from other respondents - that the term is used in the both a light **and** 'true meaning', which is seen in a derogatory and controversial manner. However, even for this particular participant, the use of the term *'insane'* **could** be used, as way to identify someone with mental health difficulties (in 'extreme' cases):

> Extract 11 <lines 1815-1818>
> R2   Yeah. >An EXTREME form< of mental <u>ill</u>ness.
> I: So:-but WHO do you think it still means >an extreme form of mental illness< for? (.)
>   <u>Do you think?</u> ((becoming very quiet)). (0.1) For:-
> R2   And the <u>ULTRA</u> extreme is the CRIMINAL- CRIMINally insa:ne.

The association of madness with mental health appeared to evoke an accusation that I was asking if R2 thought mental health professionals used the term. This may have had an impact on the choice of phrase he used with me. The respondent was however able to offer an opinion when filtered through the viewpoint of a 'general health patient'. In Extract 12, respondent 2 offers a particular use of madness 'in the medical field'. This choice of this Extract from this respondent serves to deflect away from what mental health professionals may use and instead changes the focus to the use of the 'lighter' version of madness being used by 'general' medical professionals:

Extract 12 <line 1648-1657>

R2   I spoke to a senior nurse about that many years ago. .hh>and she said, yeah. 'Stops
        US (.) from going mad.'

I: OH Oka:y?

R2   Y'know? You know because they have to (0.1) DO IT lightheartedly.

I: Yeah.

R2   They mean it VERY seriously, (.)>but they speak< light-heartedly.

I: SO:: (.) In that exampl:e,(.) The:: >the staff< said that used flippant way of speaking,
        to prevent themselves[:: (.) from going   mad?]

R2:   [Y::es].

Speaking as a *general health patient*, respondent 2 gives a recollection whereby the 'senior nurse' excused her use of language in order to prevent what the she calls 'madness'. The participant appears to have understood that the intention of the 'senior professional' is to be able to account for the use of light-hearted language in the work-place in order to *stave off* madness. Interestingly the use of the term madness here is also referred to in a light-hearted manner and yet seems to be understood by the speaker and the nurse to 'mean' something more. The tone between the two parties here appears also to be 'light' in the way their use of talk allows both to talk about 'serious' matters without letting it apparently effect their 'emotional wellbeing'. The nurse is also suggesting perhaps that if staff did speak in the serious way, they may end up 'mad'. The use of 'light-hearted' language is understood, without explanation to the patient (Respondent 2).

On the far extreme of this position, madness could again be seen as marking a sense of difference from the norm, however, this time without it being the intention of the person involved. The consensus across all respondents was that this end of the definition was not something to be desired. The contexts in which this 'extreme end' manifested varied from

personal experiences, film and television to imagined contexts of the past. However, the respondents varied with the freeness at which they would be able to acknowledge this other, non-flippant side. Initially, Respondent 2 presented the flippant side as the only use of the term for most of the interview:

Extract 13 <lines 1141-1144>

R2   Well <u>these</u>-days when people talk about things, being a bit outra::geous or something (.) >underline>anything</underline> like that< (or just) rea::lly   silly, they'll say <u>OH that's ma::d</u>, >that's mad< it's got nothing to   do with the <u>true</u> meaning of madness.

Describing the contexts of those who use the term in the flippant, light way, was expanded to 'everyone'. In this extract he alludes to other words that suggest the same thing, being used for the same purpose, for Extract stating 'anything like that' but speaking so quickly that it left no room for him to have to explore what 'anything' was or to confirm the word 'that' meant madness. This respondent maintained his argument that this light-use of madness is the only side used in everyday discourse throughout the interview. However, even at the beginning he described something that no other respondent did, that there is an alternative, a '*true* meaning of madness':

Extract 14 <lines 1157-1167>

I: [Okay] So em:: >anytime people can use it< as:: as an
        expression?

R2   I think so, <u>they</u> do, >whether they <u>should</u> or not<,

I: Yeah

R2   ..but <u>they do</u> yes.

I: So:: >whether they <u>should</u> or not<, eh:: does that mean that this   perhap[s::
        occasions when,]

R2   [(well it's em::)]

R2   Well i-it's not fair to <u>insane</u>-people is it? (Well y'know sort of) <u>really</u>, TRULY mad
        people, y'know? >Is that< I don't whether the term is MAD is still <u>u:sed</u> in medical
        terms:: >by officials:< in CARE.

In Extract 14 above, the respondent adds to his notion that there is a true meaning of madness by stating that there are also '*TRULY mad people*'. Linked to the previous extract from this respondent (Extract 13), he states that people do use the term madness, in its

flippant sense, but is cautious as to whether it '*should*' be used. Given the purposefully

tentative tone in which my own discursive utterances are presented, the use of '*should'* by the

respondent alludes to an orientation towards a moral debate between the respondent and I.

Only the fact that this is brought up within the context of this interview can be

commented on, however, as the respondent queries the *use* of the term in medical contexts

and attempts repeated confirmations from myself through the use of '*y'know'*, my own

position in this moral debate was perhaps questioned. Although I never invited a debate into

the morality of the use of the term, or queried the use in medical contexts, the respondent

appears to be establishing or re-establishing his own position in this moral debate, whilst

information-seeking from my side. The position sought by the respondent is one in which he

is sane, and from this position he is telling me, positioned as the mental health professional

that the use of the term by everyday people may be morally ambiguous, given that there *are*

truly mad people out there, and therefore the flippant usage may not be free from negative

connotation as there *is* a *true* kind of madness that exists. This contrasts with his earlier

declaration that the term madness is only used in the flippant sense in current everyday

language use.

3.3.4 Society's (mis)perception of (ab)normality.

In the other interviews, the rest of the respondents began by describing madness as

something that could be seen as a societal difference from the 'norm':

Extract 15 <lines 2153-2163>

I: <u>We can</u> start off with madness in general.

R3:   Madness:: – <u>the word madness</u> I would relate to somebody that's   mentally::

<u>unstable?</u>

I: Mkay.

R3:   Umm::

I: What - what does <u>that mean</u>?

R3:   .hhh <u>Some</u>body that's not their usual:: – what w-we describe as <u>norma</u>l::. Erm, you've

>normal <u>people</u>< and then:: you have people that ar::e not normal so:: if:: >you say<

<u>madn</u>ess you think there's some either <u>chemical imbalance</u>? or:: there's >some family

<u>hist</u>ory::< of like, say, the word <u>insane</u>?

On the surface of Extract 15, respondent 3 offers a biomedical discourse as a proposed definition of madness. This biomedical discourse appears to be offered in order to explain the *causes* of madness within a person, following a question posed by me in relation to personal *meaning*. Instead of giving an idea of what madness may mean, the respondent describes what or 'who' the term relates to. The term madness itself is instead labelled as something that is perceived to relate to a type of person. 'Not normal', chemical imbalance' or 'family history' are terms drawn upon to explain this person – this phenomenon. After this the sources of explanation appears to end, this phenomenon is repositioned to another term, 'insane'.

However, in looking more closely at the discursive manoeuvres employed by respondent 3 in Extract 15, we can see a number of different functions, through spoken and *almost* spoken discourse, in response to the interviewer. In her first attempt to convey her understanding of the madness (line 2155), she appears to be searching for a term, which will attach to 'mentally' (with an elongated 'y') and offers <u>unstable</u> as a suggestion. The response from my side appears to infer that I was responding to a social discourse that respondent 3 was describing, though my response also served to warrant more than a general discourse. This is seen in the respondent's search for something more to say ('Umm::'), perhaps looking for the 'correct' response or the response I was looking for. Following my challenge to the term 'mentally unstable', the respondent begins to say a person might not be there usual self, though the term 'self' is omitted and instead the idea of 'normal' is offered in its place.

Furthermore, the respondent switches from her own ideas on the matter to '*we*', implicating both a wider discourse on what people in general would '*describe as normal*'. At this point the idea of who '*we*' might encompass is not made clear, though it may relate to my own '<u>*we can* </u>start off with madness in general' in line 2153, and the respondent it returning to a joint, shared discourse.

The term chemical imbalance and other biomedical discourse, genetics, are also offered as an explanation of '*cause*' in the group interview when GR3, recalls her father's search for a reason within a 'common discourse' for her mental health difficulty. The general biomedical discourse is feely recited back by her peers. This common discourse may relate to the societal 'we', seen by respondent 3 in Extract 15, that constructs a societal discourse necessitates a search for 'cause':

Extract 16 <lines 3478-3483>

GR2.. was ac<u>c:epted</u> (.) and my Daddy worried a lot that maybe HED HAD cau::sed (.) OR

WHATEVER, er- the <u>gene::s</u>, e- <u>who</u> knows::, (.)   GENETIC, or CHEMICAL–

((looks around group, lower tone))er:: >what is   it?– chemical something< can

<u>cau:se</u> it.

GR3:   [Im<u>balance</u>.]

GR4:   [Im<u>BALANCE</u>.]

(ab)normal Behaviour. The theme of normality is widespread in the individual
interviews as well as in the group discussion. The utterances used included stability,
normality and difference, all in comparison to 'the alter' – those who are categorised as
'mad':

Extract 17 <lines 3159-3170>

GR1:   I mean, <u>ma:d</u> madness for me::, er, >you know<, it can ha:ve >different meanings<,

but er: (.) BASICally:: something that you   don't understand.

I: <u>O</u>kay.

GR1:   Some people might– you kno::w – and you behave in a:: (.) <u>different</u> wa:y from

everybody else=Some people might define <u>that</u> as madness. (.) >You know<, <u>you're</u>

not con<u>for::ming</u> to the: >norm< enough. To <u>some</u> people that might be.

I: <u>O</u>kay (.) so there's <u>some</u>thing abou:t em (.) ><u>some</u>thing that's< nor:mal or <u>norm</u> and

then if it's something that seems very different from <u>that</u> then <u>that's</u> what this term

might be about?

GR1:   ><u>Ye-ah</u>!<

The above extract again uses the utterance 'you know', though the function here
seems to serve two purposes. On the one hand, it follows 'madness for *me*', indicating the
ideas may not relate to a general discourse or 'fact'. This is given further 'disclaimer status'
by *quickly* adding madness can have '>different meanings<'. On the other side, the use of
'you know' may also, despite his disclaimer, be a request for me to acknowledge a discourse
that I am familiar with.   The latter function appears to re-surface when he uses '*you*' in
'something that *you* don't understand' which may serve to refer to a generally accessible
knowledge/discourse.

The way in which he situates his words deflects attention away from the 'different
meanings' of madness, by stating this quickly, placing more emphasis on the more

fundamental meaning, which he seems to suggest I would be familiar with. My response appears to serve as an agreement, which then invites him to continue, again using '*you know*', though in this attempt, perhaps due to the previous statement, it invites me to almost guess what he is about to say, as if I would already know the lines of discourse he is about to unveil before he does. The idea he presents fits with a general discourse seen throughout the interviews in which a person '*behaving*' in a certain, way, outside of '*normal*' social standards, could be defined as mad. The use of 'some', in explanation of who might 'define' this behaviour as that of a mad person, implies that this *behaviour* may not be seen or deemed this way by everyone. In the 'reclaiming madness' chapter of this analysis there are Extracts of how this abnormal behaviour can and has been re-framed.

(ab)normality of the mind? The discourse surrounding madness as being something 'mental' or something to do with a 'state of mind' is also seen throughout the interviews. The respondents differed only in the extent to which this was described and in what guise they were speaking from (i.e. as seen from the view of self, from a general discourse on madness, or through the lens of a biomedical discourse):

Extract 18 <lines 336-347>

R1:   And I think if you use madness it's much more <u>serious</u>. I think it-it em is a state of mind isn't it? And if somebody who's, y'know (.)perhaps doing something which they shouldn't or doing something which does not em (.) fit within the normal boundaries,

I: Mkay.

R1:   ..Th't-that at <u>society</u> ((over annunciation)) expected, so that's what madness can come to mean.

I: Okay. So and it, with other people outside of having a mental health problem, would they be able to understand it in that meaning?

R1:   Oh yeah (light high tone)), <u>definitely</u>.

I: Okay

R1:   Yeah, <u>absolutely</u>.

An alternative explanation of madness in Extract 18 appears in the early part of the interview with Respondent 1. On the one hand he suggests that this 'state of mind' is what is thought of to represent madness, using '*isn't it*' as a rhetorical term to confirm this generally understood discourse. The construction of normality is brought into play again. The idea of

normality versus abnormality is also thought to be something that is a recognisable discourse both in and outside of the mental health world. Respondent (R1) above offers an opinion which he firstly prefaces by stating it is what he thinks, though expands this to a knowledge base I would be familiar with, by using '*isn't it?*' The function of the discursive manoeuvre of '*y' know*' again serves to invite me to guess what he is about to say, perhaps from a shared general discourse, before he pauses. This pause reveals that he may have altered the interpretive repertoire that was actually voiced.

From Extract 18, the emphasis on another construction - '*society*' - appears to describe those who do fit within boundaries of normality and can see those whose state of mind does not conform to the expected standards of their group. Linking this to the example used in Extract 17 and other examples describing *behaviour* as the 'sign of madness' (e.g. Extract 19), there is a discourse whereby to '*society*', the *expression* (though observed behaviour) of a state of mind that does not fit in with societal standards indicates '*madness*'.

This appears to create a simplified discourse of 'us' versus 'them'. Throughout the interviews, the respondents position themselves as both parties through the different use of '*we*':

Extract 19 <lines 2170-2175>

R3:   ..– if somebody said "what do you think madness is?" just em – just-just people aren't <u>behaving</u> normally, they aren't >within what< we would assum::e (.) we're   expected in today's society to be – y::ou >have somebody that's   normal< and somebody's ma::d. Em:::: that (.) *((shrugs shoulders))*

'They aren't *behaving normally*' or not 'within' normal expectations of society provides the extent to which the general use of the term madness comes to be understood. In the above Extract respondent 3 struggles to provide another means of understanding the term, other than these pre-defined roles.

Madness of the soul. In Extract 20, from the group discussion, the entire group appear to agree to the statement from GR3 that there is confusion over the interpretation of madness as sourced from general literature, mis-identifying madness with possession.

Extract 20 <lines 3366-3380>

GR3:   Yes   [Possessed, yes]

```
GR2:    Yes::, YE::s:.

GR3:    And AGAIN it's negative, [TOTALLY] negative, but um: (.) you can see  how that

GR4:                            [Yeah]

GR3     .. THAT >sort of<– because their::– the-THE outcome >of the person who IS
        possessed< is (.) NOW >easily comprehensible< then you could      say, "Well you
        kno::w (.) it's a devil that entered them,"

I:      Yeah

GR3:    ..because they're confu:sing them and .hh, and >the-the old thing< as well, >the-the
        Latin thing em<, "Who:m the Gods would destroy they fir:st make ma:d," and um: (.)
        so it-it-it's sort of >if you like< can be a step towar:ds destruction or obliteration or
        whatever.       ((quietly)) just,

GP:     ((all nodding))
```

The use of discourses from literature adds to the discourse of what a person labelled as mad might be seen as 'by others' in the 1800s. It also draws the discourse into the present, deeming that being mad '*can* be a step towards destruction or obliteration'. Although the respondents in the group interviews agree they have been given mental health labels in the past, only respondent 1 (individual interview) identifies with having a *personal experience* of madness. Therefore the chosen position from the other respondents is based on their 'perception' of what madness would look like to others.   The part(s) of the GR3's they are agreeing to is not evident. However, after GR3 stated, 'the *outcome*' of the person being misperceived as being possessed is '*comprehensible',* the respondents then led to personal experiences of the negative consequences of being seen as mad to be provoked. Therefore discussing the meaning or (mis)understanding of madness provoked a discourse of the **outcome** of (mis)perception of madness. The certainty of GR3's statement which described a person who '*is* possessed', backed up by his peers in the group, points to the possibility that these ideas on madness are understood by all. However it also suggests that society's idea(s) of madness is misplaced.

3.3.5 The Continuum: How mad can the term madness be?
This idea of society's perception of madness appears to interweave with the perception of the medicalised view of madness. This view appears to provide a resource to

which general society can use. In the Extract below, the use of the phrase '1 in 4', indicates the idea that mental health applies to some people in 'society'. However, for the respondents, this view of mental health is synonymous with a view of mad people. Furthermore, the respondents indicated that the 'deemers' of madness can be both 'mental health professionals' as well as wider 'society', which perhaps lends to the idea of societal stigma through labelling:

Extract 21 <lines 3210-3223>

I: Yeah. (0.1) So– SO <u>with</u> there being this one of four you're saying >there's something about< em: (.) cer-<u>certain</u> people are saying the   term "<u>mad</u>ness" in a <u>negat</u>ive way to<u>war:ds</u> people [(.) that have   mental] health problems?

GR1   *((quiet))*   [Yes, yes:: it is]

GR2:   Yes, in a *((frustrated))* judge<u>mental</u> (.) de<u>rogatory</u> way!

GR3:   It is essentially a negative term.=

GR4:   =YES!

I: <u>O</u>kay.

GR3:   ..And EVEN >for people who< would be DEEMED to be ma::d (.) to <u>use</u> the word <u>about</u> themselves is kind of negative.

G: >YEah<.

GR3:   ..I mean if you <u>wanted</u> to be more positive or more light-   hearted   >you'd say "You're bonkers"< or:, er:, <u>possi</u>bly CRAZ:zy,

---

This Extract also shows a difference in the use of other terminology, with 'bonkers' or 'crazy' apparently being deemed 'lighter' than the term madness. Indeed others described madness as a 'strong' term. Respondent 3 struggles to explain her own reaction to the term madness, using an emotional phase, *'uncomfortable'* to respond personally:

Extract 22 <lines 2207-2224>

R3:   I'd think, "Oh::, ok:::ay, >I don't like that< because it makes me feel <u>uncomfortable</u>?" *((upward questioning inflection))* >because it's outside the realm of< <u>ho:w I would want to be</u> or how I'd expect <u>other people to be</u>. So I would just fee::l madness is erm (0.1) er:::::m   >it's hard to define< really, because *((cough))* it comes within – to me it comes within the sphere of 'madness, insane, cra:zy' (.) or '<u>ab</u>normal', >so to me< madness is abnormal. I would describe <u>madness</u>(.) as abnormal=

I: =Okay so:: <u>you seem to</u> >kind of separate it< to say it's a type of <u>BEHA::VIOUR</u>

---

someone might have, >so you say< there's this <u>nor:mal way of bein:g</u> >and then< <u>all</u> these other terms are about <u>ANYTHING OTHER</u> than that (.) so:, if someone's, the term crazy, insane, or:: the <u>term madness</u> is used, it's anything that's outside, outside what's <u>seemed</u> normal=

R3:   =What's seen to be normal-

I: -[yeah]

R3:   [..in society], today's society, what do   you expect it to be?= *((upward questioning inflection))*

The extract above asked respondent 3 to say how she sees madness in comparison to apparently similar words, such as insane. Respondent 3 chose to speak from her own personal viewpoint in her reply. The use of the position of 'self' brings in some of the ideas expressed by other respondents in acknowledgment of societal norms, though in this instance, this particular respondent speaks from the first person, looking out at these norms which appear to cluster madness with *any words* that describe '*abnormality*'. For this respondent, the function of this chosen social discourse appears to be to distance herself from any such terminology, not wishing to be seen as '*what's seen to be normal'*. The later use of 'self' in this passage (e.g. '*I would* describe madness as abnormal) serves to ally the respondent *with* this social discourse, and thus removing her from the position that would identify or be identified within the realm of abnormal. This effectively evades an *'uncomfortable'* discourse, and instead allows her to speak from the more objective, societal, safe position. In the last 2 lines, the respondent does still qualify her own remarks to the possibility that these ideas are societal ideas, and perhaps a construct of 'society', and '*today's* society', to be specific. In this way she is able to question this construction, whilst maintaining her position outside of that of 'madness' or 'abnormality.

The idea introduced by respondent 3 taps into another broad discursive theme seen by the other respondents. On the one hand, as seen by the previous extracts (e.g. Extracts 19-22), any term that 'society' would position a person as 'abnormal' are clustered together to embody the message of someone, or someone's behaviour existing outside of 'normality'. However, for some respondents, including respondent 3, there is a difference in terms of *how normal or abnormal* these terms position someone. Madness, as otherwise positioned as the polar opposite of normal (see Extract 27), is not always the 'extreme' opposite of normal, though there are terms which, to some, do fit this positioning. When removing themselves

from attachment to the term madness, respondents offered up a view of madness within a **continuum** of how 'severely ill' a person is judged to be. At the far end of this continuum lay the term 'criminally insane':

Extract 23 <1818-1834>

R2   And the <u>ULTRA</u> extreme is the CRIMINAL- CRIMINally insa:ne.

I: <u>OKA:Y.</u>

R2   You kno:w:. That's <u>that's</u> the- as <u>extreme</u> as you can GO:!

I: Is <u>that</u> PAST madness?

         (0.2)

I: Or is it different?

         (0.2)

R2   Criminally insa:ne (0.1), 'mad ma:n'. >Oh it's< be<u>YOND</u> madness isn't   it?

I: Okay.

R2   <u>OR</u> can you get CRIMINALLY insane mad *((smiling))* people as well? *((laughing)).* <u>I:</u> don't kno:w.

I: So:- well it's INTERESTING >because you have< the:- the term- say <u>mad</u>ness::, and it's em- <u>you're</u> saying that it mean:s, <u>severely</u> mentally ill::? (.) And then >CRIMINALLY insa:ne is< (.) even <u>beyond</u>   that?

R2   Yeah.

Within this construction of 'insane' being the term that is used only for mental health description comes something apparently even stronger (for respondent 2).   'As *extreme* as you can go' positions this term as something that would be beyond any of the *clustered terms* of mental health. The rhetorical use of 'isn't it' here appears to suggest I am aware and perhaps agree with the discourse whereby 'criminally insane' is seen as '*beyond* madness'. Some of the respondents agree that the word 'insane' is an extreme term attached to someone who is labelled 'mentally ill', though not all describe '*criminally* insane' as the '*ultra* extreme' of these terms:

Extract 24 <lines 2226-2242>

R3:   -..I probably:: – ma:ybe >I can reflect back and say< em yes I would yes incorporate 'madness', 'insanity', and 'cra::zy' in that al::-<u>altogether</u>, *((upward questioning inflection))* but: (.) you have   <u>mad</u>ness >which is< just slightly outside

---

> the realm of <u>normality</u>, >then you have cra::zy< which is slightly <u>worse than ma::d</u>,

I:　　OK=

R3:　=..then you have insane which is:: >totally just beyo::nd< any sort'f >normality <u>what-so-EVER3::</u><. It's:: em:: <u>it's the ultimate</u> end of:: the sphere of madness, crazy, insa::ne (.) >insane is like you're 　　totally< <u>not in control of anything</u> *((upward questioning 　　inflection))*(.) *((hard swallow followed by exhale))* hhh >whereas madness can be< – madness is:: – it's quite a hard, er:: (.) word to:: –<u>what</u> we're expected, <u>what we're to::ld</u> by people *((upward questioning inflection))* Madness is:: you can be mad <u>AS-in</u> (.) 'mad as a hatter' or:: >as I just said like< y'know? you're <u>beha:ving</u> 'abno:rmal', 'abnormally', >because society tells us< that's not the way we should behave *((softer upward questioning inflection))?=*

In the above extract we can see that respondent 3 appears describe a *'sphere'* (which she later calls *'spectrum'*) within this bubble of mental health terminology. Within this 'sphere' is a clear continuum in which mad, crazy and insane are positioned respectively. The term 'insane' is not only positioned at the far end of this continuum, but also described as an entity that defies description, *'beyond* any sort'f normality what-so-EVER'. The way in which the term insane is positioned here appears similar to what '*criminally* insane' is positioned as for respondent 2. The commonality between the two is that the idea of what these terms may mean appear to be constructed without any clear basis for their choice of placement within this 'continuum'. There is no reported example from their own personal experience or that which they have observed in others. The difference is that for respondent 2, the idea of 'true' madness appears to be constructed, outside of his own experience, whereas respondent 3's discourse appears 'closer' to the term madness, understood by something outside of how '*society* tells *us*' 'how *we* should *behave*'.

For these respondents, the term madness is one of many that describe someone that is different, or mentally ill, or both. Both respondents **do not** position madness as the extreme end of this constructed continuum. In other examples there are certainly terms that are also *less extreme* that madness, (e.g. lines 3222-3223, Extract 21) however, there isn't agreement between respondents on the ordering and perceived severity of these terms. Therefore we may assume that the term madness might be lost in the mix of these terms. However, it seems the idea of a *true meaning* of madness persists between respondents.

3.4 Sourcing the 'true' meaning of madness.

Within the discourses expressed through the interviews, the ideas around madness appear to come from a variety of sources. As you can see from Extract 25 below, the sources of this social knowledge stem from early childhood, through a variety of mediums. From these sources there are discourses that appear to continue to have meaning and be recognisable. The idea that there is a 'true' meaning of madness makes an appearance within these discourses:

Extract 25 <lines 1469-1482>

R2   I haven't (known anybody. I mean) and I have only (seen   interpretations of it) on TV, films, and books. Things like that.

I: Okay.

I: And eh, I'm not quite sure (how I should answer this then) *((quiet))*

I: THAY sounds it was pretty <u>hon</u>est, (.) so em: (.) this:: this sounds   like it comes from say <u>TV</u> and a fil::m <u>may</u>be,

R2   Yes::.

I: ..that <u>image</u> of a person who is >as you say< >as you say< sick and that word mad <u>fits</u> somehow with that em::. And how about,

R2   It's <u>very</u> very sad. It's the <u>sa:d</u>dest thing in the world (.) >in<u>sane</u> people< (they've) got no voice:: they've got no choi:ce:: (.) they can't have <u>fu:n</u>, they can't <u>do</u> things, they can't <u>choo::se</u>::. They've got- it <u>must be</u> the <u>sad</u>dest thing in the world. It must be (.) <u>t</u>errible (.) terrible, terrible, you know?

Interestingly, the respondent in the above extract, sources his idea of madness from external mediums and states they show '*interpretations* of *it'*. We can assume '*it'* refers to madness from the context of this part of the discussion. However, this *interpretation* provides a strong reaction, as respondent 2 orientates himself towards a position of strong pity for those who are 'truly' mad, despite the previous acknowledgement that his idea of madness is from interpretations seen by external sources.

Instead of finding new answers, respondent 2 draws from a different repertoire, using terms such as 'they *have* no voice' appears to further bolster his reaction, and invites me to agree with his own reactive *interpretation.* This appears to be in the guise of a presented 'fact' whilst manoeuvring me into a discourse where '*we'* should feel sorry for these 'truly mad' individuals. As a result of this manoeuvre, the previous acknowledgement that

discourse has been based on assumptions from media *interpretation* (line 1470, Extract 25) seems to be back-grounded.

3.4.1 The true (media) meaning of madness.

An Extract of the type of media that has become a go-to source of knowledge and reaction of the term madness is shown below:

Extract 26 <1319-1322>

R2:   Well-well I I remember that (specific scene, they were walking down the staircase at the time) at the time in a very <u>grand</u> house (.) *.hh* this <u>very</u> (.) this thing which Doctors had <u>confused</u> young relatives. "Is there a na::me for this?" "Yes::, MADNESS!" Y'know?

In Extract 26 above, the construction of madness appears to be brought into existence. The setting of the usage was apparently sourced from general media, when recalling times when the respondent has heard the term madness used. One of these settings in which a doctor was thought to use the term was in film. The respondent described a particular scene in a movie that conjured an image of what the term could mean. The use of the phrase 'this *thing'* appears to imply that madness has not been conceptualised. This fits with the general discourse of most of the respondents where a description of madness, other than '*difference to*' or '*consequence of*' are difficult to vocalise. In reference to this film, the *'thing'* remains a source of confusion until the 'doctor' gave a name to it – '*madness*' was born. Respondent 2 recalled the film and used the 'y'know' utterance. This function of this utterance in this context appears to be to facilitate the positioning the 'film reference of madness' as a familiar reference point. This may assume that I, as a member of the public, would be familiar with. It may also serve for me to disconfirm this reference point of madness, or to query if the image I hold is the same as the image that is seen in this film and hence by the participant.

This particular example appeared to be the only direct connection any respondents had to their own 'sourcing of knowledge' of the term madness. Other respondents were able to draw upon general sources, though mainly dismissed them as mis-conceptions.

However, respondent 1 offered the view that these 'general discourses' actually provided a real source of understanding in his life:

Extract 27 <lines 1043-1064>

I: And is that something about (.) you said it's a word you picked up a long time ago?=

R1:   =Yeah, because again this <u>time-line</u> is very strong in my mind and I think about <u>mad</u>ness being something which initiall::y I came across <u>the TERM</u> <u>mad</u>ness, you know and used it and was comfortable using it, probably quite early on in childhood and I probably thou::ght to myself, in terms of how I'm doing (0.2) sounds fantastic you know that my brain works this way but *((slight laugh))* em that, perhaps madness eh, >is the opposite of normal<.

I: Mmkay.

R1:   So:: >psychologically< you are using it <u>from a very early age</u> and <u>understand that,</u> there is another (0.2) there is another way <u>your brain can woR1::k</u>, >if you like< or another context which your brain sits in?

I: Yeah.

R1:   Which is contextualised by the words <u>madness</u> and <u>sanity</u>? So you've got those two <u>o</u>pposing <u>po</u>lar opposites, if you like and I think that it just works into the whole idea of (.) understanding <u>people</u>, understanding yourself, >you know<, <u>what's acceptabl::e</u>, <u>what's norma::l</u>, <u>what's ab:normal::l</u> >whatever<. And I think madness would be one of the terms which you could, you could <u>tell a chi::ld</u> and they would understand what they were talking about.

The age at which a person comes to know about the term madness comes to the forefront in this extract. Here respondent 1 begins to explain his 'acquisition' of the term madness. Although he fails to place an obvious source from which to place the moment of learning about the term, he explains it *must* be from 'early childhood'. His recollection appears to blur between past and present, towards an objective way of viewing himself and the term. There is a subtle shift in his discursive positioning from a personal childhood recollection to the objective scientific point of view that hypothesises what this term can mean in language and how it fits into developmental learning. The child viewpoint seems to be loaded with curiosity, without judgement. The term is part of language, without stigma or negativity.

The contrasting scientific discourse also positions what I would expect to hear and the way in which I am cued to respond, using '*psychologically'* to indicate a the proceeding information is going to be within the realm of 'science'. This may have been caused by my shift from my usual supportive or encouraging tones of 'okay', or 'yeah', to a more curious 'mmkay', indicating I perhaps saw something new and wanted to know more. The

respondent then re-directs his discourse to a scientific one. This enables the respondent to generalise his understanding to theories of 'developmental learning' and create 'hypotheses' about the 'social dynamics' involved as a consequence. In this case it presumes a child would understand the term madness within opposing positions of normal functioning brain/different functioning brain, given further language such as madness and sanity.

The respondent also alludes to the idea of what is '*acceptable'* within a theme of identity: self versus others (or '*people'*). In using the discursive position of an objective, scientific viewpoint, as shared by GR3 in the group discussion, the use of strong statements is enabled, without having to argue their position solely from personal experiences. In this case, he does not state whether he identify himself within either normal/abnormal camp.

Instead, respondent 1 foregrounds the idea that the term madness is learnt from early childhood, that it would be a term a young person would have an idea about, without having to have a more developed vocabulary, or direct experience of the phenomenon of madness itself.   Respondent 1 therefore somehow establishes the beginnings of a learned discourse of us/them normal/abnormal. However, in the adult world, this construction, whether there is a 'true' madness or not, appears to have 'true', real-world consequences.

3.5 Consequences of madness:

Extract 28 <3392-3402>

GR4: ..af<u>te:r</u> >my child was born< and my <u>FA:M</u>ily were very s<u>upp</u>orti::ve >before that<- very close family- and then <u>ONCE</u> I star:ted to <u>do</u> things (.) >that were a little< <u>strange</u> .*hhh*, (.) the <u>MO</u>ment I got   <u>seen</u> by a psychiatrist I WAS (.) ><u>deemed</u> as< <u>MA:D,</u>

I: <u>O</u>kay?

GR4: ..<u>fro:m</u> THAT day to this day, (.) they've had <u>no</u> con– <u>apar:t</u> from– my <u>PARENTS</u> or my <u>chil</u>dren– ><u>none</u> of the <u>fa:</u>mily< have any contact because 'I'm the ma:d one (.) in the family'[, (0.1)]and it's just – it's been

GR2:   [*((tuts))*]

GR4: >22 years< *((angrily)).*

In the above extract, respondent GR4 describes being shunned from the rest of her family, due to the *attachment* of a mental health label. This label appears to be *translated* by her family to mean madness. This mirrors with respondent 1's viewpoints that being attached to psychiatric services is akin to being deemed mad.:

Extract 29 <232-233>

R1:   ..and somebody who has been through *((audible swallow))* psychiatric services, is
        somebody who is a 'mad person'.

It also mimics the discourse seen by the other respondents where behaviour 'outside of
normality' warrants a label of madness. However, respondent GR4 refined this construct
further to state that the **act** of being seen by a psychiatrist invoked a label of madness
instantaneously. The consequence of this 'attachment' for respondent GR4 was an act of
shunning from her family. This act apparently extended to her children by association. In
this sense, it appears as though the label of madness, and especially its consequence then
encompasses more that the person being deemed.:

Extract 30 <3406-3413>

I   [->And that<]- >I mean< ther::e (.) it's >really specific< what happened ther::e that it
        was this experience that you ha:d (.) and where, as soo:n as you saw a
        psyCHIATRIST the::n (.) then this label was there.

GR4:   Yes, and it was kind of "SHE's got- [SHE's] got the LUR::GY, stay   away

GR3:   *((quiet soft tone))*   [yeah]

GR4:   ..from her, it's contagious" [or [[something]].

        The discourse of being tainted is then foregrounded by the respondent GR4, with
words used to give a sense of being both infected and having something that can be
transmitted. Interestingly, this discourse is recognised by her peers, acknowledging the
existence of this discourse before GR4 had even completed her sentence. The choice of the
word 'lurgy' is something that casts further mystery into the perceived impact of madness,
with the term 'lurgy' being a fictitious, yet highly infectious disease, and the 'true' madness
not able to be articulated by most of the respondents. In this way both 'true' madness and its
consequence are social constructs. However, it is not clear whether the respondent denies the
existence of true madness, but rather, that it is perceived consequences, whether via a
construct or not, have real-world implications for her and those who surround her due to the
attachment of this label.

Extract 31 <lines 4167-4186>

GR2:   I maybe – >I think maybe people< are sca::red (.) where in the odd case, maybe >I
       don't know<, paranoid schizophrenic or NUTTER kills   someone or HURTS A

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> CHILD,
>
> GR3: Yes.
>
> GR2: ..>or any of that<. It is all kind of <u>lumped</u> into one- mental health- and it's <u>all so</u> very different.
>
> I: It <u>SOUNDS it,</u> in the way you <u>say</u> it. So there was these <u>labels</u>   somehow and the <u>labels</u> are-
>
> GR2: And many differentialities within (.) ONE label.
>
> GR3: And a lot of <u>damage</u> is <u>done</u> to the mentally ill when there is – like <u>recently</u> there was a famous case of-of-of someone who IS mentally ill >committing a terrible CRIME, (.) like MURDER or whatever.
>
> GR4: YEAH.
>
> GR3: And <u>then</u> that reflects VERY MUCH <u>back</u>-on all people who are <u>ment</u>ally ILL::,- so that-that sort of adds to the <u>STIGMA</u> (0.1) if only for a <u>period</u> of <u>time</u>, *((recedes to quiet tone))* but it <u>DOE:S.</u>
>
> GR4: It TAKES the <u>HEAD</u>LINE, doesn't it?
>
> GR3: <u>Yes</u>, exactly.
>
> GR4: It's that <u>WHATEVER</u> ILLness or whatever <u>PROBLEM</u> they had-
>
> GR3: THAT'S what caused them to be:: em murderers

In the above Extract the respondent (GR2) seems to speak against the predominant social discourse that the construction of 'abnormal'. In this case she states that medical terms such as 'paranoid schizophrenic' and lay-terms like 'nutter' are deemed synonymous with one another. The context in which this discourse has been described lies within the media. 'Or *any of that*', used in a quicker pace of speech serves to re-affirm her assertion that there is a disregard for difference in the use of terminology which she states is 'lumped' together and yet argues that these terms are in fact 'very different' from one another. The next respondent (GR3), replies as a peer, then asserts that the consequence of this 'lumping together' has a direct effect on those with mental health problems – terms which are clustered to become synonymous, are then effected by anyone who's label is encompassed by the synonymous terms. Interestingly, the way in which Gr3 frames the repercussions of media labelling to those with mental health labels is that it '*reflects,* VERY MUCH' back, '*adds* to the STIGMA', and does 'damage'. In this way GR3 does not position himself as the one being reflected back on (still making reference to '*them*') but emphasises a number of assumptions: that there is already stigma against people with mental health issues; that the media's

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synonymous use of terminology foregrounds these issues as the problem in criminal headline stories; the apparent effect is a temporary **increase** in the perceived spotlight (or stigma) that was already focussed on those with the label of a mental health diagnosis.

Extract 32 <lines 1890-1906>

I: Mad<u>ness</u> might always mean something a bit mo::re (0.1)- >a bit more serious?< (0.1) If you used the term madness?

R2 Em:: (0.1). NOT the- Not <u>these</u> days, the <u>gen</u>eral (.) [public.] NO.

I: [<u>Okay</u>] So: the general public using it, it's still:: (.) <u>that</u> kind of-

R2 <u>INSANE</u> is still <u>INSANE</u>. But not many people <u>use</u> the word flippantly, insane. <u>In</u>sane is still <u>in</u>sane, I think.

I: <u>Ok</u>ay. (0.1) So that still <u>mean:s</u> something quite <u>ST:RO:NG?</u>

R2 Yeah, yes.

I: Em: a::nd- Is it NEGAtive? The <u>word</u> insane?
(0.2)

R2 A negative word?=No! It-its j::ust a description, a MEDCIAL em [de<u>scription</u>.] As far as <u>I'M</u> concerned.

I: [Okay]
So it's <u>neutral</u> somehow?

R2 Of <u>COURSE</u> it's <u>NEGATI:VE</u>, it's <u>not</u> GOO:D. [((laughter))Y'kno::w?]

I: [((laughter))]

R2 But em: (.) you <u>CAN'T</u> describe it >as a< <u>negative</u> wor:d.

For some, the **use** of terms such as madness still lies outside of the 'cluster' of mental health synonyms, and are instead used in the 'flippant', 'light-hearted' fashion amongst the general public, without any connection to mental health. Other respondents described other uses of the term madness, such as to describe anger or an ill-thought out idea, however, they felt it still had a presence within the mental health 'cluster'. Respondent 2 previously suggests there is a 'true meaning of madness'. Respondent 2 goes further to suggest that on the one hand the term insane is '*strong*' (agreeing with my own suggestion) and is negative, though is not allowed to be described as negative within discourse, due to it '*just*' being a '*medical description*'.

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My own attempt at clarification by suggesting the term is seen as *'neutral'*, due to R2's previous respondent's medically emphasized discourse, then established a brief switch in R2's interpretive repertoire, outside of the suggestion of a medical neutrality, though he then re-positions it back towards this position of neutrality after this moment of lapse, in talk of 'acceptable' discourse. Here the use of 'y'know' appears to suggest I was aware of the alternative discourse, of it being negative, whilst the respondent was attempting to maintain the guise of the medical, neutral, descriptive position.

3.5.1 The healing power of madness.

The construction of madness is not seen as completely negative by all the respondents. Respondent 1 provides the strongest voice to create a new window into discourses surrounding madness. In particular, through the use of de-construction of the term, and detaching the term from sole use of the 'normal society', against those deemed 'abnormal':

Extract 33 <lines 118-123>
R1:   =by that I mean you know seeing the psychiatrist or a care coordinator. You know it's just gotten to me now and if somebody came back with the idea of perhaps it was "just a bit of   madness" *((croaky jokish tone))*
I: Yeah?-
R1:   -..And it can happen to anyone, it can be normal,

The function of the term madness appears to change again when used by mental health professionals to attempt to explain a particular mental health **experience**. On this attempt, the term can be used to relate to something that both the mental health worker and the patient, can understand. In Extract 33 the mental health professional is tentatively putting the idea to the patient that their experience could be this 'thing' they both would be aware of, this 'thing' called madness.

The idea of 'normal' is re-introduced. Here the respondent, whilst identifying himself in the role as a NHS patient, speaks with hindsight, and imagines a scenario whereby the use of the word madness can be both minimizing to the 'experience' of mental health concern, but also 'normalising'. In this sense the function appears to be to allow the 'professional' to both reduce the intensity of the experience but also to allow it to fall within the realms of what can be considered to be 'normal'. The tone of humour adds another dimension to this

function by possible allowing the experience to be 'dismissed as madness'. Here we do not know the 'type of madness' being spoken about but appears able to be laughed about – allowing a mutual reference point where both parties are able to identify through humour.

This runs in contrast to the function perceived earlier in the analysis whereby the person identified as being mad would be 'singled out or seen as different'. Perhaps it is because in this extract, the person's identity is not being positioned as 'mad', but instead an 'experience of madness' is offered, allowing the respondent to be included as member of the 'normals'. This enables the respondent to make use of a term that is not a construction within the 'clinical' world of mental health professional:

Extract 34 <lines 766-780>

I: So there is a clinical term ve::rsus (.) the term that seems to hav::e <u>may</u>be not more <u>mean</u>ing, but it gets, >gets it a bit more?<

R1:   (0.1) >Yeah perhaps< its perhaps it's a bit closer to <u>the bone</u>,   perhaps we we all:: .h have an understanding of how day to day lives   can be affected by madness.

I: Yea::h.

R1:   Em:: (.) and it <u>goes</u> a bit beyond that as well (.) <u>for ME</u> (.) having   an experience of psychosis and 'delusional beliefs   y'know'*((whisper))* <u>THAT</u> sort of <u>thi::ng</u> em (.) it goes a long way to   de<u>scribing</u> what that, what those feelings are like and and how that   situation em, can evolve y'know? because it' closer to em:: (.) using what is a more understandable way of of em (0.1) of diagnosing myself >if you like< if I used if I say I'm I'm you know if somebody who has experienced a psychotic <u>BREAK</u>down and that's <u>all</u> to do with (0.1) <u>mad</u>ness.

In the extract above, the respondent agrees with part of my suggestion, though directs it more towards the idea that the term can be more tangible. In suggesting that by offering the phrase as something to consider when thinking through a mental health experience, the respondent suggest it could be 'closer to the *bone*'. Respondent 1 then expands this closer understanding to include everyone, with the omission of my/your/our in '*how* day to day lives can be affected by madness'.

When compared with the other respondents, this suggestion further emphasizes the particular discourse respondent 1 uses, in allowing the term madness to be described and investigated '*closer*', rather than keeping it at a distance, as the per the position other respondents tend to take.

Respondent 1 takes this discursive manoeuvre further and manages to re-claim the function of the term madness for his own use. In this way, despite explaining his role in the position of a patient, he is able to self-diagnose, instead of being diagnosed. At the same time he acknowledges the clinical 'given' terms used to label his mental health difficulties, though feels his own use of madness can 'closer to' and a more understandable way of' self-diagnosis and moves this understanding to the foreground. Look more closely at his choice of phrase, '>if you like<' implies the diagnoses term is directed towards myself, as the interviewer, and perhaps as a mental health professional. Using the phrase 'diagnosing' is perhaps, as with 'psychological' used earlier, an attempt to ally the discourse with a repertoire I would be familiar with as a Mental Health Professional.

In other Extracts, the use of madness as a type of diagnostic offering by the mental health professional **can** be used. Furthermore, it is positioned as something very different to other official, psychiatric diagnoses:

Example 35 <486-495>

R1:   I think would put people (.) um: in a different frame of mind about their own,
        condition, about their own experiences hh um, in the in   the first instance, if
        someb'dy who was trying to <u>diagnose</u> my >mental   health< condition .hh, em with
        the <u>term</u> madness, I may <u>fee:l</u>, slightly more comfortable with it. I know-I know that
        sounds bi<u>zarre</u>, b't madness seems something that is transient, that doesn't stick,
        whereas something like schizophrenia <u>really</u> that seems like something that I'd never
        be able to get away from =I know NOW that it isn't that,

I: Yeah

In the above extract, respondent 1 appears to speak on behalf of mental health suffers. The phrase 'mental health' is spoken rapidly, foregrounding the '*term* madness' instead. After qualifying his next statement by disclaiming is as being seen as 'bizzare', respondent 1 suggests that the term madness does not have a permanent branding on the person it's attached to like psychiatric terms such as 'schizophrenia'. This may appear to run in contrast to the opinion of other respondents, however, respondent 1 is talking about the impact of the label as seen from his own viewpoint, rather than others. In his expert, survivor role, madness has an ending whereas psychiatric terms as perceived as not having an end, perhaps even a brand for life.

Furthermore, in Extract 36 below, madness appears to have a more flexible role than other 'diagnosed terms'. In talking about how a mental health professional might use the

term madness to reach out to the patient in order to understand an experience, respondent 1 continues in his survivor patient position, asserting that the relationship between client and patient would allow for the 'appropriate use' of madness. The adjustment can be seen in line 373 where he begins to suggest a mental health profession would treat a patient 'as their diagnosis', rather than 'as a *person*'. This is adjusted to a softer, more palatable phrase that constructs an image of two individuals in a helpful relationship, rather than the expert labeller vs. passive patient. The 'disintegration' of everything other than madness in the Extract seems to dissolves the use of other terms, as well as the roles between the two parties:

Extract 36 <lines 361-378>

R1:   ..if they are any good. .hh and I think that that meaning then is somehow em (.) it sort of disintegrates everything else. >I mean< once you've gotten down to madness and used it as a a a in context, I   think there is very little you can detract or add to it. Cause I   think it is quite (0.1) it is quite em (.) specific in-te:rms, I mean if you use it as a as a label or if somebody says to you, how do you   feel about .hh being diagnosed (.) or how do you feel about 'your

R1:   ..madness',

I: Yeah

R1:   ..I think (0.3) the (.) the reaction you get would be very different   and I think it's dependant - it depends on how you see yourself inside of that relationship with the professionals. So >if that   professional treats you as a person< rather than as their diag- as somebody they are trying to make better.

I: Yeah

R1:   Then I think it has got a place, I really do, I mean I think that madness it it's is a very broad term, but it is also very (.) em::, it sort of leaves very little room for misunderstanding if you like.

This proposition of a potentially equal relationship is noted in by other respondents. This is largely in relation to how relationships between mental health professionals and patients can be more helpful. However, respondent 1 talks specifically about this relationship in the use or misuse of the term madness. He aligns this with another clinically based discourse – *'recovery'*:

> Extract 37 <lines 421-426>
>
> R1:   And there is a lot of, there is a lot of effort goes into I think <u>recovery</u>, I think you have gotta put a lot of things to one side >and you've gotta stay< and <u>fo</u>cus on recovery. So anything that under<u>mines</u> that is really dangerous. But at the same time, I think madness can   start to bridge that gap between (.) em what it is that professionals do for us 'nd what we have to do for ourselves.

However, even this term 'recovery' is *re-claimed*. As seen from the Extract above, respondent 1 switches from the position of a champion of 'recovery' to a champion of equality. At the end of the paragraph, he foregrounds the use of madness as the decision of choice, despite alluding that it could be seen as something that *undermine*s 'recovery'. The destructive power of madness is also positioned as the healer, 'bridging that gap' between the functions of the professional and the patient's own healing abilities. Later the respondent re-affirms this equalising movement:

> Extract 38 <lines 512-519>
>
> R1:   Em (0.1) B'cause it is not (.) in-in a <u>funny</u> way it does not feel very <u>psychiatric</u>, it does not feel very <u>big</u> and sort'f of<u>fic</u>ial.
>
> I: Yeah.
>
> R1:   Um, it seems quite a <u>kind</u> way to speak to a person .hh, you know if you can introduce the <u>term</u> and you can say to them, this may be, perh:aps what you are experience and perhaps, you know, we can say we don't know a lot about it, or we can say, we know <u>enough</u> about it to give you some he:<u>lp.</u>

In the above Extract respondent 1 alludes to the suggestion that psychiatric, medicalised terminology are 'big' and 'official', by stating that he feels madness is the contrary. The disarming effects of madness are highlighted with this new discourse of equalising and healing. This particular use of madness positions the mental health professional on a more equal footing to the patient. Indeed the term patient transitions to 'person' in these past few extracts. The holders of the 'big and 'official' psychiatric terminology appear to admit limits to their knowledge by introducing madness as something that can be understood. The power divide remains unequal in this Extract, as the suggestion that the mental health professional know 'enough' about this madness is still present. However, this 'knowledge' is framed as limited in itself and serves to help the 'person'. The

use of more psychiatric terminology is framed in a way that it is something that a person, in role of a patient, is *given* by the mental health profession, and they cannot do anything to get rid of it. However, even for some that have been *given* a psychiatric title that others translate as madness, the consequences can also be something positive and useful for the person who has been deemed mad:

3.5.2 The gift of madness:

Extract 39 <lines 3675-3693>

GR4: My <u>fam</u>ily still ha:ve tha:t. They sti::ll (.) >have no< <u>contact</u> at   all: apart from–
my Mum and Dad find it <u>very</u> har::d to accept that   their <u>daughter</u>'s got mental health problems, (.) >so we just don't talk about it<. But my <u>chil:d</u>ren (.) on the other han:d– it's KIND OF– when you say <u>MAD</u>NESS to <u>ME::</u>– (0.1) <u>PERSONA</u>LLY for <u>ME::</u> it- it's been the biggest <u>gift</u> in my life.

I: <u>O</u>:ka:y?

GR4: Becaus::e it's changed the way <u>I</u> look at <u>peop</u>l:e. I've never::– if   someone is: <u>different</u> to me (.) it <u>doesn't</u> mean that they're <u>not</u> nor:mal,

I: Yeah.

GR4: We're just all different people. >But it's< been a GIFT for me because <u>my</u> children have grow:n up (.) >and I've had< <u>cust</u>ody of them al:ways. They've <u>bee:n</u> to (name removed), they've <u>bee:n</u> in the da:y

GR4: ..hospital- they've <u>seen</u> all different people, >so they are< <u>so:</u> open <u>mind</u>ed and so– they don't see a difference bet<u>wee:n</u> (.) what <u>other</u>   people see as <u>normal</u> and <u>ab</u>normal.

I: Yeah.

GR4: So for ME:: it's bee::n >a gift<.

The extract above is different to the previous extract 37, from respondent 1 in that the respondent (GR4) is talking about the effects of being labelled in a psychiatric, traditional way, that is then translate by others as 'madness'. Speaking as a survivor, the respondent challenges the personal meaning for herself and the 'contagious' consequences. GR3 is able to shift the prevailing discourse of negativity/stigma, and allow it to re-dress how she sees others. The 'madness' that her parents apparently find hard to accept, is able to be re-cast, as neither normal nor abnormal. This consequence is also 'contagious' for her children who

apparently have the same 'open' attitude towards people who would otherwise be see as one or the other – normal or abnormal.

There are numerous Extracts repeated attempts by the respondents, **particularly** in the group setting to re-position madness in creative people (Extract 40) as a *source* of their creative flair:

Extract 40 <lines 4019-4032>

GR2:   >I JUST THINK<– well again I go <u>back</u> to ecc<u>entric</u>, <u>different</u>,   .*hh*<u>HIGHLY</u>
         creative <u>people</u>. There are many people in the <u>acting</u> profession, there are <u>many</u>
         people I know >with mental health issues::< who can paint, write, se::w, (.) all the
         <u>creative things</u> you can think of, (.) DA:NC:E. (.) ALL of which is very <u>therapeutic</u>.
         Take good <u>pictures</u>. YOU NAME IT, and one can go to <u>cla:sses</u> and <u>progress</u> with
         that (.) and <u>that</u> is <u>therapeutic</u>. (0.1) I-I think >probably< with-out the so: call::ed
         >mad people< or >whatever l<u>a</u>bel you're going to sa::y<, (.) the <u>world</u> would be a
         <u>dreary</u> dull place.
         (.)
I: It sounds <u>there</u> as though- if it's <u>sold</u>?, in the right <u>wa:y</u>?- then <u>actually</u> in that way it's
         almost <u>desirable</u>,
GR1:   YES, EXACTLY.

This differs from the idea that someone has chosen to have this term identify them. The respondent suggests that madness could be the source of their talent. However, as can be seen in the above transcript Extract 40, this view is disputed. Here the respondent (GR2) not only attempts to position people in the creative industry as having a label such as madness as part of them, but **fights** to position them as different from how they are currently seen. This is demonstrated in repeated emphasis in GR2's accounts of people in this industry as 'highly' creative, capable of 'YOU NAME IT', perhaps meaning a number of different talents which she goes onto **state** (as opposed to suggest) include those that are therapeutic, meaningful and important (at a societal level).

The temporary de-emphasis of terms like 'madness', 'mental health' or 'any other label' through discursive manoeuvre of quicker speech ensured the main point received the most attention. These terms appear to be synonymous with one-another in this particular statement but the respondent does not impose a judgement on whether this is a good or bad trait to have, but rather implies that people who have these traits are talented.

My own response in Extract 40 appears out of synch with this, going further to suggest that it is something good, something to be desired if 'sold' in the right way. Respondent GR2 appears to do a good job of 'selling' this idea to me. My own statement appeared to provide a 'pitch' to the group from my own understanding of GR2's initial 'sell'. My pitch initially appeared to gather some consensus from some of the group, however, not by all:

Extract 41 <lines 4033-4042>

I: ..you kno:w, for <u>some</u>one to be highly <u>creative,</u> highly – <u>you:</u> know,- if [it's <u>framed]</u> in
         the right way.

GR3:   [Ye::ah, ah::] So <u>long</u> as you don't take it >so far as to say< you <u>have</u> to be, um,
         <u>mad</u> to be creative. It's just that <u>some</u> creative people <u>are</u> mad– <u>or</u> >whatever you
         want to call it<– (.) um >but it's not essential< to <u>creativity</u> to be mad.

GR2:   It's be INTERESTING to know what the <u>percentages</u> ar::e.

GR3:   <u>Probably</u> actually if you <u>think</u> about it <u>probably</u> not– <u>not</u> very much– maybe <u>slightly</u>
         more <u>crazy</u> people are creative than <u>non</u>-crazy people (.) but I <u>doubt</u> if there's a hu:ge
         difference actually.

However, overall, the respondent GR3 held his position as the expert over all other parties. The particular discursive manoeuvres employed appeared to be boosted by other external factors not noted on the transcript, such as note taking, which no other party did. The theme of specific discursive resources used such as 'probably' then 'actually' he successfully orientates his position as the expert/skeptic, against the voices of curiosity being encouraged by the rest of the group, including myself. Whilst I attempted to encourage what I understood to be a possibility for positivity from the other respondents, the action orientation of GR3's discourse served to disqualify my own curious positioning. However, attempts to rebel came in through the ranks as the other members used raised tones coupled with words like 'interesting', which had the effect of a rebuttal from GR3's expert discourse. The overall effect was that the emerging discourse of madness as being the source of positive and meaningful creativity was quashed. In a way, the dynamic of this particular discursive dance resulted in a scene where the suggestion of madness as a positive, was 'deemed mad', and '*reason'* was brought in to keep these ideas from becoming too far from reality.

However, this opinion changes whenever the speaker of the term madness is changed to that of mental health 'peer'. In the Extract below, GR3 struggles to find the correct term to emphasize the meaning and function of the term madness when used by mental health sufferers – peers. He disqualifies my suggestion that the meaning is different when said by a

mental health peer compared with 'other people'. The Extract follows a statement from another group respondent that compared the use (or misuse) of mental health terms in the media with that of racial terms. The respondent GR3 deflects my own suggestion, adding that the 'meaning' might be the same, and foreground the importance of who uses the terms. His suggestion that 'mentally ill people' use it and 'it's jocular' is seen in the discourses of other respondents, though only when it is 'meant' in the 'light-way'. GR3 asserts that the meaning here remains the same and that for a mental health peer to use it enables a 'jocular' function, where 'other people' use the term, perhaps indicated media due to the preceding comments, though is not clarified as who the limits of 'other's are here. GR3's discursive position of expert then allows him, after support from his peers (e.g. GR2) to classify the use of madness by these 'others' as 'less acceptable':

Extract 42 <lines 3806-3816>

I: That is:– it's a REALLY big thing, because <u>that</u> way you're saying– so if it's <u>something::g</u> you said, someone that >has a mental health< problem, (.) if <u>they're</u> saying these words then <u>THAT</u> means it's >something very different< to anyone else using them.

GR3: Erm, it may MEAN the same <u>thing</u> but it's not– it's not, i-it's not   em: (.) >accusatory< or-or em– >trying to think of the right word< I'm trying to think of- but if >mentally ill people use it about   themselves< it's <u>jocular,</u>

GR2: YEA::H.

GR3: ..whereas if <u>OTHER</u> people use it it's normally more <u>sinister</u>

GR2: Yeah.

GR3: ..and less (.) <u>acceptable</u> >in that respect<.

As mentioned, the conversation leading up to that point surrounded media usage of mental health terminology. The direction assumed to be taken by the media, as per the assertion of the group respondents, was to use terms that could possibly describe mental health problems in a person, though used in a flippant, careless way. Here the term 'bonkers' is discussed:

Extract 43 <3783-3791>

I: ..and it <u>was</u> seen in a contro<u>versial</u> way at the ti:me but then::- what does <u>that</u> term even mean?

GR2: Well "NUTTERS" and "all sorts" and "PSYCHO:", and (.) ALL OF THAT is very

---

> wron::g. (.) No disrespect, you wouldn't be able to put "NIGGER" in em:: [the paper
> or a RACIST REMARK OF ANY SORT.]
>
> GR3: [Well I was just going to say in a way] it's the kind of equivalent of,
>
> GR2: IT IS as ba::d.
>
> GR3: ..<u>black</u> people using nigger. Because if you ARE::– if you DO >suffer from mental
> illness< you <u>don't</u> mind calling yourself "bonkers" or-or   – but you don't want other
> people calling it.

In Extract 43 an accusation of mental health terminology being used in a flippant way is suggested by GR2. This frames the use of mad-words in a careless, reckless manner, rather than a 'light', jovial usage of 'mental health terminology' as seen previously. The tone of GR2 also suggests a personal attack and a sense of victimhood through discrimination. Her speaking role switches to that of a victim, defending her rights as the discriminated against. This is taken further when she compares strong racially sensitive words that are no longer allowed to be used in the same way in the media.

GR3 asserts that the self-use of these words would change the function of this discourse to have a different effect, just as it has with racial terms. Respondent GR2 begins to suggest that the use of these types of mental health terminology are not seen as equivalent to racial terms in the media currently. What she later calls 'mentalism' appears to be the attempt to begin to show that the (mis)use of such terminology **should** be seen as mental health's equivalent to racism:

> Extract 44 <3838-3850>
>
> GR2: AND YOU'RE <u>NOT</u> ALLOW:ED TO BE <u>RAC</u>IST OR <u>SEX</u>IST, so WHY SHOULD
> YOU BE ALLOWED TO BE::– >WELL LET'S MAKE A WORD UP!<
>
> GR4: Prejudiced.=
>
> GR2: =Mentalist.
>
> GR3: Yeah.
>
> I: Ye:ah.
>
> GR2: You kno:w? (.) And they <u>DO IT</u> IN THE <u>PAPER</u> and I think, "That's <u>wrong</u>."
>
> GR3: Yeah.- And I <u>THINK</u> probably– I mean times <u>are</u> changing and-and I <u>think</u> (.) in time
> >probably not< (.) <u>all</u> that many years it will become (.) <u>not</u>-acceptable to use sort of
> – >if you like< 'mentalist' terminology.
>
> GR2: OH: I ho:pe so::. *((breathy, soft tone))*

At the end of the conversation segment, the respondent GR2 continues her emphasis on of the victim-protester role, with the emphasis on 'hope' indicating that GR3's preceding comment would be favourable though without certainty. The direction of GR3's comment asserts that there **is** a change in the current status of public attitude towards acceptable mental health terminology. It this way he frames GR2's 'mentalist' as a construct that is likely to come into existence and serve the similar function of the term racist.

Previously in this analysis we can see that the function of the term madness could be seen in a different light, whether it be used by a fellow mental health sufferer and in some cases, if obviously used in a light, jovial manner. It was even changed in retrospect to look at ways in which celebrities could be changing the derogatory discourse to that of the celebrity norm. Again in retrospect, the idea that 'creative people' could have madness as the source of their 'power'.

In taking a similar social movement of adjusting a construction through the de-construction and re-construction, the idea of re-claiming madness is another area that could be seen within the interviews. This was not limited to retrospective ideas of how people (or their madness) can be re-positioned, or as a future hope for media's misuse. Instead terms such as madness were de-constructed with the idea they can be re-constructed to serve a different function in present and future contexts.

3.5.3 Re-claiming Madness

In the first instance where we see the re-framing of madness is through the use of existing repertoires. Here respondent 1 changes the direction of focus outward, to society, and how they can be guilty of madness, though without been deemed mad:

Extract 45 <lines 707-720>
R1:   'Cause >it's kind of< its very (.) it's very <u>ea::sy</u> to see sort'f the <u>word</u> madness is being emm something that <u>society</u> can suffer from just as much as an individual (I guess),
I: Okay *((curious tone))*
R1:   Eh and therefore your mo::re, your closer to to to people y'know, you don't have to worry about the division of of your diagnosis, th't <u>THAT</u> creates stigma.
I: So:: it can be applied to society? (.) emm.
R1:   Yeah definitely. [I think]
I: [<u>O</u>ka:y] Emm (.) >can you think about<, ways in which:: it can be in

R1: =Well we had the roits (.) didn't we? And we saw a lot of people acting in a particular way mm and that was <u>shear</u> and <u>utter</u> <u>madn</u>ess *((whisper of last word))*

Interestingly Respondent 1 choses to say madness is something 'society can *suffer* from', as can an individual. However, the sense of suffering was not a discourse I was familiar with until he directed the focus to acts of mass rioting in London. This linked with ideas about how behaviour can be seen as madness, seen earlier in the analysis. However, for respondent 1, speaking from his role of mental health survivor, he asserts that the 'division' caused by the construction that madness is for the mental health creates the second construct of stigma, which has negative social functions. It is not clear whether respondent 1 feels the rioters were experiencing madness, but the ability of the term to fit for this Extract in general society appears to be enough to dissolve the division of mental health versus society. Although 'people *acting* in a particular way' is deemed by the respondent as 'madness', this *deeming* describes their *acts* rather than *them.* This differentiation is seen again on the last line where respondent 1 proclaims '*that*' rather than *them*, was 'shear and utter madness'.

In the group forum, one of the respondents explained that the process of changing the meaning of madness is already occurring in India:

Extract 46 <lines 3997-4004>

GR1: So– but the <u>Indian</u> film industry is now <u>using</u> – promoting "<u>bogal</u>" like we said it's <u>eccentric</u> or somebody

I: <u>Oh</u> okay.

GR2: Yeah:.

GR1 ..you know like "bogal" like madness has now been <u>related</u> to the– because to a <u>lot</u> of Indians the <u>films</u> is ALL THEY HAVE as an   <u>escapism</u>. So the– a <u>lot</u> of people, a lot of actors, whatever, they   use this word now "BOGAL"!

The respondent GR1 speaks as both a mental health peer but also as a member of another culture, therefore able to take a role of educator to the group. As such, there is no ability for the other members to refute what he says. In this Extract he declares that the Indian film industry is a source of mental diversion and perhaps therefore a relief to the other parts of their life. This builds on a previous assertion that actors are 'revered like gods' (line

4015). These 'gods' appear to have shifted the use of the term 'bogal', their equivalent to madness, to the eccentric, 'mad hatter' style noted by other respondents, but also as something to aim for, in the way GR2 attempts to re-position 'creative people' in general as holding as the source of their creative power.

At first, there seems to be a similar pattern within the U.K., though with psychiatric terms. The respondents who identify as British suggest that there is a positive 'spin' on mental health with 'celebrities':

Extract 47 <lines 3878-3886>

GR3: ..it->it's a kind of< a badge of HONOUR now to be labelled manic depressive when in fact it certainly isn't that, it's fa:r more of a problem.

I: That seems like a new shift as well.

GR2: Well YES::!-

GR3: -It seems to me. >I MAY BE WRONG< [but that's] what it...

GR4:   [NO::]

GR2:   [No no no::.]

GR4: Especially the young POP STAR:S as well.

Even here there is a discourse of 'us' and 'them' with 'celebrities' and 'non-celebrities', with a momentum of assumption spreading and being encourage amongst peers. Here the idea that having a diagnoses mental health issue could be seen as something to be proud of when a celebrity is judged as inaccurate by GR3. His peers concur with this assumption at first. However, he then adjusts this to suggest parts of this changing social discourse could be useful for mental health acceptability in general:

Extract 48 <3855-3862>

GR3: [The MORE people, artistic people or whatever], who are deemed as mentally ill,

I: Yeah.

GR3: ..then >the mor:e it becomes acceptable< to BE that way.

GR4: It's fashionable [then.]

GR3:   [Well yeah] actually yes.

GR2:   [Well one in fou:r.] YES, >I believe< biPOLAR's quite fashionable now.

When talking about terms that appear to have been or are currently seen as similar to madness, the group respondents looked toward a role seen as 'mad' in the past, perhaps similar to the bogal term re-claimed in Indian film now. They explained the role of the court jester, and how the use of this term, could be seen and related to very differently:

Extract 49 <lines 4125-4159>

GR3: I think MAYBE (.) in <u>earlier</u> times people were more ACCEPTING of <u>difference</u> and of-of-of craziness than we are <u>now</u>.

GR4: I <u>agree</u>. I agree with that <u>totally</u>.

GR3: We had the court <u>jester</u> (.) that was <u>clever</u>, >I think<, although they call them fool as well. But I think th-they were <u>talented</u>. I WASN'T THERE.

GR4: It doesn't SEEM so <u>insulting</u>

GR3: NO.

GR4: ..and <u>negative</u>.

GR3: No, the term <u>fool</u> was not used <u>derogatively</u> at all until it was – it was-

GR2: -And the <u>gooseberry</u> [fool's very nice.]

GR4:   [And the village id]iot was a kind of <u>fun</u>,

GR3: Yeah!

GR2: Yes.

GR4: ..it was not– (0.2) I-I-I agree I think that it's *((mumbling))*

I: It <u>seems</u> that that person had a <u>role</u> *((questioning tone))* then?

GR3: If you like, yes.

I: And:: (.) it's odd to think em: (.) how– I mean WHAT image comes to   <u>mind</u> really when you think about that person in that role, erm.

GR2: Well I think I PROBABLY WOULD FEEL quite <u>maternal</u> towards them.

GR4: Yeah.

GR2: <u>Because</u> if they have– are unable to be <u>educated</u> or whatever, only reached to maybe the level of 11 or 12::, you would WANT TO <u>care</u> for   them and look <u>after</u> them if you had any <u>empathy</u> or <u>caring</u> feelings.

I: And there seems to be <u>there</u>, it's easy to em:: RELATE to that person?   >It <u>sounds</u> like you're saying< there's <u>something</u> there that you would <u>understand</u> and want to – in that sense you're saying look <u>after</u> them.

GR2:	<u>Child</u>-like.
GR4:	And <u>ACCEPT</u> them.
GR2:	Yes, and <u>ACCEPT</u>.
GR3:	<u>ACCEPT</u> I think is the word, isn't it?
GR2:	I don't have a problem <u>accepting</u>.

In this longer extract, GR3, under his expert subject positioning, explains that social reactions to 'difference' and 'craziness', was different in the past, relating this to the Extract of the court jester. Without any encouragement, this proposal was immediately verified and accepted by his peer GR4. The way in which GR4 positions the role of this jester appear to be very similar to how GR2 positions individuals in creative industries nowadays. Being about to inhabit a position of 'clever' whilst being called a 'fool' seems to foreground their 'talent' as their identifying feature. Looking towards this past, the term 'fool' is removed from derogatory function also.

My reaction suggested a role within society, though only partially validated by GR3. Instead, looking for their reaction this retro-constructed character GR2 was able to provide an emotional reaction, framed as maternal. GR2 created a bigger construction around this imagined character to explain her maternal reaction.

In lines 4152-4155 my attempt to make a hypothesis can be seen. This served to offer a different discourse, breaking down disconnection and distancing from 'difference' towards the opposite: a person who can be related to and whom one would want to connect with. This resulted in a general consensus amongst the group that had a function of 'acceptance'. GR3 concurred that 'accept' was the right word and his peer affirmed that the social function of 'accepting' is something she would be willing to do.

Chapter 4 - Discussion

This chapter has a number of objectives to: 1) recall the original aim of the study and then to summarise and draw initial conclusions from the analysis; 2) locate discourses within current research debates and relate them back to the current finding; 3) outline implications of the current study on research and clinical application; 4) provide a critique of the current study; and 5) conclude with reflections on my epistemological/methodological position post-research will then conclude the chapter.

4.1 Aim of current study

The aim of this research study, as outlined in the earlier chapters, was to explore the various constructions of the term madness for mental health service users, and the perceived consequences of various discourses on *madness*. The analysis of the interview data provides some initial insight into the ways in which madness can be perceived and used within different contexts (e.g. in the media, amongst friends/family, in professional use).

4.2 Identity parade: Reviewing the identities used

As mentioned in the analysis chapter, the ways in which the respondents positioned themselves appeared to influence what discursive manoeuvres were then available to them. The use of these different voices serves to achieve different social actions. Before summarising the findings from the analysis, it is therefore pertinent to explicate the different identities, or the 'speaking from' positions that allowed the constructions of the term *madness* to be conversed in particular ways.

There were many different subjective identities used throughout the analysis. No one participant identified themselves 'as a Mad Person'. However, there was strong support for the idea that a person could be seen or 'labelled as mad'. The identities chosen generally included: the mental health patient, a member of general society or an expert/survivor of the mental health societal experience. Within the identity of the mental health patient, respondents varied as to whether they could talk 'with knowledge' or 'without knowledge' of what madness means. Interestingly, the only respondent who spoke of a 'true meaning of madness' was someone who hesitantly identified himself as a mental health patient but also as someone 'without knowledge' of this thing called madness. The subject positions, as they are otherwise known, can be more or less divided into talk from the view of the 'voice of reason' ('normal' member of the public, and/or a general health patient) or the 'voice of unreason' (mental health service user, or 'the other', the mad), as Foucault (1965) and his successors describe. The different identities that the respondents adopted appeared to serve a

number of functions:1) Eliminating self from madness; 2) Being able to talk as 'a normal'; 3) Talking as a 'person' who is externally labelled as mad but whose opinion is not only valid, but an expert by means of being a veteran.

4.2.1 Identity parade: The Unknower.

Some respondents made attempts to distance themselves from a label of mental illness, despite being told they have a mental health diagnosis. In this case, their diagnosis was shifted towards something 'neutral'; a medical description. As seen in the analysis, this is most obvious with respondent 2 in the individual interviews. As a result, his ideas on madness were positioned as 'guesswork', stemming from media replications and ideas of asylum days, rather than something that he could safely draw upon from his own subjective position. This may replicate what Foucault (1979) terms 'internalization', whereby a person's viewpoint is subjectively believed to come from themselves but is the internal reproduction of ideas imported from those in positions of power/authority, in this case, the media. Furthermore, this respondent was insistent in evading any attempt to express opinion about 'the voice of reason', the perceived voice of mental health professionals. This may have caused a degree of censorship in his responses, perhaps due to the researcher's position within the mental health field or for reasons of power, in the sense described by Foucault (1977).

However, the use of the phrases such as 'I think, I THINK [sic] so, but I don't know that' established a means to avoid having personal knowledge of mental illness, therefore the internalization that was shared was limited media reproductions of madness. This choice to position himself away from certain knowledge suggested that there *was something to be known* and positioned the researcher as the 'expert' on the meaning and use of mental health terminology. However, this respondent later clarified that he felt the term 'insane' is the most powerful and active term used to describe someone with severe mental health problems from his own perspective. Using this un-knower identity, wearing the 'voice of reason' hat, this respondent championed the idea that *madness* is also something neutral, flippant and non-offensive. This will be explored further in the later parts of this chapter.

4.2.2 Identity parade: From reason to (un)reason.

The other identity used throughout both individual and group interviews was positioning oneself as someone who spoke through medicalised discourse. This established an 'y'know' feature in which knowledge was presumed to be shared amongst speaker and listener (researcher included).

However, this also served to allow for stronger subject positions to be established, which enabled the speaker to show awareness of the 'voice of reason' discourse and challenge established constructions through an expert 'voice of unreason'. This expert came from personally gained knowledge through self-experience, or from a 'veteran', 'survivor' discourse at having been through the system and allowing the self to speak via 'reason' or 'unreason' identities in order to express diverse views on madness. Through the use of this dual identity, more 'established' general discourses were able to be challenged and the researcher was recruited 'into the fold'.

4.2.3 How do these identities identify madness?

The analysis indicates a number of discursive positions available when the term madness is explored by mental health service users. Overarching these positions, the term madness itself was placed within a continuum of similar words (e.g. *crazy, insane, abnormal, bonkers, and criminally insane)*. The particular ordering of terms in this continuum varied from person to person and therefore although it is of interest that some words appear to be *more* mad than others, we cannot say they are representative constructions for the group and therefore cannot place particular emphasis on any word over madness. However, the analysis did indicate that for some respondents, *madness*, was not the *maddest* a person can be. In such cases *insane* or *criminally insane* was positioned as 'the ultimate extreme' of mental un-wellness. The term madness was however actively held within the language of the respondents. The constructions and function of those constructions showed variation in their meaning, intention and consequence for the speaker and the receiver.

4.3 Constructions of madness

Through the use of different identities, the analysis can be summarized by the following broad discourses:

The analysis chapter indicates that the term 'madness' can be placed within a continuum of similar terminology such as insane or crazy but the use of the term has varied functions: 1) Flippant non-offensive or labelling term; 2) Labelling and harmful, with or without intention to do so; 3) An accurate description of 'an experience' and; 4) Something labelling but positive, indicating creativity and uniqueness.

Flippant Madness. The first function of 'madness' was outlined as something that does not carry any offensive weight. Instead, it was positioned as a phrase used in a light-minded manner to describe a personality trait of someone, or as a phrase in language to

describe something 'silly'. The sense of difference is indicated but this difference (from the 'normal') is within the boundaries of normality. For one respondent in particular, the term *madness* is 'so far away from mental illness, that it doesn't really mean mental illness anymore.' The 'accused' is therefore not excluded and the term can be used negatively (without intentional harm), or positively, to describe a positive difference from normality, though again, still within 'allowed boundaries'. Through the use of madness constructed in this way, the term is not seen as labelling in the 'branding' sense but rather as a temporary label or a 'bit of madness'. Having 'a bit' appears acceptable to those who use the term, though there is variability in *how* it is received. Therefore, despite *intention*, the end impact of the *flippant* use of madness may be injurious to those who are receiving this 'bit' of labelling.

Harmful Madness. However, from the counter-view, the analysis indicated that for some respondents, the term madness is both labelling and harmful no matter what the intention of the speaker was originally. Furthermore, the speaker who inflicted this intentional or unintentional harm could be from either a mental health *peer* or by a member of general society. This negative construction of madness was positioned as negative when used to talk about an individual or an individual's behaviour, or even when used to describe an action or trait of the self. The analysis suggests that the 'deemers of madness' will always associate madness with something 'other' and negative, therefore whether a person speaks about someone else or themselves, they are positioning the receiver of the term as the 'other'.

Experience of Madness. Another way in which madness was perceived was as 'an experience'. Having 'an experience' of madness was not vocalised by all the respondents, though when it was, it fitted with what mental health professionals would otherwise term a 'psychotic episode'. This experience was felt to be temporary when talked about *following* an 'episode', which was seen as reassuring, rather than labelling. For the particular respondent who identified with madness being used by the mental health professional to explore or suggest an experience, it was felt that this term was accurate, 'closer to the bone' and more useful that psychiatric terminology which was felt to be more permanent - a branding that does not fade with time. This experience was thought to be something that, when correctly acknowledged through the use of the term madness, could be relieving and understood. There was also a temporality or fleeting nature to the term positioned in this way, which ran contrary to the more diagnostic terms which were understood fully by 'the expert' and not by the receiver, and perceived as neither 'removable' or 'temporary'.

Madness as a 'positive'. Lastly, madness was positioned as something positive. This varied in three ways: 1) As a positive way of re-constructing ideas of both madness and normality, which can have a contagious effect on those around; 2) As a way to self-label in a positive way 3) As a way to positively re-label madness (or similar terms) for others.

The first two variations came from a respondent in the group interview who found that after being seen by a psychiatrist, she was then positioned by her family as 'a mad person'. However, she was able to the re-construct the meaning for herself and for her children, who then felt that having experienced the reality of psychiatric services, their ideas of normality and abnormality broke down – people became people again. Despite the rest of her family continuing to position her as mad and 'contagious', her own view of madness was re-constructed.

The last identified variation was seen in the group interview. The way in which this positive re-branding was actioned differed between respondents. On the one hand, respondents were able to talk about celebrities and those in creative fields and re-construct their positive traits as something stemming from madness. Overall this was found to be 'debatable' for other respondents, although the ideas of looking back at characters of the past, such as a court jester, and reframing them as clever and talented individuals. They added that this character had perhaps a child-like quality, which enabled them to be relatable somehow, leaving some respondents to re-position their imagined reaction towards them as maternal. This invited respondents to re-frame their subject position as one that encouraged 'acceptance'. Another perspective was relayed by a group respondent who explained that in India, the term 'Bogal' has been reclaimed to celebrate uniqueness and difference, which has been absorbed as a positive trait in film stars, who are apparently revered as gods in India. Therefore, in this case, the reclaiming has already begun and re-sold as desirable for 'normal society'.

4.4 Consequences: Who can wear madness and get away with it?

One of the common associations of madness across the respondents was with the identity of 'The Mad Hatter' from Alice in Wonderland. This connection appeared to serve a number of purposes for those who used the term. Firstly, the breadth of its recognition meant that respondents were able to talk about the term and have it recognised. This also enabled them to be seen as speaking from 'the voice of reason', the majority side of society, looking objectively at a construction that is light-hearted and inoffensive. With the character being a part in a fictional tale, there seems to be some creativity allowed in how the character's mad

identity can be viewed by larger society. In denouncing the character's actions as 'silly', respondents also manoeuvred the meaning of madness into 'silliness' as opposed to something relating to severe mental illness.

The use of the reference Mad Hatter allowed a use of language understood by all the potential players of the mad debate. This would include people with experience of having a mental health problem, mental health professionals and the general public. Although the character-term served as an example of 'light' usage, it also creates an image that anyone can be familiar with, even without having contact with someone who could be described as 'mad'. The character image that appears to be recognised by all the respondents then goes further, to be allowable to describe eccentric people in society. With a comparison made to a famous film critic, one of the participants suggested that the image exuded by the individual was powerful and yet positive. Although he described the critic as being 'feared' by the creative industry, an image of strength and empowerment was echoed in his recollection. For the respondent, the label of 'mad' was conveniently sourced as stemming from an object - the 'mad hats', she wore. Interestingly, this somehow symbolised the wearers willingness to be seen as different and eccentric. Being an object, this also perhaps enabled to wearer to drop the 'mad' label when it suited her. Wearing the 'mad hats' would therefore show that the wearer wants the world to see them in a way they want to be seen. Overall, although 'different' and 'eccentric', the ability to choose how to be seen, even with madness attached, exudes an image of power, control, confidence and respect. This self-labelling runs contrary to societal labels or statuses that are given or attributed to someone (see Goffman, 1963). This particular 'mad hatter' used the label of madness to control her image and to stay 'the right side of different'. That is to say, she remained within the border of normal society, but projected an image of the 'allowed' parts of what it is to be seen as 'mad'.

4.5 Maddening ideas of 'normality'
Overall the analysis of the individual interviews from the respondents indicated something unexpected – a stronger construction for 'normality' than madness. The ominous 'true meaning of madness' was alluded to, in order to identify someone with severe mental health difficulties, though an actual image of what this might look like remained elusive. Positioning madness as *an experience* appeared to be the strongest connection to a construction of the term itself rather than a construction of what it *is not*. However, this frame of reference was voiced following a personal experience of such a phenomenon - an experience - but then creating an imagined scenario in which it would have been used

between the respondent and a psychiatrist or mental health professional. Therefore, ideas around how 'actual madness' can be talked about in a mental health setting were only enabled through a 'survivor' or 'veteran' subject position. Without this, and despite madness 'sticking around' in language, the clearest image of what madness might be is from media representations or from a much more defined societal identification of what it is not – normality.

4.5.1 What do we know of normality?

Returning to the ideas of French philosopher Foucault, we have some possible insight into the introduction of what can be seen as 'normal'. In his story of the origins of medicine, titled 'The Birth of the Clinic', Foucault asserts that the original role of medicine was not as it is today. Rather that conceiving ideas 'health' against a single standard against which one can be measured, Foucault suggests that early medicine's focus was in terms of a harmonious functioning of the individual, and that the role of medicine was to provide 'techniques for curing ills' (Foucault, 1976, p.34). In the later 18th Century, Foucault states that medicine began to fashion ideas around the 'healthy man', by study of 'the non-sick man' and a definition of 'the model man' (Foucault, 1976). At this point medicine assumed a 'normative posture' by which advice around health and dictated standards of normality (including morality) for individuals and the society in which individuals live, became cemented in modern culture. In the accounts given towards ideas of madness, such constructions of normality are so entrenched into society that what we may take to be natural, or understand as our own (what Foucault calls internalization), may in fact be disseminated from readily available powerful discourses from medicine, media and society.   Therefore, constructions of 'normality' have been established for some time and the author of this social language appears to be medicine.

More recently, according to Parker and colleagues notions of 'health' only continue to make sense when the idea of 'sickness' in constructed and compared against it. In this way, Parker asserts that constructs of "insanity', 'illness' and 'abnormality" could not exist without their 'powerful partners ('sanity', 'health', or 'normality')' (Parker et. al, 1995, p.4). The analysis indicates that such ideas remain present in the discourses of the mental health service users interviewed.

Within these discourses of normality came the idea of what constitutes madness as a counter-part to normality. This was seen mostly in non-conformist behaviour but extended to a 'state of mind' by which a person would somehow know to be beyond the boundaries of

normality. Who 'a person' would incorporate here was extended to those with and without mental health problems. This implied sense of knowledge over this understanding of abnormal behaviour or state of mind was directed towards the researcher for confirmation by some of the respondents. For other respondents, the action of directing this assertion towards the research appears to function as a self-confirmatory social acknowledgement (i.e. as members of society we all know this – we have access to a shared knowledge). Parker adds that these ideas should be 'put under erasure', by which he defines: to 'question [a word's] taken-for-granted meaning, to mark it as a problem to be challenged' (Parker et al., 1995, p.4). This idea encompasses the deconstructive goal of the current study.

4.5.2 Madness: The deviant within us all?

Much of the literature that discusses ideas of normality comes from sociology and parts of philosophy. Within the former example, the work of Scheff (e.g. 1966) is widely recognised in sociological circles. However, it does not appear to have branched out into psychology and certainly not into clinical practice. The reason it is important to highlight this is because these theories are relevant to psychology and deconstructing these ideas could promote a positive social change. Much of the early work on 'normality' has been limited in terms of its links to mental health and instead focussed on 'deviance' with regard to anti-social behaviour and criminality. A brief look at the introductory chapter of this thesis highlights the overlap of 'deviance' with madness, especially with regard to nonconformist behaviour. If historical ideas of madness created ideas of 'other' and a break from normality, then revisiting the ideas from this part of sociology is therefore also relevant to deconstructing ideas of madness and consequences thereof. The overlap of theories of power from names familiar in psychology (e.g. Parker, Foucault, Szasz, Bentall) are present in sociology. For instance, according to Becker (1963), studying the act of the individual is unimportant because 'deviance' is simply rule breaking behaviour that is labelled deviant by persons in positions of power. This would overlap with psychiatry (inclusive of general society), otherwise known as the 'voice of reason' who are enabled to judge a rule break as behaviour outside of that which society 'allows'. Indeed Becker (1963) describes rules as the reflection of certain social norms held by the majority of a society, whether formal or informal. Therefore one does not have to be 'an expert' but knows the generally held 'rules' and are attuned to noticing 'rule breaking'. Importantly, this also includes 'the self' being aware of these rules:

In Discipline and Punish, Foucault (1977) describes a Panopticon: a circular prison with a central tower that would allow for maximum observation of all the prisoners by a

warden. Importantly the prisoners would act as if they were observed, even when they were not. This self-observation lends itself to the idea of internalisation, that observations and judgements of others are believed to be our own. The idea of 'discipline' then 'moves from something inflicted on others to something which becomes internalized and we move from regulation by others to self-regulation' (Parker et al, 1995, p.60). Therefore these societal norms are not just imposed by 'the normals' but within us all. However, fear of breaking a rule just by having a human experience and reacting to that experience sounds a difficult burden to manage. This may produce a self-stigma before an individual is 'out' to others.

4.5.3 Stigma, Status, Other.

The debate on the term 'stigma' can be sourced from Erving Goffman in his seminal 1963 book where he defines it as 'an attribute that is deeply discrediting within a social interaction' (Goffman, 1963, p.3). Once having this 'attribute' a person is thought to be 'reduced…from a whole and usual person to a tainted, discounted one' (Goffman, 1963, p.3). Therefore, relating this to mental health, if a person feels they have this part within them they would understandably have reservation about sharing this with others. In doing so they risk, what the respondents in the current study have described as madness – difference from what society expects or will allow. As noted earlier, for one respondent, the act of being seen by a psychiatrist was enough to 'fit the mould' of madness in the view of their family. Goffman also describes the same positioning of madness 'by association' as the respondent endured: 'to spread from the stigmatized individual to his/her close connections' (Goffman, 1963, p.30). In his later 1967 essay 'The Stigmatized Self', Goffman talks about the stigmatised person having a sense of being a normal person, 'a human being' as everyone else, though 'he may perceive, usually quite correctly, that whatever others profess, they do not really "accept" him and are not ready to make contact with him on "equal grounds".' (Goffman, Lemert & Branaman, 2008, p.75). This may make one wonder how it is that anyone manages to access mental health services.

This is very relevant today as it would undoubtedly have an effect on how people feel they can interact with others (including seeking help) when the idea of 'a bit of madness' surfaces within them. In the current study, the term was also associated with heinous acts that 'make the headlines' and position the person's mental health issue as the cause of their behaviour. Labelling terms such as 'pycho' were also deemed synonymous with this aspect of madness. This was noted in the introduction with regard to media and public perceptions of madness (e.g. Wessley, 2012). Overall, throughout the analysis, a strong construction of

madness (in this case as synonymous with mental health), was described as something 'essentially negative' and break from 'the norm'. As this was described as a general view, rather than an ideal held specifically by those with mental health complaints, it indicates a degree of stereotyping of mental health terminology and those with an 'attribute' of a 'mental health problem'. This can be either a self-held attribute or one which is *given* to a person. Studies show that the assignment of negative attributions to these socially prominent differences (i.e., the perception that the differences or 'otherness' is undesirable) lead to separation. According to Green and colleagues, separation occurs when the reactions of others to these differences lead to a pronounced sense of "otherness" or "felt stigma" (Green, Davis, Karshmer, Marsh, & Straight, 2005). In these cases the individual's personal awareness that others are treating him or her differently due to some personal attribute is 'felt', just as it was described by the respondent in the analysis.

The analysis also indicates there are different ideas of what constitutes mental health, and for some, the action of being seen by a psychiatrist is enough to be tarred 'mad' by those around us. Even in making an appointment to see a psychiatrist, the person is already 'a patient', speaking to 'a specialist'. Therefore how can one be able to talk on equal grounds. This links to Barrett's (1996) assertion (outlined into introduction chapter) that patient's narratives are only included as part of a diagnostic construction. This reduces opportunity for equal talk in a number of ways: 1) the subjective position of feeling unequal inside the medical setting; 2) The discursive manoeuvre of voice being translated into 'patient talk' and transformed into a medical construction; 3) the 'person' being transformed into 'patient', which can equal a label of 'mad' for some members of 'normal society'.

Goffman is also cited for his work on 'status'. The most relevant area of status for the current study is the idea of a master status (Goffman, 1963). This is generally depicted as a stigma or attribute to an individual that takes precedence over all other parts of their ascribed (or otherwise) identity. Goffman related this to physical disability but also to those who may be discriminated against due to stigma. In mental health, this would mean that an individual would first be seen as a 'mental health patient', or 'mad', and then as whoever, mother, father, employee. This was reflected to impact on the person's perception of ability to function in the 'normal world'. Worryingly, current changes in the clinical domain indicate that 'the normal world' is becoming increasingly harder to inhabit.

4.5.4 Normality crisis.

This issue is more pressing than it may initially seem as the barriers of normality are shrinking. What is 'allowed' is changing. In the newest addition of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; APA, 2013), which was noted in the introductory chapter, there have been updates which have proved controversial for a number of reasons. One example, which is representative of the type of changes decreed, is the adjustment of Major Depressive Disorder (MDD). Previously, a person would be allowed 'diagnostic immunity' if symptoms such as persistent low mood, loss of enjoyment and pleasure and disruption to everyday activity followed a recent bereavement. However, the exception (or exemption) has now been removed. Grief, much like many other human behaviours and previously 'natural' processes, are now subject to medical scrutiny – grief is mental illness/madness. The latest edition has been received scathing criticism from a number of bodies including the British Psychological Society, who issued an official response to the DSM-5, noting the increasing medicalization of normal human responses and behaviours and recommended a rejection of a 'top-down', 'diagnostic fit' approach (BPS, 2011). As Winnicot famously described:

The capacity to become depressed, to have a reactive depression, to mourn loss, is something that is not inborn nor is it an illness; it comes as an achievement of healthy emotional growth ... the fact is that life itself is difficult ... probably the greatest suffering in the human world is the suffering of normal or healthy or mature persons ... this is not generally recognized. Winnicot (1988, p.149)

More recently, Harper (2013) describes the current dilemma faced when a person weighs up whether to access services or not. This adds to the consequences self-stigma as 'many people in distress and their relatives seem to feel that without diagnosis, they will, in some way, be "blamed" or seen as morally responsible for their distress. That a moral discourse is so culturally available as an alternative to a discourse of psychiatric diagnosis hints at its powerful social functions' (Harper, 2013, p. 80). Therefore a moral discourse exists at a societal level that created a push and pull of responsibility. Harper adds that if we are to move away from a diagnostic discourse, we need to consider how we address these social functions (Harper, 2013). If these discourses are held at a societal level it may be that some of the constructions (and consequences thereof) can be located within a more general medium – the media.

4.6 Locating constructions of madness: Media

As noted earlier in this chapter, the analysis also indicated that the use of the term 'madness' is not always flippant. That is to say, it can be both intentionally used to indicate something unintentionally negative but with the consequence of being potentially offensive. Therefore despite there being variety in terms of how madness can be intentionally used by a person, it is evident that the influence of the media and it's chosen style of wording is not acceptable those with mental health concerns. The analysis points to common themes depicted in media headlines where a person who has committed a serious crime and has a mental health problem will 'make the front page', and a media-chosen synonym for mental health is used, often with 'mad', 'insane', 'bonkers', 'psycho' or 'nutter' being used interchangeably. According to the respondents of this study, these terms are not synonymous and not acceptable.

According to Philo (1994), media items that link 'mental illness' and 'violence'' received front page coverage whereas the contrasting 'sympathetic' positioning (such as health columns or problem pages) received back-page treatment. Philo (1994) found that the 'violence to others' category of coverage outweighed the 'sympathetic' alter by a ratio of 4 to 1. In the current study, the effect of such careless usage was reported as a temporary yet powerful increase in the social stigma of mental health. Specifically, respondents reported that although the person being written about may have a completely different diagnosis, the effect is nonetheless like 'a torch shone on anyone with mental health problems'. Indeed Philo (1994) argues that media presentations are also 'a very powerful influence on beliefs about the nature of mental illness' (Philo, 1994, p. 173), and worryingly suggests that this influence can override an individual's personal experience. This ability to override could have influenced the interpretative repertoires used by the respondents and thus the information. The emotional impact of shame and anger, discussed by Scheff (1999) as a consequence of labelling could be felt in the tone of the respondents when discussing this particular social phenomenon.

Some of the terminology noted in the introduction chapter are present in the interviews. Nairn's (2007) reports of media depictions of madness indicated an overlap with the respondents' own constructions. Firstly, the idea that someone would be 'out of control' is seen in the reports of murderers who have mental health issues. For one respondent, a person who is 'criminally insane' conjures an image of someone who has no control whatsoever. According to the respondents, the focus of the media narrative is that the mental

illness is the cause of the terrible acts, but that the person being talked about becomes the label. The analysis indicates that there is still is a mis-understanding of someone with mental health problems as someone who is mad. The additional identical citing of 'possession' as a description of someone with a mental health difficulty also mirrors Nairn's (2007) depictions. These examples were assumed to be both negative and stemming from a lack of knowledge over mental health and how to talk about people with mental health concerns. These suggest that media depictions of madness and mental health may relate to constructions that continue to exist in the public psyche. Furthermore, if Nairn (2007) is correct in his suggestion that society relies upon recycled vocabulary, metaphors and narrative fragments (not just those seen in the media), the findings from this study indicate that this general discourse exists and that it will persist.

Another construction that was identified from the analysis was the idea of someone with a mental health problem being related to as contagious. Within this negative context, this association of contagion apparently spread to those who surrounded the identified person. The idea of contagion is part of a wider discourse which Parker and colleagues have reported (Parker et. al, 1995). In their statements, they suggest that this produces a 'demonising' effect, positioning the individual as 'the other' and therefore speaking from the voice of unreason.

Barrett (1996) conversely describes the ability of clinicians to use 'lay' language in determining official diagnoses, describing patient's behaviour as 'odd' and using lay language to create a bridge to discuss mental health symptomology (e.g. they are 'settled'). This shows a mutual understanding of lay constructions of madness that not only are both parties aware of but both are able to make use of.

4.7 Reclaiming: Madness or Normality?

As noted in the introduction, Thomas Scheff has been cited as the main figure in the debate of Labelling Theory. In his recent work Scheff (2010a) appears to mirror some of the narratives proclaimed in the current study. He states that 'eccentricity and unconventionality may be labelled as mental illness' (Scheff, 2010a, p. 232). Furthermore, he goes on to support the position taken by the respondent GR3 in suggesting that 'unconventiality is accompanied by a high level of eccentricity' (Scheff, 2010a, p.232). As mentioned earlier, respondent (GR1) outlined the changes occurring in India, where the term Bogal (the equivalent to madness) has been reclaimed by the film industry and is now championed as a positive trait of difference through eccentricity. On the surface, this does not appear to have

taken place in the UK at a recognised level. However, the Mad Pride movement described in the introduction (see Curtis et al., 2000) shows that some re-claiming of the term for these purposes may be gaining ground. If this the case, where does this leave the traditional debate of labelling theory?

In recent work, Scheff (2010b) explains that he feels the ideals of labelling theory failed. He hoped that initially labelling theory could provide a social alternative to the medical model. However, Scheff states that the reach of the theory became limited to sociology, and did not extend to the public domain it was meant to upon impact. However the language that Scheff uses does appear to correspond to similar interpretive repertoires used by the respondents of the current study. In particular, the idea that anything outside 'societal norms' positions a person as 'abnormal', within the realms of madness provides an overlap of labelling theory and discourses seen in this current context. With a quick glance at some of the quotes from the respondents, it can be seen that a construction of 'us' versus 'them' is persistent. In not thinking or behaving in a way that 'society expects' respondents felt that madness has come to embody this labelling or positioning – you are one or the other. The idea that this is a construction, or a recycled assumption on societal views is also present. Therefore the psycho-social discourse debated by Scheff may indeed have penetrated into some general awareness. However, the ability to choose which side of the divide to position oneself appears to lie with those on the more desirable end – normal society.

The current study indicates that ideas of normality may be clearer in the mind-set of society than madness. Therefore, this provides an opportunity to create a debate or 'put under erasure' (Parker et al., 1995) both normality and madness. One could tentatively infer that madness has been constructed to mean little more than 'opposite to normal' and therefore there is less to deconstruct than there is to're-construct'.

4.8 Implications of the findings

The current study provides some initial insight into the constructions of the term madness held by a small group of service users. Whilst there appear to be differing views on what the term has come to mean, there is an indication that there are four different types of usage of the word. At this point in the discussion these ideas will be re-stated for summation: 1) Flippant non-offensive or labelling term; 2) Labelling and harmful, with or without intention to do so; 3) An accurate description of 'an experience'; and 4) Something labelling but positive, indicating creativity and uniqueness. Each of these areas can be helpful in dismantling currently held positions held on the term madness.

From a clinical point of view, the use of the term, and similar terms should be considered from both a professional and user perspective. This is because the current study suggests that the source of knowledge related to the term is the same for everyone, from literature, media and cultural/familial dissemination. The study also provides a window into the positive use of the term as used in individual professional-client environments. Instead of the sole use and explanation of psychiatric diagnosis to fit the person (or person's) symptoms, the additional or alternative use of the term madness to identify an experience the person may have gone through is available. If building on Barrett's (1996) observation of using lay and clinical terminology to bridge understanding, this would indicate something to which patients could relate and understand more easily than clinical terms.

The analysis also revealed that if used in this way, it would indicate a temporality for this experience, a passing phase. Indeed Parker and colleagues advise that 'we have to connect language with the institutions in which it is used' (Parker et. al, 1995, p.4). However, they add that 'we need some account of the 'irrational' or the 'unreasonable' in human experience which language excludes. It excludes what it deems to be irrational at the very moment it constructs it' (ibid). Therefore this allowance of language should be two-way. Rose (2009) on the other hand favours increasing acceptance rather than 'restrictive normalisation'. In this way, Rose would allow those with experiences of distress to be able to 'come out' as coined by the LGBT community. Scheff (2010b) highlights the problems with automatic labelling (with stigma consequences) and normalising (with enabling consequences) and instead recommends discourse that re-connects the person as a normal member of society, which can occur through non-clinical conversation. However, normalising may be difficult for professionals to relay when talking about (or around) psychosis. Instead a movement towards 'acceptance' in the way Rose (2009) advocates may help normalizing conversation.

Another concept that is currently used in mental health services is 'recovery'. Rufus May, a Clinical Psychologist who has experienced and been treated for schizophrenia in the past, has discussed the importance of different factors in seeing 'recovery' (May, 2014). Instead of using psychiatric diagnoses, May describes using 'individualised mad experiences' and 'individualised labels' rather than macro labels that create assumed individual and societal repercussions - usually of failure and permanence. These macro labels are felt to hinder the process of recovery and add to the real-world consequences of mental distress (stigma, unemployment, poor housing, loss of rights etc.). May identifies these consequencial after-

effects as being more difficult than recovery from the distress and confusion itself. (May, 2014, p.2).

Therefore, in liaising with other professionals, psychologists may be able to support recovery for the service user, not just from clinical symptoms. The use of clinical language is important in teams as well as with patients. This study indicates the use of the term 'mad' to describe an experience may be useful (as suggested by one respondent). However, the de-construction of terms and the use of service user's language if it includes terms such as *madness*, may be more fruitful.

Many clinicians reading this may find these statements 'interesting' as opposed to practically applicable. Diagnostically speaking, 'psychosis' is perhaps thought to represent a true experience of *madness*. In the introduction chapter, the idea of 'psychosis' being synonymous with *madness* is present in current literature. Some may feel that moral, social or philosophical ideas proposed here 'go out the window' when dealing with this type of complaint. However, research from Garrett and colleagues (2006) showed that when exercising a degree of reflexivity and guidance, clinicians were able to 'normalize' psychotic symptoms by locating analogies to psychosis in their own mental life. They found that 'transient' disruptions occurred frequently meaning 'at least some psychotic symptoms are a pathological expression of psychological processes latent in and widely distributed throughout the general population' (Garrett et al., 2006, p.595). This may suggest that there is little need to maintain the 'us' versus 'them' divide, and that it may be clinically and socially useful to relocate focus into what it is to be human.

4.8.1 Clinical applications, considerations and future research.

In this section the implications in terms of clinical practice and research will be separated. This is to allow a degree of space for social action to be highlighted before returning to the shortcomings of the current study and recommendations for further investigations.

4.8.2 Implications for clinical practice.

Counselling Psychologists sit in a unique position, not only within mental health services but within the community. Therefore, they are suited not only to voicing concerns over clinical practice on a number of levels but also as agents of change in the community. This could include, GP, schools/universities, Local/National Health Authority, Parliament and within Service User Groups. A degree on independence from external institutions

facilitates this role. As such, Counselling Psychologists have free rein to take forwards concerns such as the BPS on DSM 5 updates and work within with levels of public debate to ensure that policies and procedures (e.g. NICE guidelines) are aware of all the voices (reason and unreason) and decide upon future action based on a wider body of opinion than is currently endorsed/encompassed.

4.8.3 Empowering reflexive and reflective clinicians – An era of the deconstructionists?

As noted above, Counselling Psychologists hold a number of positions. One of these is in Multidisciplinary Teams (MDT) in private or NHS groups. The underpinning philosophy of Counselling Psychologists is such that all human responses to the world are seen as equally valid. This means that as a profession, whilst acknowledging his or her expertise, he or she does not automatically assume the hierarchical position of expert in relation to the client 's experience, and can instead advocate for the client's experience (Orlans & van Scoyoc, 2009; Woolfe, 2010). This philosophy may prove difficult for other professions to accept, especially when psychiatry is usually positioned as the *most responsible* person authority in charge of an individual's wellbeing. However, from the current study and on reflection of relevant literature thereafter, it seems that the perception of such (in)equality may be relevant in terms of people accessing services. It may also impact on patients who remove themselves from services, in order to retrieve/reclaim normality status and dissociate from mental health 'attributes'. This may be familiar to those who observe patients who disengage and try the 'cold turkey' approach to medication removal.

In terms of context, Counselling Psychologists work in public (Primary and Secondary Care) and private practice, lecture, research and provide consultation. Therefore they are uniquely positioned to encourage a degree of deconstruction on terminology and encourage reflexive practice. Rather than separating out such behaviours as 'abnormal' and 'mad', Psychologists can describe and encourage other mental health professionals to act in ways that increase understanding and compassion, grounding them in their appropriate social context.

On a skill level, this would be supported by Counselling Psychologist's ability to formulate (HCPC [professional practice guidelines], n.d., p. 17). As proposed by Johnstone (2010), the strength of psychology lies in its use of formulation: in contrast to psychiatric diagnosis which reduces meaning and context to a list of visible symptoms, formulation enables restoration of meaning to a person's distress, placing their problems within an

understandable context. In MDT meetings, a degree of group de-construction, refection and formulation should be encouraged.

Counselling Psychologists could also encourage a range of clinicians (as well as NHS managers/stakeholders and politicians) to attend Service User Forums where a process of deconstruction and re-construction in mental health terminology and functional consequence of currently held constructions can be understood in terms of real-world impact and service provision.

4.8.4 Immediate and future impact of the study.

At present there is an ongoing movement from mental health charities such as Mind and ReThink to bring mental health into the open and give the 'general public' an opportunity to talk about mental health and to support those who experience mental health concerns. This has been named 'Time to Change'. Over the course of this study it has gained momentum and exposure, no doubt creating a means to highlight the difficulty normally faced by those who experience mental health distress. It highlights 'statistical information' (or constructions) such as 1 in 4 will have a mental health problem. However, this does not challenge the assumptions of mental health labelling and unwanted 'membership' of the mental health community itself. Instead we might look to provide more overlap with LGBT community with media posters re-claiming terminology (e.g. 'some people are gay – get over it' from Stonewall). Something similar, such as 'people experience mental health problems – get over it' might be an interesting way to challenge current assumptions. As Meg Barker reflects:

We need to move to a more biopsychosocial model of distress. We need to recognise that distress – in its various forms – happens for complex multiplicity of reasons, and that we can have a personal role in exacerbating and ameliorating it, but that acknowledging such a role does not mean that we are totally 'to blame' or 'at fault'. We need to understand that we can all access support rather than it being something only for a certain few, and that different things work for different people at different times. We need to challenge either/or illness/wellness dichotomies and to consider other possible models and metaphors for distress. Barker (2011)

The current study will be disseminated back to the Service Users who took part in the research, as well as any other service users and NHS staff who wish to receive this information. An executive summary will be made available to them as well as reporting back to the NHS REC Ethics Committee. The thesis will be reviewed and converted into a publishable format so that it is accessible to any interested parties. At the time of writing, the project has been accepted for a poster presentation at the DCoP 2014 annual conference. The researcher's role as a visiting lecturer for MRCPsych students (Psychiatry Training

Programme) will also provide a means to reflective, deconstructive thinking in diagnosis and clinical practice.

4.9 Evaluation of the study

As noted in the methodology section (see 2.2.3 Validity and quality: scientific rigor), the usual notions of validity and reliability should be considered differently with a qualitative project, especially one viewed from a social constructionist perspective. Some of the strengths of the current study are that the inclusion of participant validation within the interviews, maintaining ecological validity by interviewing within a familiar environment and engaging reflexively throughout the study, including the write-up. The study engages with the notion of deliberate limited reliability in terms of terms of generalizability, however the addition of the studies on stigma, labelling, status and diagnoses, show that the sample may be representative of service user discourses.

Issues of validity were addressed by the open ended flexible approach taken whereby the researcher's assumptions on the meaning and relevance of concepts and categories as qualitative research uniquely allows (Willig, 2008). A degree of participant validation encouraged, rather than adhered to, in order to 'check-in' with the concepts discussed by the researcher and to clarify statements of the respondents.

Qualitative research is less concerned with reliability as it does not try to gain consistent answers that can be generalised. However, as the methods and reflexive activity of the researcher were outlined clearly, they may be replicable and used to find similar constructions as Silverman (1993) endorses. Additionally, as Willig (2008) notes, when a phenomenon -in this case constructions and functions of discourses- are found, it shows that this aspect of experiencing the world exists, and may exist for others. Therefore, although this research does not claim to have revealed some ultimate truth or that the opinions shared are the same as for all service users, the data gathered remains rich, relevant and provokes some thoughts for further research.

Issues and solutions. One of the issues faced by the researcher of the current study was how best to collect and analyse data from the group discussion. At the time of writing, there is no specific guidance as to how data from focus group discussions can be transcribed and/or analysed by Discourse Analysis. This could be developed further in order to allow the importance of turn-taking, 'rupture' in the interview, and provide additional non-verbal cue information that could be realised via video interview methods.

The current study had a small sample size. However, the type of data being collected and the amount of time needed for transcription and analysis meant that this number was acceptable for the aims of this doctoral research. If a larger study were to be conducted with similar aims, the sample size would not need to be much larger if using discourse analysis.

4.9.1 Future research.

Future studies may benefit from retaining small groups, in order that the treatment or assessment of the topic be conversational and open enough for all parties to feel able to share where they can. The ability to feedback findings in a more formal way would lend itself to a Grounded Theory methodology. However, without an initial study such as that being undertaken here, there would be a degree of loss as ideas may be censored or altered if taken too far beyond a usual 'debate format' to which these service users are accustomed.

Given the variability in which respondents in this study volunteered an opinion on a mental health professional's ideas on madness, a further study may look towards obtaining different population groups which would include: NHS professionals (mental health and general health), NHS service users, non-NHS individuals with mental health concerns and general members of the public without a mental health concern. In addition, the use of documentary data could be used to establish an analysis of generally held discourses on madness. In the journey of this research, the flurry of relevant media depictions of madness were evident to the researcher. A further story may even track media depictions as they occur during research in order to capture present, rather than historical portrayals of madness.

Some themes of future research might pick up on areas which appeared interesting and relevant in the current study but were beyond the scope of the research question:

1. 'Continuum' terminology – What means what for whom?
2. In-group stigma – disassociation from within. How mad is mad and what kind of human distress can be admitted without loss of master status?
3. Video interview and techniques for analysing micro conversation – dominant versus quiet voice. What is not being said in vocalised discourse.
4. Service User led Research on necessary conditions for equal talk inside and outside of mental health services.
5. Demystifying normality: What is normality? What are the boundaries? Who decides what is allowed?
6. Anti-psychiaty and pro-psychology in service users – is this a phenomenon?

7. Texture of madness – Fluid versus fixed/transient versus permanent.

8. Reclaiming feminism – Mental Health, racism and LGBT: Oppression for all?

9. Combatting a master status of mentally ill or 'mad' – Service User Perspective.

4.10 Conclusion

The aim of this research was to begin to get an understanding of what constructions of madness are held by NHS service users. The study used Discourse Analysis to explore the service users' constructions of madness through the use of language and examined the function of different interpretive repertoires on their subjective world.

Contemporary understanding on the meaning of madness seems to be evolving so that idiographic knowledge can be obtained to inform current practice. It is debatable whether there will come a point where a consensus is reached whereby the meaning of madness today is fixed and becomes generally accepted from all points of view. Therefore the search for nomothetic, generalizable knowledge in research may prove futile. However, understanding and perhaps challenging currently held views may be useful, both at a societal level and a clinical one. Presently the meaning of madness is explained through psychiatric publications or through attempts to unravel power dynamics between psychiatry and patients. The beliefs about what it is to be mad, mentally ill or having a mental health problem today is particularly important for the counselling psychologist and their client. Indeed when talking about 'beliefs and illness', Halligan (2007) suggests that this influences how clients make the facts and causes of their presentation understandable, how they evaluate expectations of recovery and how they respond to treatment. Perhaps more importantly, our ideas about madness are everyone's ideas on madness, therefore we must act to deconstruct ideas of both madness and normality if we are to understand what is it to be human and experience human suffering.

In closing, it seems as if the voice of unreason is becoming more accessible to the academic and therapeutic community. However, if a slight adjustment in practice is encouraged, the gateway to debate can allow for the voices of all levels to be heard. This does not necessarily mean that the power divide between mental health professionals and those who access services will be dissolved. It may however prove to be a more equal playing field where clinicians are allowed to be curious and service users are able to feel heard as though two humans are in the room together. The implications for research and clinical practice are encouraging. However, the biggest outcome of deconstructing madness may be that society looks for answers outside of the media. As the term madness is

seemingly 'up for grabs', one wonders how a word which stands up to Bhaktin's idea of 'great time' (Lindsey, 1993) will be re-constructed and who will re-claim it? Instead of the current movement 'Time to Change' encouraging comforting talk to those in need, a more powerful request is to talk about what is not being talked about – let's begin with 'what is normal' and see what is left when we attempt to reconstruct 'what is madness'.

4.11 Personal Reflection

As a member of the LGBT gay community myself– and it has been with hesitation that I vocalise my membership of this group – I have noticed a tendency from myself and from my peers to speak as though from the voice of 'the normal', the majority. In being part of something which at times you do not have to identify yourself with, a silent identity, there is a sense that you can have more authority, be taken more seriously and heard, if speaking from the voice of 'the normal'. Parker and colleagues (1995) talk about the identities of the Irish or Jewish community as another example of a group who are not always immediately identified as 'the other', though face discrimination. Looking back over my own decisions, I now feel I identify with the discursive positioning used by some of the respondents. In particular, respondent 2 who appeared to be trying very hard not to identity himself with 'true mental health'. For him, the use of clinical language helped to neutralise his unwanted membership of 'the mentally ill' and instead talk to me, as a member of 'general society', peer-to-peer. The parallel process in my own life might be not to be too loud when making LGBT statements, not to make too much of a fuss or 'rock the boat'. The world treats me 'well enough' and although some are obviously oppressed, I am not, at least in my day-to-day life. However another parallel process come into play when thinking about something that shines the limelight on my membership, such as a pride event, a celebrity coming out/being accused of some sexually deviant scandal, being gay makes the headline, and it's positioned as the cause of 'the deviance'. Just as the respondents talked about media scandal positioning mental health as a problems with heinous acts, the same aftershock occurs within my own community. I do not feel this has impacted on my analysis or reporting of the findings, though it reassures me that whilst we are talking about madness, we can also be talking about difference, which more people might identify with than it seems.

From my beginnings in lecturing psychology to psychiatry trainees, I now see the idea of normality and abnormality in a new light. In both preparing and disseminating the information to these medical doctors, I noticed the interest in 'the abnormal' with positive and moral intentions - to help. However, due to my epistemological positioning and also

thanks to this research project, I find myself deconstructing the very same topics on which these doctors will soon be examined. As such I re-state things that are languaged into existence and necessary for their exam whilst re-directing their attention towards themselves and the acknowledgement and understanding of human pain without such language.

One might say I am trying to 'normalise', though I would contest that this assumes 'normal' is an actual way a person can be. Therefore, I would prefer to be accused of 'de-constructing'. I have had good feedback following these lectures as this approach gives them validation of experience of mental health, daring to be sourced from their own 'expertise' of what it is to be human, rather than as soon-to-be experts of the mind translated into a medical discourse. I sincerely hope that this process of deconstruction is contagious, and that a cure cannot be found!

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CITY UNIVERSITY LONDON

What is this thing called 'madness'?

Could you spare some time to talk about mental health language, sharing your thoughts and feelings?

If 'YES' then please contact the researcher using the details below to take part in a 20-60 minute interview or group discussion.

I look forward to hearing from you.

Brian Murray

Doctorate Counselling Psychology Student

City University London

███████████████████████

- Alternative contacts:

Dr. Jay Watts   **Dr. John Prentice**

Academic Research Supervisor   **Principle Clinical Psychologist**

City University London   **WLMHT**

████████████████████   j███████████████████████

CITY UNIVERSITY LONDON

Researcher: **Brian Murray** **Email:** ████████████████████

Telephone: ██████████████████

Information Sheet

The study: What do we mean by madness: How and where do we use it today?

What is the purpose of the study?

The purpose of the study is to find out how people use mental health terminology and how they feel about these terms.

What will happen to me if I take part?

You will be interviewed for 20-60 minutes by the researcher who will have a conversation with you on the theme of the research question. The interview will be recorded, typed up like a script and stored by the researcher for analysis later. The study will not affect your care in any way.

What are the possible benefits of taking part?

Talking through some of the feelings people have on mental health topics can be informative and empowering for the participant. It is also hoped research will help mental health professionals and service users to be aware of different ways to talk about mental health so that a more transparent exchange is available when people access mental health services.

What will happen to the results of this study?

The results will be as part of the researcher's Doctorate Thesis. They data will be anonymised and kept a period of 5 years as per the British Psychological Society guidelines for research that may be published. A copy of outcome of the study will be made available on request.

Limits to confidentiality and further support

No personally identifiable data will be used in the results of this study. However, if the researcher feels you are at harm to yourself or others during the study, the researcher will speak with you and is obliged to break confidentiality in order to relay necessary information to your care coordinator in order to provide any necessary support.

Your consent to participate in this study is based on the understanding that the data will be used fairly, held securely and that you have the right to withdraw your consent at any time without having to give a reason.

Thank you for taking the time to read about the study.

Feel free to ask any further questions.

General information on participating in research:

http://www.nimh.nih.gov/health/publications/a-participants-guide-to-mental-health-clinical-research/

CITY UNIVERSITY LONDON

RESEARCH CONSENT FORM	
Title of Project: What do we mean by Madness: How and where is it used today? Name of Researcher: Brian Murray **(The participant should complete the whole of this sheet himself/herself)** **Please circle "YES" or "NO"**	
Have you read the participant information sheet?	YES/ NO
Have you had the opportunity to ask questions and discuss the study including any possible risks?	YES/ NO
Have you received satisfactory answers to all your questions?	YES/ NO
Do you understand that your participation is voluntary, and that you are free to withdraw from the study: at any time; without having to give a reason; without affecting your future medical care, or legal rights?	YES/ NO
Have you been told that strict confidentiality will be maintained?	YES/ NO
I understand that the data collected during the study may be looked at by individuals from regulatory authorities and/or West London Mental Health NHS Trust, where it is relevant to my taking part in this research. I consent for these individuals to have access to my records.	YES/ NO
Would you like your GP/care-coordinator to be informed of your participation in this study? *(delete as appropriate)* *If yes, please give details:*	YES/NO
Do you agree to take part in this study?	YES/ NO
Participants initials and signature: _____ Date: _____ **COPY KEPT BY RESEARCHER AND PARTICIPANT**	

Brian Murray – City University Doctorate Student   email: ████████████████ k

Supervised by Dr. Jay Watts   email: ████████████

CITY UNIVERSITY
LONDON

General questions for interview:

- I would like to talk to you about the terms people use when talking about 'madness'.

  (Await possible response or go to first question)

- What comes to mind when you think of that term? *(Can you tell me more about that)*

- What does that bring up for you? *(Can you tell me more about that)*

- What do you think that may bring up for other people? *(Can you tell me more about that)*

- Where and when would you use the term? *(Can you tell me more about that)*

- What happens when you use it? *(Can you tell me more about that)*

- Where do you think other people use the term? *(Can you tell me more about that)*

- What does do you think it beings up in that instance? *(Can you tell me more about that)*

Themes to explore

- How do we talk about madness today?

- What terms do we use?

- In what way is the word used?

- In what context does it have meaning?

- What are the implications of these meanings?

- What effects may they have?

CITY UNIVERSITY LONDON

School of Social Sciences

Northampton Square
London EC1V 0HB
T +44 (0)20 7040 5060
F +44 (0)20 7040 8562
www.city.ac.uk/social

18 May 2012

Dear Sir/Madam,

Project Title: What do we mean by madness; how and when is it used today?

We confirm that we fully support the above research to be carried out by **Brian Murray** as part of his DPsych in Counselling Psychology at City University. We believe **Brian Murray** to be a committed researcher with the ability to carry out this piece of work. City University will sponsor the research and has the appropriate indemnity insurance to cover the research.

Yours faithfully,

Yours faithfully,

Professor Dermot Bowler

Chair, Psychology Department Research and Ethics Committee

Mr Peter Aggar

Quality and Researcher Administrator

The University for business and the professions

CITY UNIVERSITY LONDON

Thank you for taking part in our study.

As you were told initially, we are looking at what different ideas people hold when they use the terms around the theme of 'madness'.

The study hopes to build a better understanding of how we understand the term and the perceived implications of those different ideas. In gaining individual opinions from a variety of settings, it is hoped that a more informed view might taken when the modern-day terminology is used in current services. This may impact on service provision of mental health services and also our general understanding of the meaning and use of these terms.

Please keep this sheet to contact us with any further queries regarding the study. On request, you will also have the option to have a copy of the outcome of the study when completed.

As mentioned before, you have the right to withdraw your consent to participate in the study. This right continues after this time and you may have any data collected from you removed from the study.

Thank you again for participating.

Please note that participation in the study is voluntary and that you are free to withdraw from the study at any time without having to give a reason and without affecting your future medical care, or legal rights.

Brian Murray – City University Doctorate Student

email:

Supervised by: Dr. Jay Watts   Dr. John Prentice

email:

Notation	Example	Description

[ ]	over[lapping]
	    [lapping]
	      speech
		Speech that overlapped

> <	it's >almost as if<	Increase in speed of speech
::	Em:::	Relative increase in length of preceding letter (holding the tone)
(( ))	((nodding))	Comments on non-verbal cues in interview
(.)	Well (.) I guess so	Short pause in speech (less than 1 second)
(0.1)	Yes. I'm (0.1), I'm sure	Pause of 1 second (0.1=1 second, 0.2= 2 seconds etc.)
____	<u>may</u>be that's true	Emphasis on particular vocal delivery of word or part of word
=	Speech is= =Latched by someone	No discernable gap between speech
.hh	well .hh yes!	Audible in-breath (length indicated by amount of h's)
.hh	I guess so .hh yes.	Audible out-breath (length indicated by amount of h's)
CAPS	well I THINK so, YES	Speech that is noticeably louder than surrounding speech

Note: Courier 10pt font was used as recommended by Hepburn and Potter (2009)[14]. This marks speech overlaps etc. more clearly.

In addition, the following conventions were adopted for grammar and punctuation:

- Commas, semi-colons, colons, hyphens, exclamation marks, question marks and full-stops were used as per prose
- Commas were used between repeated words
- Commas were used between letters or sounds that were repeated (stutters)
- Commas were used between unlinked clauses
- Hash was used for interrupted speech (mostly self-interruptions)
- Double quotation marks were used for direct reported speech, or active voicing
- Speech errors were included
- Contractions (gonna, dunno, wanna, kinda) were used

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[14] Hepburn, A. & Potter, J. (2009). Transcription. Retrieved from
http://homepages.lboro.ac.uk/~ssjap/transcription/transcription.htm

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3283   GR3:   Yeah.

3284   I:     ..You know, if >some of the words< you've said are- well:: (.) say
3285          "crazy" "bonkers" >but also< terms like "nervous BREAKDOWNS" which
3286          ar::en't al:ways use:d now::,=

3287   GR3:   =No.

3288   I:     ..em: (.) and are they talking about different things or the sa:me
3289   thing?

3290   GR3:   Well a NERVous breakdown (.) can take many for:ms, (.) >I would have
3291          thought<, and-and not necessarily would >any of them< be-be manic or-
3292          or-or ma:d >or anything<.

3293   I:     Okay.

3294   GR3:   ..Em: you could just- >you could just< colLAPSE through a nervous
3295          breakdown[ and] just [(.) st]op functioning .hh and em that >wouldn't
3296          be ,

3297   GR4:          [Yeah]

3298   I:                     [Okay  ]

3299   GR3:   ..necessarily mad at all<, it would just be (.) a breakdown.

3300   GR2:   BUT WHAT HAPPENED to a friend of mi::ne, (.) >she thought< she was
3301          talking totally norm:ally (0.1) but she wasn't, it was all
3302          gobbledigoo:k,

3303   I:     Mmm ((nodding))

3304   GR2:   ..and she wrote things dow::n >and she thought< they made sense on
3305          the pa::ge (.) but they didn't.

3306   GR3:   Yeah, well it's- >yeah< ((quiet soft tone)).

3307   GR2:   They CALLED THAT that a ner:vous breakdown (.) but a:fter >it was
3308          discovered< she's bi-polar.

3309   I:     Okay.

3310   GR2:   ((croaky)) Apparently (.) if we ar::e to belie:ve.

3311   GR1    It also, >you know (it)< depen:ds ((moves chair forward)) (.) on your
3312          culture (.) on background.

3313   GR4:   ((soft tone)) Yea::h

3314   GR1    ..You kno:w, >it doesn't have to do anything< with eh:: >you kno:w<
3315          what you belie:ve in like religiously or whatever but (.) in some
3316          cultures they DO isola:te- >because I come from Africa< and I've
3317          see:n .hh (.) er:: >the AFRICANS< or the people who are >behaving
3318          differently< being isolated to a mental health unit.

3319   GR2:   Oh::::.
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Section C: Case Study

Hysteria or Human Suffering?

1.1 Introduction and Rationale

"Lock me away and throw away the key".

This was a common sentence used by this client. It seemed to serve to support the acquired persona as a 'hysteric', in the classic sense used by Breuer and Freud in (1893) to describe Anna O. and others alike (see Breuer and Freud, 1957). Interestingly, the image exuded from her during our first meeting was likened to a painting from 1887 in which Jean-Martin Charcot demonstrates to his colleagues that the symptoms of hysteria were as real as those of any organic disease (Appendix I). Being wheeled in by her husband in a wheelchair and with eye-gaze mimicking that of a blind person, this client had baffled NHS services. The reason for choosing her for this client study is to explore the consuming force the client exuded on others, including myself. If thought of as 'a classic case of hysteria', akin to the early era of psychoanalysis, how might a modern day psychology service make sense of this person? I will attempt to open this up to try to offer a possible explanation as to how the client's early history, gave rise to the need for a barrage of defences and how these same protective mechanisms brought her to the brink of self-destruction.

I hope this will be useful for future cases where the client mistakenly seen as an unfathomable spectacle rather than a classic case of human nature, struggling for survival by all means necessary. Interestingly, keeping track of the therapist's own humanity will turn out to be fundamental for the therapy process.

1.1.1 Why Psychodynamic Therapy?

After at the presenting problems from the referral letter during my pre-assessment supervision, this client was deemed most suitable to undertake psychodynamic therapy. It seems that the client's current issues were a reflection of long standing difficulties, largely in connection with personal relationships, manifesting in anxiety. A previous course of CBT had enabled her to manage symptoms of agoraphobia, though not address underlying

difficulties. It was felt that the psychodynamic model would be best suited to 'hold' the

client, as Winnicot (1945) describes, in order to explore the causes of her psychic pain and

begin the move from a position of absolute dependence to relative independence.

1.1.2 Psychodynamic – The Adaptive Perspective.

Overall, this piece of work was formulated within the 'Adaptive' perspective (see Johnstone

and Dallos, 2006) of psychodynamic thinking. According to Johnstone and Dallos (2006) this area of

the psychodynamic perspective has been influenced by systemic and behavioural thinking, in terms of

"the relationship of the internal [past] to the external 'real' world" (Johnstone and Dallos, 2006, p.59).

This is particularly pertinent to this case as the client's difficulties fit with what Johnston and Dallos

(2006) describe as a dynamic process in which internal and external interact with a variety of

processes of the past. They go on to specify these problems as "the distortion and misinterpretation of

other people's motives and actions; the selection of specific individual and relationship contexts

which are familiar and meet our expectations; and the subtle pressure which at unconscious levels

invites others to respond in particular ways" (Johnstone and Dallos, 2006, p.59). For this client, the

current difficulties in her present life, in romantic, family, and social relationships, have reflected

patterns of relating to others that prove to be maladaptive and echo failed attempts at resolving

conflicts that have been used in the **past**. As well as current life situations revealing clues to the

dynamics of the past, the 'Adaptive' perspective also holds that through examining the 'transference'

and 'countertransference' (Freud, 1910/2001) between the client and the therapist, some of these

conflicts of the present (and perhaps therefore the past) are acted out within the therapy space.

From my first encounter with this client, she presented with almost the full range of known

'defence mechanisms[15]' (Freud, 1937). Linking this to Malan's (1995) schematised figure of the

'triangle of person' (defense, anxiety, hidden feeling) and 'triangle of conflict' (other, therapist, past),

summarises the dynamic interplay between the client any myself in order to taken to explore,

experience and work through some of the difficulties encountered by this client throughout this piece

of work.

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[15] Terms that Anna Freud adapted from her father's (Sigmund Freud) earlier work on Ego Defences (see S.
Freud 1894, 1896; A. Freud, 1937).

1.2 Context

NB: For the purposes of this Client Study I have altered personally identifiable information to protect the anonymity of this client and her family.

The client, Gill (pseudonym), was seen as an outpatient in an Older Adult Psychology Service based in London. The client was aged between 60-70 and only just met the age criteria for the Older Adult Service. New patients were first assessed by a member of the Community Mental Health Team. However, as this client was known to Adult Mental Health Services and had previously received psychological treatment (CBT), it was felt that a psychologist would be best placed to conduct the initial assessment and make an informed decision as to further intervention. The MDT would then be updated about any significant changes, particularly in terms of risk. A psychiatrist would only be involved should there be a need for a medication review. Any changes to diagnosis could be made by the assessing psychologist and seconded by a peer. The GP will only be updated on initial plan and an end of treatment review letter.

1.2.1 The referral.

This client was referred by her GP due to 'extreme distress as a result of physical difficulties'. The GP added that there had been extensive physical and neurological investigations to explain the client's ongoing complaint of intense dizziness', which has 'left her debilitated', although none have come back with any explanation. He noted a 'psychiatric history of PTSD, Anxiety, Depression and Agoraphobia', as well as 'inpatient admission in her youth'. The GP history stated there was a query of 'early abuse from age 13-17, reported by her previous therapist'. The GP also felt that her husband was 'affected by the strain of being a full time carer for the client'. There was no mention of the presenting psychical complaints stemming from a somatoform aetiology but rather that the client's physical condition, which was undiagnosed, was causing symptoms of distress for which he felt psychiatric medication and/or psychological intervention would be necessary.

1.2.2 Convening the first session.

I telephoned Gill in January 2012 to explain we had received the referral and to offer an initial appointment in which my supervisor would also be present. Gill was happy to confirm her attendance and noted no special requirements. At the appointment, two weeks later, Gill arrived 30 minutes

early, pushed in on a wheelchair by her husband. Immediately we changed our plans and had the appointment in a large meeting room. This was in order to fit in the wheelchair and have all four of us present (plus the wheelchair).

1.1.3 The presenting problem.

Gill explained that her **current** problems began 1 year ago when she had an argument with her eldest son's wife, Vicky (pseudonym). According to Gill, they had a number of disagreements which culminated in Vicky writing Gill confrontational letters. Gill stated that this happened around the same time that she had a dizzy-spell whilst in a local supermarket. This episode resulted in a physical experience of the 'world falling apart', according to Gill. This meant she felt unable to walk unaided, or be a passenger in a car without the windows being blacked out and sitting in a particular position in the backseat with a pillow. It also left her unable to bathe, dress, walk unaided and also not able read or write. The problem was deemed physical and as yet unsolved.

1.3 Initial assessment and formulation.

From the referral and the initial meeting, I was able to formulate a provisional understanding of the client's distress. On the surface it appeared that Gill is suffering from an unknown physical problem. This has caused her to rely heavily on her husband, as she feels disabled by the experience of dizziness whenever she makes any movements. It has also stunted her ability to read or write and communicate with the world independently. As a result her world became small, requiring her husband for everything.

At this provisional formulation, Gill's psychical difficulties were not discounted as purely psychological. However, it was clear that she was experiencing an extreme emotional reaction to her ongoing physical experience. Gill related the cause back to some bullish, emotionally demanding letters from her daughter-in-law. The significance of the relationship with her daughter in-law was outlined in the first session, as a sort of intense mother-daughter arrangement. This appears to be significant. It is possible that Gill over-identified with this needy cause (child-Vicky) that was later to become the wife of her son, and actually experienced Vicky as version of her younger self. Gill appears to actions suggest she 'projected' (Freud, 1915/2001) herself onto Vicky and created an

enmeshed relationship in order to engage in a pattern of what Freud (1909/2001, 1926/2001) calls 'undoing', in a sense re-writing the her own past by making sure that Vicky was 'protected' until adulthood. When this relationship changed, Vicky became angry, resentful and quietly threatening towards Gill. This de-stabilised Gill's existing image of her younger self and transformed instead into the darker, feared image of her adolescence, her abuser. Gill's world became intolerable, just as it did when she was 19 when she felt incapable of sustaining herself was admitted to a psychiatric hospital. The solution from her 'unconscious' (see Freud, 1915/2001) was to hide from the pain she experienced as a teen and was re-experiencing in the present. Her physical difficulty enabled her to be protected from reading hurtful letters, hearing hurtful phone calls and safely able to give the responsibility of engaging in the world to her husband. Just as he cared for her during her agoraphobia, he was again forced to accept his carer role. This maladaptive pattern of hiding from pain did well to protect her from the outside world, although the unconscious engineering of these actions were not in her conscious awareness. Therefore, Gill felt understandably anxious about the prospect of being debilitated for the rest of her life.

1.3.1 Negotiating a contract and therapeutic aims.

I agreed to see Gill for 50 sessions of psychodynamic therapy. The aim of the therapy was to try and explore, confront and 'work through' (Freud, 1914/2001) some of Gill's anxieties in the present, to enable her to feel more able to function in day to day life. At the initial meeting there was no explicit mention of abuse but Gill did talk about dark events that she found traumatic, during her adolescence, that were perhaps connected to everything. We agreed to try to look at and attempt to process some of those early painful experiences during our work together.

1.3.2 Biographical details.

As mentioned previously the client's details identifiable details have been altered to protect her anonymity. I have also altered the specifics of her family details for the same reason. Gill is 67 and was an only child to Dereck and Belinda who died in their 70s. Gill is married to Graham, 65 and they have 2 sons, Barry, 40, and Martin, 37. Both sons are married. Barry is married to Vicky and they have a daughter together, Isabella, aged 5.

1.4 The sessions

1.4.1 First steps (Session 1-4).

During the first few sessions, Gill insisted that her husband come with her into the room. They held each other's had for most of the designated 50 minutes. Gill would speak in a high pitched, shrill voice. She was able to discard the wheelchair after the first session and use a crutch thereafter. Gill usually began by talking about physical problems, such as dizziness, headaches and sinus problems. Often she would talk through me, not joining my gaze directly. With her husband present, Gill would only every trace her difficulties back for 1-2 years, to the worst part of the conflict with her daughter-in-law.

Both Gill and Graham explained the desperateness of their situation and focused their anger at the lack of help from the medical profession. Gill was tormented by the lack of ability to do anything without her husband, whilst her husband Graham felt increasingly suffocated by this role. Although Graham would back her up with some of the recent events, such as the hospital appointment attendance and problems with their daughter-in-law, he consistently questioned why the problems have gotten worse. Gill would squeeze his hand tightly when I asked anything other than medical issues.

Reflection: During this time I felt as though I was able to contain the emotions within the room, though barely. When it came to discussing medical appointments and hope for recovery, I felt I was participating in a lie, a group denial. The pressure they appeared to place into a medical cure seemed unreasonable. It felt as though it was very obvious that the pain from Gill's early history needed to be acknowledged, however, nobody, including myself was doing so. I felt a knot in my stomach and little room to escape the feeling, other than to hope alongside the couple that some investigations would come back with an answer.

Supervision: In discussing the problems with my supervisor, he thought I should explore my counter-transference. It was felt that my reactive-counter-transference, as Clarkson (2005) calls it, had limited by inner disquiet with the situation in the room. The part of myself that did not agree with the 'false hope' that was being expressed by Gill and Graham was felt to run in conflict with the part

that needed the 'false hope' to be true within the couple. In exploring what would happen if this collective agreement were removed, we believed the true cause of the pain might feel too overwhelming to speak of. Certainly this would fit with Gill's history of being admitted as an inpatient when she was 19 due to what she calls 'a nervous breakdown'. Therefore, instead of removing this important defence entirely, it was thought that acknowledging that there was a feeling from my side that there was a lot of things unspoken and unacknowledged. Gill agreed to this and asked her husband to wait outside for the remainder of our sessions. This was the first sign that we were able to talk beyond the surface, beyond the context of medical appointments.

1.4.2 Getting to the bottom of the surface –Sessions 5-10.

Without her husband present, Gill felt able to discuss the different aspects of her past, including her abuse. She told me that her husband did not know about this, although when Graham was there previously, it seemed from his reactions to 'talk of the past' that he did know, although they never spoke of it. **To protect the client's anonymity, I will highlight only the main parts and change any identifiable details.** Gill explained that her abuser was known to the family and employed her in his local business from the age of 13. As our sessions progressed, Gill would go through periods of removing herself from this story and saying it was all talked through with a previous therapist. During our conversations around her more recent difficulty with her daughter-in-law, the topic seemed to flow back to the time she was abused. Gill eventually found herself able to say that her abuser initially made her feel special and looked after. She apparently tried to preserve this feeling when the abuse began, though found this increasingly difficult. When the abuse ended, she informed her parents, who informed the police, though nothing was done and her family did not discuss it further. During this time she met Graham who wanted to date her. She described how she was not interested in him and asked a friend to let him down gently. However, when she was admitted to a psychiatric hospital 2 years later, Graham visited her in the ward. Gill explained that she felt unable reject his proposal of courtship. She recalls him being very caring at the time and found herself getting married within a couple of years. I felt Gill desperately wanted me to know that he was very caring, polite and helped her in every practical way. I reflected this back to Gill, bringing in the current context in which this caring role still remains within their dynamic. Gill explained that

she had two children after that point but due to her agoraphobia, could never walk them to school, play outside with them or go to any events. She assured me they were fine and well-rounded adults now. However, I felt as though there was a break from acknowledging her true feelings from the point at which she found herself in a marriage that she was not altogether happy with.

Reflection: I felt that Gill squeezed in a lot of information in a few sessions. I recall feeling very tired on those days when I would have my appointment with her. At the time I thought this was due to a lack of feeling of progress, though my supervision helped me to understand that once again I was being duped into consenting to 'glossing over' strategy where psychic pain existed. I feel that it was perhaps the experienced of feeling emotionally stretched by account after account of events that were traumatizing that I perhaps needed to go with the client's defence of rationalization and suppression (Freud, 1937) .

Supervision: My supervisor discussed the possibility of a dissociated narrative being required for both the client and myself for these painful events, in order for them to feel tolerated. The tiredness I felt before and after the sessions left me with a feeling of disintegration. This perhaps mirrored the more intense experience of disintegration within Gill. At the time of her abuse, this was needed. It fits with Milton's (1994) thoughts on perverse attempts to solve feelings of childhood abuse. However, it did not answer why I had this feeling.

Personal therapy: In exploring my own feelings within personal therapy (without disclosing case details), I found myself reacting as though I was being abused during the sessions with this client. I realised that I had not just been 'going along' with talking around painful issues but I had no opportunity to speak at all sometimes. For the first time I recalled the client interrupting me several times so that I could not speak. Eventually, I stopped attempting to speak and had a barrage of painful events thrust upon me.

1.4.3 Change of response.

Through supervision and personal therapy, I could see that the client was using the defensive nature of what Klein (1946, 1952) calls 'projective identification'. However, although discovering that the client was ridding herself of the unwanted parts within herself was useful, it did not give me a

grasp of how I could keep or somehow give back this feeling to the client in a non-painful way - I did not want to become the abuser.

Looking at Bion's (1962a, b) developed notion of projective identification, I felt that Gill was trying to use the 'evacuative' process to forcefully rid herself of unwanted feelings. At first glance this would seem to link with the unwanted pain from the time of her abuse. However, it also includes the suppressed memory of an unsupportive mother and father following the abuse, who did not function as the 'container' (Bion 1962a, b) that she needed. Gill's retreat within herself then lead her to marrying a partner who she was not attracted to but felt protected by. The blame and shame that perhaps would otherwise have been attributed to 30 years of being an agoraphobic woman who could not be the mother she felt she should be was instead 'evacuated' into me. I felt an inner self-blame for not being able to handle this onslaught of painful information from Gill. However, in being aware of this process unfolding between us, it meant I could develop the capacity for what Bion (1962b) calls 'reverie'. This would enable the confusing, painful and at times unbearable feelings and impulses to be contained and reflected upon during our sessions. The hope was that the client could 're-introject' (Bion, 1962b) her raw feeling states, with an increasing capacity to cope with them. Through repeated cycles of me being able to cope, and Gill introjecting the capacity to do so too, we could establish what Bion (1962b) describes as the 'container-contained relationship'.

1.4.4 A life lost to madness - why would I do this? (Sessions 10-35).

When I next met with Gill, she began by updating me on her medical appointments. She had a new physical ailment that she felt should be investigated. We discussed how she felt about the process of therapy and if she thought on some level that I should be finding and taking painful feelings away from her. Gill agreed that if her anxiety was not there that the physical problems may be more bearable but questioned whether I would be able to sort out everything. Gill drew the discussion back to the time when she was 'rehabilitated', following behaviour therapy. She explained that she was able to go out, meet close friends and go shopping. According to Gill this is all she could have hoped for. Gill became both angry and desperate within her tone of voice. The target of her anger was her husband. Gill explained she was angry at him for not being more understanding and

emotional when she was unwell and that she needed a husband not a carer. Looking back at her history we discovered 'a new ailment'. Gill found herself taking her anger out on Graham, though felt guilty as he was also her only source of practical help. Gill explained this dynamic has existed since they first met, although she 'lived through [her] 20s on psychiatric medication', so it was not an obvious problem for some time. She then disclosed that they were not at all suited and that she felt that her life could have been very different if she had been with someone more emotionally and creatively in tune with her.

We began to explore the possibility that there was little room for Gill to emerge from her anxious state to the person she would like to be with some being 'so caring'. Gill explained that during the times when she has began to be more like the person she would like to be, something usually intervenes to stop her. Examples of this included her husband needing to go out to the pub with friends or their son (leaving Gill at home), insistence form her husband to take it slow, or a the emergence of a new physical ailment. For the first time we were then able to explore a connection between her emotional experience and her physical difficulties. Gill was at first able to make the connection between feeling trapped, experiencing anxiety and noticing physical problems. Then on one session she told me I should have her locked away and throw away the key because she was obviously mad. In exploring the reason why she felt this way, Gill exclaimed that if her physical and emotional experiences were created by herself that she must be mad. She became tearful when adding that it would mean that she missed her children's important milestones, that she sacrificed her own life, making herself disabled 'just' to avoid problems. At this point Gill disagreed with the whole theory and was furious – with me.

Supervision – During my supervision appointments at this tense time in the therapy work I was able to try to make sense of the processes at work within the client and myself. My supervisor felt that we had potentially removed the client's largest defence, which he painted as a survival strategy. The anger she felt towards me perhaps reflected the need for her to displace the feelings she felt toward herself and project them onto me. We explored the possibility that the client needed to be angry at the part of her self that stole her 20s, forbade the emergence of the person she could have

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been and for getting into a marriage that would cement this pattern. This may have released some

feelings of guilt from the period she had to deny her children a full-time parent. During the

supervision it was felt that I needed to maintain my ability to contain these negative feelings, so that

the client could bear to hold these parts within herself through re-introjection.

1.4.5 Reformulation.

During the time when Gill told her parents about her abuse (and perhaps implicitly

beforehand), she must have attempted to communicate her sense of being frightened, ashamed and

distressed to them. As little action was taken to resolve the problem, and with nobody else to turn to

Gill may have used the 'communicative' form of projective identification (Bion, 1962a, b) to rid

herself of her feelings whilst seeking the necessary containment from them. However, her parents

were unable to be emotionally attuned to her need for this distress to be held and managed.

Therefore she was unable to re-introject the part of herself that had would otherwise have been

painful, yet containable. Remarkably she was able to survive for 2 years before having a nervous

breakdown and admitted into a psychiatric hospital. The treatment was medical sedation which further

supported Gill's idea that her experience was uncontainable. Gill then found herself in a relationship

with someone who was again not emotionally attuned but was willing to take care of her practical

needs. Years later she met a neglected young neighbour (and future daughter-in-law) Vicky, and

found a chance to fix or 'undo' as Freud (1909/2001, 1926/2001) uses the term, the damage she

suffered as a teenager by becoming the perfect mother to Vicky. This was not a problem during

Gill's agoraphobia. However, she then began get 'well', becoming more independent and able to go

out, spending time with friends her own age. This shattered her intensely close relationship with her

Vicky, as well as strained relations with her husband who was forced to become more than a carer but

a husband. Whilst Graham resisted this change by going out more with his friends to the pub, Vicky's

response was more detrimental. Vicky began to pass messages through her husband Barry, Gill's son.

She would also write emotionally charged letters to her stating her feeling abandoned my Gill and that

she was manipulative and deceitful. This resulted in Vicky being re-cast the abuser Gill felt she had

escaped from. Gill had nobody to support her emotionally, just like when she was 17 and found

herself unable to remain able to stand the environment, surrounded by dizziness that would keep her

safe (yet disabled at home), unable to read or write (unable to read painful letters) and relying on her husband to return to his caring role.

1.4.6 Pleased to finally meet you Mrs. Butler (sessions 35-45).

In the following session, Gill informed me that she had a huge argument with her husband. Apparently this happened quite frequently, although this one was more significant. Gill's husband ended the argument by going out to the pub. Gill told me that she had made some important decisions. She decided that she was not going to return to the person she used to be, no matter whom this was a problem for. The argument with Graham apparently surrounded Gill's need for him to 'step it up' and get what she was going through, not just helping her around the house. We explored the past and wondered how possible it would be to change the person she chose to marry. Gill became tearful and began to tell me about the real person she missed, her younger self. She told the story of a girl who was full of hope and wonder. Part of this was apparently preserved during her 20s. At this time she would write stories and poetry. Gill wanted to regain this part of herself and write poems so that her granddaughter could one day read them.

In later sessions, Gill would now and again return to our discussion over her past and the role it played in her physical status. Gill felt it was impossible to fully accept that her current difficulties were due to her unresolved past due to her ongoing physical health appointments. She then explained how she knows of cases of conversion disorder, whereby someone could lose one of their senses in order to protect them from something traumatic. When asked if her past could be classed as traumatic she responded 'yes', but deflected the spotlight by stating she was talking about famous cases in the past. I realised I was once again the presence of a highly intelligent woman who was using intellectualization (Freud, 1937) in order to avoid the pain associated with her past trauma. It also served to help her function in the present, as her physical symptoms were becoming more manageable. I did not push the connection to the past, though the intertwined themes emerged whenever Gill would speak about her husband or daughter-in-law. Gill spent the net few sessions planning small goals for herself, such as going out in the garden unaided and writing a line of words at a time.

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Then on one particular session I noticed that Gill was able to look directly at me. Her voice sounded different, the shrillness had gone. As she told me about her small but significant successes, she reminded me that she was not going back to the person she was before. As she left the room I noticed that she was no longer using her crutch.

Supervision: During the meetings with my supervisor, we explored the change in character. Although Gill had said she would not fully accept the connection with the past, she was able to talk about it when she intellectualised, keeping her distance from the true pain. I felt more able to contain her distress and talk with less pressure about connections between the past and the present. I no longer felt the extreme tiredness before and after our sessions. I felt this was a sign of some progress, although my supervisor shared his idea that I too could be intellectualising, keeping my distance from the pain and therefore making it bearable for myself too.

Reflection: With the end of our work approaching, it would make sense that we were both hoping for progress. Gill did not tell me out loud that her past trauma caused a fantastic string of defences (Freud, 1937) that left her disabled, though I did feel that she was testing the waters with the 'intellectualisation' of this idea, perhaps slowly making the idea bearable.

1.4.7 Ending.
At the end of our work Gill brought me some of her poems. She wrote them down and her husband typed them up. Gill explained she had found humour in her creative writing, a part she had long forgotten in her personality. Instead of taking away her success and wanting to interpret this act as a type of 'sublimation' defence (Freud, 1937), I felt it was more fitting to highlight the strengths shown in Gill throughout our time together. Gill learnt how her past defences were once needed for survival and that more mature defence could now be used for everyday living.

Talking about the ending of our work left Gill feeling sombre. She explained that there is a part of her that feels like a young child crying and she does not know how to comfort her. Drawing upon her re-discovery of her creative side, Gill added that this would be her means to look after that part. We shared the feeling that the journey together had been long and not always easy. She had come to terms with the idea that her husband could not soothe her pain but was instead a practical,

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loyal husband. Her relationship with her daughter-in-law was unresolved, though Gill had begun to feel that she was the adult in their relationship and that she would decide how close or far she lets Vicky get. I hoped this more adult-self would remain able to look after her own needs whenever she feels the threat of pain that life can bring.

Gill requested no further psychological input and refused the offer of a follow-up review by a Community Mental Health Nurse. She was discharged from the service back into the care of her GP. She was made aware she could be re-referred at any time should the need arise.

1.5 My supervision journey

Throughout this work I felt my supervisor's role was needed more than usual. At first I thought this was due to the nature of the case, my need to get it right and the pressure of a 'trainee' holding a 'complex case'. My supervisor presented this case to me initially a case of classic hysteria, in the sense Breuer and Freud (1957) used. Contemporary terminology would probably term this a Somatoform Disorder (DSM–IV–TR (2000) 4th ed., text rev.).   When introduced in this way, I felt that my supervisor would expect some type of remarkable recover, just as in the classic texts (see Breuer and Freud, 1957). As the client became to behave in this way, deposing of the wheelchair after the first appointment, the pressure to continue that pace inflamed the situation further. The most useful part of my supervision was my supervisor allowing me to say that I felt stretched by this client. During this time I feel he was able to provide the same thing I was eventually able to provide my client, the 'alpha function' (Bion, 1962b), or container that allowed such raw material to be processed. Strachey (1934) talks about an 'auxillary ego', which I think fits my supervisory relationship by expanding my capacity to deal with the client and reflect upon it in words. Identifying my own counter-transference (Freud, 1910/2001) helped me to gain an insight into the client's world, as well as those around her. If a fraction of what was experienced by me was experience by someone else, e.g. her husband, it would be understandable not to feel able to cope. In this example, he went to the pub.

In the end (and through making use of personal therapy) I realise that I must create a space to nurture my own internal supervisor to be able to develop as a therapist.

1.6 Learning about psychotherapeutic theory and practice

I have never before experienced Projective Identification (Klien 1946, 1952; Bion, 1962b) in such a strong way before. What supervised me is that I was not aware of the 'symptoms' I carried, or that they did not belong to me. I was happy to decide I had a cold or did was affected by the cold weather (my own rationalising). Working with this client has allowed me to be less 'anti-defences'. I now feel that carrying some of the more mature defence mechanisms are perhaps a requirement for living. I have read about this way of thinking before but I have never seen it applied in such an authentic way before. It also changed the idea for me that you need to rid someone of their defensive strategies, especially as they might not be ready to have them removed, or even exposed. Working with the client at their level of readiness has been enormously helpful to understand. I've also learnt that personal therapy can be so useful to take yourself outside of the client, work, theory environment, in order to check-in with yourself. The dynamic relationship between these different environments helps to serve the client but also service the therapist's own wellbeing. I believe that this unique ability will retain my draw to the psychodynamic working beyond this doctoral programme.

1.7 Learning from the case about myself as a therapist

The pressure I felt to do well with this interesting case made me think of the classic hysteria picture with Charcot, painted by André Brouillet in 1887 (Appendix I). I never wanted to be either Charcot or any of the other professionals that were trapped in their fascination about this 'mystery'. Instead of the 'mystery' I wanted to find out about the person. I got a sense that Gill too wished to be found as a medical or psychological marvel which made it difficult to work with at times. However, throughout our work together I found that it was not the desire to be seen in this way but rather the NEED to be seen this way, otherwise a less glamorous and painful past would be the only cause.

I have learnt that I need to be able to use all of my resources to understand both the client and myself during a piece of therapeutic work. The pressure to feel I was getting somewhere was made more difficult by the exhaustion I was not aware I carried. After making use of my personal therapy and supervision, I was more aware of my inability to think in the sessions. I felt assured by my feeling of being stretched as it meant that for the client, her experience was bearable, just about. It became more containable as we progressed and I felt more able to develop my capacity for 'reverie'

(Bion, 1962b). Thinking about future clients that might stretch me in the same way, I believe I will be more in touch with what is required of me before I become over-stretched. However, given the experiences that the clients have had in their own lives, I am glad that I am in a profession that allows the idea that a person's experiences can be contained and that the world does not fall apart if they dare to let another person know how they really feel. I hope that ability stays with me.

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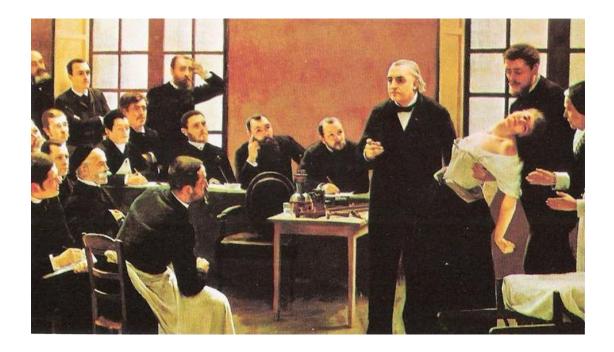
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Appendix I

Brouillet, A. (1887). *Un Leçon Clinique à la Salpêtrière* [Oil Painting] Retrieved from:

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<div align="center">**Section D: Publishable Paper**</div>

<div align="center">**Qualitative Counselling Psychologists: Why research proposals continue to be lost in translation?**</div>

<div align="center">*"Not everything that can be counted counts, and not everything that counts can be counted."* (Cameron, 1963, p.13)</div>

1.1 Overview

Current debates on qualitative versus quantitative have reached a consensus that mixed methods should be the preference of researchers (See Creswell, 2011, for overview). However, as will be seen later in this paper, this has not been implemented in a way that appears to bring any new insights due to biases in perceived readership or in research institutions. Furthermore, the identity crisis that continues to impede counselling psychologists as researchers may affect our ability to use methodologies that answers the questions we wish to seek, instead bending our epistemological stance to avoid seeming 'woolly'. According to Rafalin (2010) 'the need to grapple with the complexities of our relationship with research is greater now than ever for all psychological practitioners – including counselling psychologists' (Rafalin, 2010, p.44). Therefore if we are to maintain and improve upon our research credentials, the author argues that we should make use of our grounding in epistemological understanding and ask the questions that need asking, using methodologies that facilitate rather than compound – qualitative methods.

A brief background on the counselling psychologist's position within the debate will be outlined before relating this to the on-going identity crisis that affects this position. The connection between these two dichotomies appear to share an overlap with a world in which differing epistemological positions establish friction between research and clinical practice (and the respective identities). A case example from the author will be presented as well as some recommendations as to what ideas should be held in mind when considering whether to sacrifice epistemological and ontological heritage in order to produce recognised research.

1.2 Where are 'we' in the current debate?

The debate on quantitative versus qualitative continues from theory-level in the classroom to the research ethics boardroom. Whilst looking at the key features of the discussion, there are parallel dichotomies between areas of public health. For example, when