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**Between binaries, borders and boundaries:
Counselling psychology in liminal spaces**

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Portfolio submitted in fulfilment of the Professional Doctorate in
Counselling Psychology (DPsych)

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**CITY UNIVERSITY
LONDON**

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Declaration

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Preface

The doctoral portfolio is about in-between spaces: about how the neat either-ors are continuously disrupted by our lives and the ways in which we live them. It is particularly about how I have come to notice this during my training in counselling psychology and the discomfort of the conflicting, competing and contradictory positions I have taken up and been positioned in during this process. It also about witnessing, sitting with and deconstructing the moments when clients, colleagues and research participants have found themselves off course, and stuck in between spaces on the roadmap of where they or others think they should be. These are illegitimate spaces and places. They do not gel with the way we usually carve things up. They deviate from the binaries, boundaries and borders that our dictionaries of normal and expected fence us in with. Or rather, they show us how often we step outside of these areas, how often we slip into territories that are out of bounds or unwanted. Describing these wanderings into the hinterlands between crazy and sane, normal and abnormal or strange or native is difficult. It is much easier to be on one side or the other. The work in this portfolio is about those moments in the in-between.

The first piece of work, and centrepiece of the portfolio, is original doctoral research. It explores the social construction of ‘nervous breakdown.’¹ This has never been an official diagnostic term but functions in a diagnostic way. It comes from psycho-medical discourse, but has never been ordained as part of it. It is used as a short-hand by clinicians and the public alike, but seldom described or defined. It exists between the millions of websites devoted to it, and the handful of academic papers that subsume it under psychiatric diagnosis. We all seem to understand it, letting it slip through conversation as easily as a sprained ankle or a bad hair day. It proliferates the popular discourse, and is pertinent to but almost absent from the official diagnostic discourse. It is a liminal construct, gathered from the footnotes of Victorian nervousness and very much alive in the popular imagination as a kind of diagnosis: a

¹ ‘Nervous breakdown’ is the only construct I have emphasized in quotations in this portfolio, given its position as the subject of my original research. For ease of reading, I have left other problematic labels to the critical gaze of the reader.

reason to be positioned as not-normal but not necessarily as abnormal. It chisels out territory in between the discursive binaries of sanity and madness, body and mind and self-management and personal failure. Yet, it does so quietly, even complicitly, both evading and also passing through the expertise of psychological practitioners. This study explores its discursive function and how those who use it, find through it, a socially acceptable way to fall apart: undeniably, a liminal space.

The second piece of work is a critical literature review of immigration, the immigrant and mental health. Immigrants quite clearly transgress all kinds of borders and norms. Not only do they cross official borders but they cross socio-cultural ones too: bringing the inscriptions of poverty, war and terror into neo-liberal spaces, bringing unfamiliar fragrances, flavours and phonetics to the habitual, and bringing the idea of the native into question. Mostly though, questions of strangeness are turned onto the immigrant not the native. These positions are deemed as polarities: one can be either one or the other. Moreover, questions of loneliness, estrangement and trauma that are part of the experiences of immigration often become collapsed under the epidemiology of mental health profiling.

This critical literature review attempts to problematise the assumptions made about immigrants and immigration in the mental health literature. It questions the homogeneity that seems to be automatically assigned to the immigrant, immigration and to the native. It also questions the role of psychological services for immigrants, arguing that while the relationship between the immigrant and mental health is problematic, the therapeutic space and its literature is also one of few places where a conversation about the discomforts of difference and displacement can be had. The space functions simultaneously to diagnose, pathologize and re-colonize the immigrant and also to loosen binaries of same and other and to potentially co-create a mutual conversation. As such, not only does the construct of immigrant function in between geographical borders but it also functions to bring the liminal spaces of psychological practice and its cartographies of knowledge and knowing into sharp relief.

The final piece of work presented is a client study about my work with a woman who had miscarried. This case signalled my first foray into a more dilemmatic position between the psychodynamic theories of interiorities and the theories of social constructionism. It marked a pushing and pulling between the individualism of therapeutic practice and the socio-discursive worlds that were shaping what we could and could not say about miscarriage, motherhood, and death-in-birth among others. The work marked my turning to a more psychosocial practice and trying to find a space that could both address a personal history and also ways in which the socio-discursive shapes how a personal history can be talked about. This is a rather uncomfortable and undeniably liminal position. Moreover, the work itself was about ambivalence: a position that is also liminal and neither-nor. It was about finding ways of talking about ambivalence in miscarriage, ambivalence about being good, ambivalence about therapy, and ambivalence about being a daughter and a mother. It was about how hard this ambivalence was to articulate: how hard it is to occupy positions of both angry and good, for example. This work reflects the discomfort and relief of finding a space that can be both-and. It also reflects that this space is rarely found – rather that it is an ongoing traversing to and fro between theory and practice, between good and angry, and between therapy room and the world beyond.

Almost every rule we have to abide by demands that we occupy a clearly stated position. From immigration officials stamping our passports to the doctors deciding what sex we are at birth, we have to be something and somewhere definitive. And yet, the spaces in between definitives are where we seem to live the most but which, understandably, we find the most difficult to articulate. This is the very fodder of psychology: the cracks, the slips, the not knowing, the silences and things we would rather not say. Yet, psychology too prefers to neatly describe these as particular phenomena, techniques or symptoms. The liminal is both the grist of our work and also what we prefer to cloak in the safe scaffolding of professional theory. Somehow, as psychological professionals we need to be able to travel back and forth. We need to go into spaces for which there is no ready language, for which there is no ready map

and for which there is no legitimate social space. We also need to return back to theory, to regulations, to the rationale for what we do and why and somehow negotiate between the two.

Counselling psychology, in particular, is in the liminal bind. It embraces pluralism, critique and reflexive and relational practice and yet also seeks a legitimate place in the psycho-medical framework, which prefers fixed evidence-based diagnostics. It encompasses the pastoral concept of wise counsel, and the psychological legacies of Freud, Skinner and Eysenck. It is both the entrepreneur of applied practice and also the rigorous clinician. It is party to the imprints of straightjackets and *One Flew Over the Cuckoo's Nest* and also to Rogerian self-actualisation. At the start of my training, an established counselling psychologist told me that I would emerge from training not more enlightened but “more comfortable about being in constant flux.” It would seem he was right. This professional training has disrupted every singularity of knowing that I had previously held onto. I have realised though, that to be able to be in the spaces of the in-between, and to be there with other people is a remarkable thing. It allows for off-road travel. It allows for new experiences and conversations to emerge and for something different to happen, even if momentarily.

This portfolio documents my journey, both academic and clinical, into some of the liminal spaces accessible to counselling psychology, its practice and its knowledge. It documents my encounters, as a trainee counselling psychologist, with both my own and other people's places of flux, places of no language and new language, and places between known fixtures. Most people who violate a binary, border or boundary usually suffer in some way. They may simply suffer the confusion of being in a space they do not understand, or they may suffer harsher exclusions and penalties. Inevitably, all the people who come to be the subjects of psychology's gaze, or who choose to take up a position as client or participant, are a little bit out of bounds and are suffering because of it. To foreground the confusion of liminal spaces and liminal subjects is also to foreground the often inflexible and oppressive ways that taken-for-granted binaries, borders and boundaries keep us fenced in. It is also to foreground the

myriad of ways in which we are already disrupting their false integrity – bending them, stretching them and sliding between them. The way in which we choose to engage with the liminal determines the kind of conversations we can have with our clients, with one another and with the world that we co-construct. The liminal allows for new things to emerge, and it allows for a loosening of the tight corrals of binaries, borders and boundaries that determine the possibilities of who we can be and how we can be.

Part A – Doctoral Research

An ok way to fall apart: Exploring the social construction of ‘nervous breakdown’

Abstract

‘Nervous breakdown’ returns over nine million results on an internet search while a search of the academic literature returns as few as twenty-two. It has never been an official psycho-medical diagnosis but has tended to function as such, for variable purposes. This piece of work aims to explore contemporary popular constructions of ‘nervous breakdown’ and what the term accomplishes for those who use it.

The exploration is in two parts: (i) a mapping of the contemporary discursive terrain of ‘nervous breakdown’ through a media analysis and (ii) an exploration of subjective constructions of ‘nervous breakdown’ through participant interviews. These two sites of analysis allowed for exploration of how the discursive terrain positions the subject of ‘nervous breakdown,’ and how he/she resists these positions. In order to explore this interface, a synthesis of Foucauldian and discursive psychological discourse analytic approaches was used.

What emerged from the study was that the discursive terrain tends to position the subject of ‘nervous breakdown’ as not coping or as mentally ill, whereas those who employ the label do so to carve out a space in between these positions, avoiding their associated stigmas. This liminal position of ‘nervous breakdown’ and its consequences are discussed.

1. Introduction: What’s in a ‘nervous breakdown?’

I have toyed with how to craft a compelling entrance for ‘nervous breakdown’ in the opening lines of this thesis. I have statistics and meta-analyses, quotations from 18th century Harley Street and noir-cartoons of post-war housewives in smoky, suburban living rooms. None of these are as interesting as the ping of my live Twitter feed, alerting me each time someone refers to ‘nervous breakdown’ in a tweet. In the last hour, it has pinged over twenty times. The latest tweet reads: “Is it too early in the (academic) year for a nervous breakdown?” Within five minutes, four other users replied offering solace, deep breaths and tea. Another tweet lights up: “Curled my own hair tonight. Was trying to look like Julia Roberts. Might look more like a single mom having a nervous breakdown.” In this live conversation, ‘nervous breakdown’ is featured as a single-mom’s bad hair day and also a question of timing in student-life. In other tweets it extends to coughs, colds, spiders, breakups, Mariah Carey, immigration, depression, loneliness, coffee, computer crashes and exam results – to name just a smattering. The Pandora’s Box of things ‘nervous breakdown’ is used to talk about becomes curiouser and curiouser as I scroll down the page. Ask me to precisely define ‘nervous breakdown,’ and I’ll fumble around for words, but I have an intuitive understanding of what all the tweets mean.

‘Nervous breakdown’ slides around the discursive terrain as blithely as a canapé tray at a cocktail party. Countless celebrities from Cheryl Cole to Oprah Winfrey are claiming to have had one. Clients I have seen throughout my training have brought it to the therapeutic encounter. Friends, family and acquaintances lay claim to the term. I think I used it last week to describe a state of mind when my computer crashed, swallowing my work into its blackened pixels, resisting all attempts at resuscitation. It is a throwaway remark, a confession, a dark night of the soul. It constituted the subject of over nine million hits on a Google search on 11 June 2014¹. Yet its genesis is unclear. ‘Nervous breakdown’ is nowhere to be found in the psycho-medical diagnostic taxonomy. It does not grace the pages of The International Classification of

¹ The number of hits is subject to change as Google refines its search engine algorithms.

Disease (ICD) or The Diagnostic and Statistical Manual of Mental Disorders (DSM) and is absent from their Victorian precursors (Shorter, 2013). It has neither been invented nor formally used by the conventional diagnosticians. It appears in Albert Adams' treatise to American physicians in 1901, but as a neologism for the subject of nervous disease and its starring diagnosis of neurasthenia (Barke, Fribush & Stearns, 2000). From then on, there is scant reference to the term in the literature: popping up here and there in lay texts, diary entries and the arts, such as in The Rolling Stones' 1966 hit *The 19th Nervous Breakdown* and Pedro Almodóvar's 1988 film *Women on the Verge of a Nervous Breakdown*.

However, 'nervous breakdown' has a great deal of psycho-medical purchase in the popular conversation. From a rough scan of the smorgasbord of online sites, blogs, forums and news articles, talk of 'nervous breakdown' seems inextricably bound up with the psy-complex². It is peppered with references to diagnoses, states of mind and psychiatric and psychological treatments. For example, the first website to come up on the Google search is entitled "Signs and symptoms of a nervous breakdown" and is hosted on a website called www.professional-counselling.com. Many other websites, also positioned as psycho-medical through their branding and their use of expert voices, also claim to know about 'nervous breakdown' and to help the general public diagnose and treat it. For example, The Mayo Clinic, America's iconic medical research institution, has a whole web-page dedicated to 'nervous breakdown.' It subsumes the label under the rubric of depression, framing it as a common public entrée into this diagnostic pool (Hall-Flavin, n.d).

In a parallel conversational thread, the media's construction of Charlie Sheen's rather theatrical unravelling in 2011 made reference to 'nervous breakdown' as a possible diagnosis for the movie star's so-called deviant behaviour. For example, *The Guardian's* lead article on the story is entitled "*Charlie Sheen, a Star on the Verge of*

² I use psy-complex in this piece of work with reference to scholars such as Rose (1985; 1998) who use the term to describe "the network of theories and practices concerned with psychological governance and self-reflection in Western culture" (Parker, 1998, p. 68).

a Nervous Breakdown, Grips and Revulses America” (Harris, 2011). The same slew of articles on the nefarious actor also lay claim to terms like “mental and emotional crash” (Loinaz, 2012, para. 6), “the demons of mental illness” (Banks, 2011, para. 2), and “bi-polar” (Brown, 2011, para. 7). This is but one example. One can find direct associations between ‘nervous breakdown’ and the psy-complex in virtually every online text that headlines or hashtags the term.

Yet, a search on PsychInfo, the American Psychological Association’s pre-eminent database for psychological research, returned only twenty-two hits for ‘nervous breakdown’ as the subject of a research title. The disparity between this and the nine million plus Google hits for the search term is striking. The figure of nine million does not include references to the term on any social media, only on websites. Had the analytics I was able to use been more sophisticated, I suspect the nine million mark would have been dramatically exceeded. In short, it seems that there are two different, and yet closely related, conversations about ‘nervous breakdown’ going on. The relevance of ‘nervous breakdown’ to the contemporary subject is not matched by the very institution from which it seems to borrow its conceptual capital. Moreover, it appears to elude a consistent definition, discretely hidden as a generic, taken-for-granted thing.

1.1. ‘Nervous breakdown’ in the academic terrain: A short conversation

My curiosity piqued, I started with the academic canon and the twenty-two articles that PsychInfo found with ‘nervous breakdown’ as the subject. I broadened the search out to include other databases, but the return was still poor and remained in the mid-twenties. This made a comprehensive literature review challenging. This paucity of literature endorses the legitimacy of a piece of work aiming to explore ‘nervous breakdown.’ It encourages not only a sortie into the terrain of the term, but also the act of exploration. In the following section, I present a review of the literature that I have

managed to scour off the shelves. It can be broken down into several broad categories, as discussed below.

1.1.1. Subsuming ‘nervous breakdown’ under diagnosis and diagnosticians

A large cluster of the more recent research that speaks of ‘nervous breakdown’ subsumes the term under formal clinical diagnostic criteria that are denoted in various volumes of the DSM. These papers incorporate ‘nervous breakdown,’ often without any coherent definition, as a colloquial term used to refer to hybrid of diagnoses including depression, anxiety and schizophrenia. In these studies, the term is used in measurement scales with the aim of establishing either what defines these more legitimate diagnoses, or who suffers from them.

For example, Swindle, Heller, Pescosolido & Kikuzawa (2000) aim to investigate changes in how the American public conceptualised and responded to mental health difficulties between 1957 and 1996. Their rationale was to inform national mental health policy by painting an epidemiological picture. In 1996 they replicated the Americans View Their Mental Health (AVTMH) surveys used in 1957 and 1976 and chose to focus on the question of whether the current population was experiencing “a greater sense of impending nervous breakdown than did the previous two generations” (Swindle et al., 2000, p. 741). However, the study does not define what a sense of “impending nervous breakdown” means. Furthermore, it does not explain how it is relevant to its rationale which cites that it is important to understand why and how Americans access mental health care because evidence indicates that mental illnesses, namely depression, are on the increase. For some reason, unexplained in the paper, the authors seem to link this higher prevalence of depression to the question of whether the public feels at risk for ‘nervous breakdown.’ Their results are interesting nonetheless, concluding that there is a significant increase in the number of people who feel at risk for ‘nervous breakdown.’ Yet, the study is ultimately unclear as to whether this is because the meaning of the term has changed over time or because more people are suffering from depression. What this paper seems to indicate, much like my brief reconnaissance with the online world, is that ‘nervous breakdown’

means something to many people, something assumed to do with mental health that is taken for granted and not formally defined.

In a similar vein, Rapport, Todd, Lumley & Sebastiano (1998) examine lay meanings of the 'nervous breakdown' in a large college sample in the USA. Their research intention is to map these lay meanings onto specific symptom clusters in order to demonstrate their correlation with DSM designated symptoms of depression and anxiety. They do so with some success, finding a significant similarity between 'nervous breakdown' and the DSM-IV-TR diagnosis of Adjustment Disorder with Mixed Anxiety and Depressed Mood (Acute). This is unsurprising since they were scrutinising the participants' words with a psychiatric gaze and a honed intention. It has been argued that this gaze, when applied uncritically, can diagnose and pathologize just about anybody (Rosenhan, 1973). This notwithstanding, the research is robust from a within quantitative framework. However, it gives no space for the lay meanings of the term to emerge, as purported in its title. Rather, it overrides the term 'nervous breakdown' and its valence to the lay person with psychiatric discourse, robbing the term of its significance to its users.

Coulehan (2013) makes a similar move, providing a compelling therapeutic case history of his work with a woman who purported to be suffering from 'nervous breakdown' but who was diagnosed as suffering from paranoid schizophrenia (which the DSM-5 now refers to as schizophrenia – having dropped the subtype categorisation). Again, in this piece, 'nervous breakdown' is not defined but is accepted as a meaningful term to the reader. It is also overwritten by the diagnosis of schizophrenia. Similarly, Oppenheim (1991) in her dissection of nervous disease and 'nervous breakdown' in the Victorian west uses the term 'nervous breakdown' as synonymously interchangeable with that of the more contemporary diagnosis of depression. In this way, she completely overrides the contextual significance of the term, in effect subsuming it under the rubric of depression.

In his latest book, eminent psychiatric historian Edward Shorter (2013), goes so far as to call for ‘nervous breakdown’ to be brought formally into the psychiatric fold. He argues for it to act as counter to the blanket diagnosis of depression which he contends is a blunt diagnosis that obscures the nuances of the suffering of people who present more like the Victorian subject of nervous disease: high in agitation and who do not respond to antidepressants. His book is an excellent socio-history on the nervous subject, and a comprehensive critique of the increased medicalisation of mental illness after the 1950s but still it positions ‘nervous breakdown’ firmly in the clutches of the diagnostician and fails to ask what it means to or does for the person who uses it.

Finally, there is a slew of papers that draw on the tradition of cross-cultural psych-research that find that cultures positioned as non-western or indigenous prefer references to ‘nervous breakdown’ in lieu of references to mental illness. Most of these papers attempt to map an ethnographic description of these nervous afflictions onto western diagnoses. For example, Salmán et al. (1997, p.285) examine a sample of 156 Hispanic Americans who self-diagnosed with an “ataque de nervios” which the authors translate as ‘nervous breakdown.’ Their study aimed to subsume this presentation under formal diagnoses and they concluded with a robust significance that these “ataques” were actually incidences of panic disorder, anxiety disorders and also affective disorders. Once again, the term is subsumed under a psychiatric gaze – erased, corrected and replaced.

Cintrón, Carter and Sbrocco (2005, p. 428) do the same thing as Salmán et al. (1997), concluding that “ataques de nervios” in a sample of Puerto Ricans “shares substantial variance with panic-related constructs.” Ying and Miller (1992) dissect the help-seeking behaviours of Chinese Americans claiming to suffer from ‘nervous breakdown’ with the intention of understanding barriers to engaging with mental health services. Striking again, is their use of ‘nervous breakdown’ as a general term for something ‘wrong’ in the land of mental health, although it holds no formal diagnostic power. The authors also do not offer a definition of the ‘nervous breakdown,’ again slipping it in as a shared and taken-for-granted construct.

Askanasy (1974) offers a slightly different take. Although writing from a position firmly within the psy-institution, he uses a cross-cultural study to argue that those people that western doctors might construe as mentally ill, other cultures preferred to designate as having ‘nervous breakdowns.’ His work can clearly be critiqued for taking an etic and representative approach to language across cultures and communities. He does not specify exactly how he arrived at a translation of ‘nervous breakdown’ in each instance, and does not explicitly define the term itself. He also does not address the heterogeneity between cultures, let alone between speakers and clearly operates from a western centre. However, he does offer some space for the term to exist as a subject and not as handmaiden to the DSM. In addition, he situates ‘nervous breakdown’ in a location that is if not counter to, then at least extra to, a western psychiatric purview.

1.1.2. Exploring lay definitions of ‘nervous breakdown’

The second research cluster examines ‘nervous breakdown’ as a lay term. Most of these papers suggest that it is a folk, lay or culturally-specific term for what western taxonomies designate as mental illness. However, these studies differ in tone from those described above as they tend to place more emphasis on the lay meanings of the term as opposed to automatically nullifying them under a DSM diagnosis. For example, Omark (1980) examines the use of the term among a large American sample. He concludes that it serves a descriptive function for its users, one that can be used to denote significant emotional disturbance. Although Omark does not attempt to reclassify the term as a psychiatric diagnosis, he dissects it via the diagnostic instruments of aetiology, behavioural traits and treatments, thereby treating it as a psy-construct. Nonetheless, he makes space for it to hold some ground as a term in and of itself and one that people choose to fulfil a social purpose.

The examination of ‘nervous breakdown’ as a construct in a lay space is laden with articles that look at problems of nerves in general. I have chosen to include these in the literature review as they were returned in a search for ‘nervous breakdown’ and

because they shed some light on the terrain in which the term is situated. Moreover, these papers tend to be located in a quasi psycho-medical hinterland: seeking to give validity to the term as owned by the populations under study but also discussing it within a psychiatric framework.

For example, Nations, Camino and Walker (1988) look at nerves as a folk idiom for depression and anxiety. They conclude that it needs to be regarded as worthy of the gaze of physicians and suggest that these same physicians work with the alternative healers (seemingly preferred by the sufferers of nerves) and not in opposition to them. Similarly, Jenkins (1988) studies nerves and their breakdown as a lay term used by Mexican-Americans that she regards as synonymous with schizophrenia as described by an Anglo-American sample. Her contention, however, is that indigenous descriptors of mental illness be they nerves or schizophrenia be given equal validity by western diagnosticians, and furthermore that this is crucial for the patient's welfare. Davis and Whitten (1988) also contend in their study of nervous complaints in a small Newfoundland community that these complaints have had a variable and social history and that they counter an attempt to be fixed in diagnoses of anxiety. The authors point towards a nervous complaint as having the features of a social construct, and one that performs variable social functions for its users.

Gove (2004) continues with this line of thought and begins to explore the idea that people might deploy 'nervous breakdown' to serve a social purpose. He examines its use by subjects who wish to avoid diagnoses of mental illness and concomitant hospitalization. This research focus imbues 'nervous breakdown' with a sense of being an effective lay discursive strategy that is apart from but exists in reference to the psy-institution. However, Gove's focus is on the hospitalization process and he does not take his exploration of 'nervous breakdown' further than suggesting it has a social function within a lay or popular discursive space.

Another feature of the literature that positions 'nervous breakdown' as a lay construct are those texts that seek to examine survivor narratives: the stories of people who have

had a ‘nervous breakdown.’ These tend to be written as first person accounts and function primarily as testimonies, and as self-help recovery tools for other members of the public who may be in ‘nervous breakdown.’ They position the lay narrator-survivor as owner, author and expert on ‘nervous breakdown’ and include recommendations for psy-practitioners on how best to work with this population (Daneë, 1975; Lea, 2010; Purdie & McLennan, 1993). Here, the idea of a literature review becomes blurry. There are less than a handful of accounts within the canon, but a litany of popular texts on the internet and on the self-help shelf of the bookshop (e.g. Dent, 2013; Patkin, 2011). I had to pause a moment and think where this piece of work stands with regard to who is expert. After some deliberation, and for the purposes of this section of the work, which falls under the formal ambit of academic literature review, I have limited inclusion to those accounts in the academic literature databases. However, the thesis as a whole considers those texts on ‘nervous breakdown’ that are extra-academic to be as relevant to the construct and will refer to them throughout. This is particularly because of the disparity in volume between popular texts on the term and those in the academic literature which has driven the research agenda for this project. This suggests, as this review is beginning to indicate, that it is necessary to consider how ‘nervous breakdown’ straddles the two spaces, and furthermore what this accomplishes and for whom.

1.1.3. ‘Nervous breakdown’ as written for the lay person by clinicians

There is a significant cluster of books and journal articles that appear in the early twentieth century on the topic of ‘nervous breakdown’ and which position ‘nervous breakdown’ within the popular realm (Ash, 1920; Loosmore, 1921; Luce, 1935; Musgrove, 1913; Wolfe, 1933). These texts, akin to self-help manuals, offer empathy, explanation and a gamut of cures for those suffering from ‘nervous breakdown.’ Many of these texts are written *for* the public *by* clinicians, and tend to deploy ‘nervous breakdown’ as a way to bridge the clinical diagnoses of nervous illness, such as neurasthenia, with the experience of the common man or woman. For example, Loosmore’s (1921) study of nerves and ‘nervous breakdown,’ while a clinical text, is also aimed at the public. The very title of his text is *Nerves and the Man: A Popular*

Psychological and Constructive Study of Nervous Breakdown. Loosmore goes to great lengths to identify with the sufferer and uses the pronoun “us” frequently, bridging the dichotomy between clinician and layperson. Moreover, while he talks about diagnoses of neurasthenia, which was the psycho-medical label du jour for the nervous subject, he insists on using ‘nervous breakdown’ when speaking of the experience of the layperson-reader. For example, in his introduction Loosmore (p.1) notes that “The ominous phrase ‘nervous breakdown’ is a painfully familiar one to an increasing number of men and women these days. Happily it is merely a phrase to the vast majority of us.” Loosmore’s text thus situates ‘nervous breakdown’ in the discursive terrain of nervous disease. However, he implies that it is a term more relevant to the layperson than the vicissitudes of nervous diagnosis and thus positions himself a bit like a clinical translator: explaining this construct back to the public and explaining how they can recover from it. This is different from those more recent clinical texts that attempt to explain ‘nervous breakdown’ to psy-professionals and which subsume it under psychiatric diagnosis.

Loosmore is in good company. A host of his contemporaries were also trying to explain ‘nervous breakdown’ back to the public: to impose a clinical understanding on the lay term but to do it *for* the public. These endeavours did not attempt to wipe out the popular term, however. They did quite the opposite by giving it a clinical legitimacy in a popular space and arguably also a popular legitimacy in a clinical space. For example, in 1913 Charles D. Musgrove M.D. wrote *Nervous Breakdowns and How to Avoid Them*. This is explicitly a self-help book for the public written by a medical doctor. Musgrove makes a similar move to Loosmore – a clinician appropriating a lay term and then expertly explaining the same term back to the public and pronouncing on its correct management. Musgrove’s book would not seem amiss on any contemporary self-help bookshelf. He too situates nervous breakdown in the ambit of his clinical knowledge of nervous disease and much like a children’s story, masks this expertise through personal resonances with this common term. The same move is replicated by Ash (1920), Luce (1935) and Wolfe (1933) who aimed to compile layman’s guides to ‘nervous breakdown.’ Wolfe begins to assert that

‘nervous breakdown’ performs a social function: that of allowing a person with a psychiatric disturbance to hide behind the more socially acceptable veil of this term and also to hide behind the bed-rest it necessitates. In this regard, he and Gove (2004) are not so many worlds apart.

Crucial to all these texts is that they do not reject ‘nervous breakdown’ as an incorrect or inferior term to the official diagnoses of nervous disease. Rather, they seem to indicate that psycho-medical experts not only accepted it as common parlance but at times talked about it as if it were diagnostically valid and of interest to them. They vacillate between Wolfe’s (1933) assertion that it is wholly a lay term that belies psychiatric disturbance and Musgrove’s (1913) use of the term which seems to entertain it as some-thing real and valid within the psycho-medical realm. Nonetheless, the term did not exist in the formal taxonomy, but there seemed to be greater institutional recognition of its popular significance. There are almost no accessible popular texts on the subject from that era probably owing to the inability of the public to self-publish at the time. However, diary entries and letters of public figures do refer to nervous complaints, including ‘nervous breakdown’ as a relevant way of constructing their experiences. For example, Appignanesi (2008, p. 127) references the diary kept by Alice James in the late nineteenth century. She was sister to the famous Henry and William James. In it, Alice describes many of her encounters with the treatments of Silas Weir Mitchell, eminent American specialist in nervous diseases, and she constructs herself in terms of the language and motifs of nervous disease and breakdown.

1.2. The nervous subject

Alluded to in all these texts is the discourse of nerves, nervous complaints and the nervous subject. The exact genesis of nerves as the primary site of interest to the psycho-medical gaze is unclear – talk of nerves extends as far back as Hippocrates in 4 B.C. (Davis & Whitten, 1988). However, nervous illness emerged as the predominant modern western explanation for “neurological and psychiatric illness of a

nonpsychotic nature” in both the public and psycho-medical domains from the mid 18th to the mid 20th centuries (Shorter, 2013, p. 18). In other words, the term was used to explain mental and behavioural deviances that were not ascribed to the madness of psychosis – deviances that were reducible to an organic, and therefore curable, systemic malfunction. In 1684, Thomas Willis, the English physician heralded as the father of modern neuroscience, presented his *Essay of the Pathology of the Brain and Nervous Stock* to fellow academics and clinicians. This marked the official debut of the nervous into a scientific space (Shorter, 2013). It also shifted the site of interest away from the caverns of the mind and humours and vapours of the body to the nervous substance of the brain itself (Pryse-Phillips, 2009). This signalled a conceptual marriage of the physical and the mental: with the nervous tissue of the brain and its subsystems coming to represent both (Appignanesi, 2008).

The subsequent Victorian era saw the import of stress and machinery metaphors from the domain of engineering to the domain of the human body (Synnott, 1992). It was after all, the Industrial Revolution, and the landscape was filled with the clamouring and clattering of machines and the men who operated them. Thus, as Barke et al. (2000) contend, it was not a far stretch for the imagery of this landscape’s mechanical language – its laws of pressure and corrosion – to be brought to the site of nerves, which were being positioned as the seat of human experience. In a world that was jumpy, noisy and ever increasing in speed, it was inevitable that this would be reflected in the ways in which the public and clinicians alike chose to construct experience and the human subject. As such, nerves were inscribed with the irritability, jitteriness and electricity of the era (Thraikill, 2010). The nervous subject gained popular purchase through its resonance with these motifs, and the idea that the impositions of the time could directly affect, via the nerves, the very fibres of one’s body (Appignanesi, 2008). This idea was also popular because of its explicit organic foundation which distinguished it from the more inexplicable kinds of madness. As Shorter (2013, p.17) contends “it is much better, people think, for the nerves than the mind to be ill.”

As such, the nervous subject was constructed as inherently sensitive and volatile, and permanently susceptible to external pressures of the times. It is here that the discourse of breakdown finds its way into the space of nerves. Part of the mid nineteenth century discursive import from the engineering plant was the metaphor of breaking down under strain. Transferred from steam engines to human beings, it became increasingly common for the western subject, clinician and layperson alike, to ascribe physical or mental collapse to “the stress of his will and the strain of his perseverance” (Bucknill & Tuke, 1858, p. 49 as cited in Kugelman, 1992, p. 135). Such subjects were frequently described as broken or breaking down, just like the engines that were building the cities and factories around them (Barke et al., 2000). While initially applied to cardiac arrest, this kind of embodied collapse owing to overwhelming external strain was soon brought to the nerves. Strains of living such as worry and working too hard were construed as depleting and corrosive to the nervous system and as potentially causing physical and/or mental collapse (Shorter, 2013). This collapse, as has been suggested, was increasingly described in the terminology of breakdown. Strain was replaced with a preference for the words stress after the 1900s, but the idea that the act of living could inevitably corrode embodied nerves, via the inevitable strains and stresses it imposed, became firmly implanted in the discursive pool (Kugelman, 1992). This implied not only a mechanical construct of nerves but also an economic image of them: whose reserves could be shored up or depleted depending on exposure to external strains (Appignanesi, 2008).

In addition to this, the toll of Victorian life on the nerves was inevitably depicted as gendered. Women’s transgressions of gendered norms, through working or taking up positions of independence from their male custodians, were considered to be draining of their nerves (Appignanesi, 2008; Logan, 1997). Similarly, men who openly took up more feminized positions were described, somewhat disparagingly, as nervous (Micale, 2008). Women’s inroads into the masculine domains of intellectual labour and public opinion were considered precipitous of collapse and exhaustion owing to their depleting the female nervous economy. For women, their nervous reserves were considered already in jeopardy owing to the toll of reproductive labour and

menstruation (Cayleff, 1992). The resonance with the female hysteric, rendered mad and volatile because of her womb, is quite profound. As Davis (1989) points out in her socio-historical study of nervous discourse between the late nineteenth century and World War I, ideas of the nervous vulnerability of women seem to increase at times of dramatic social change when traditional feminine roles are necessarily disrupted.

The construction of the Victorian nervous subject, however, does not include ‘nervous breakdown’ in its formal taxonomy. Rather, the diagnostic literature focuses on conceptualising the nerves, on distinguishing the nervous subject from the humoral subject, and on forging its scientific and popular legitimacy (Beatty, 2012; Hare, 1991; Shorter, 2013). It must be noted at this point that the distinction between mind and body doctors in the nineteenth century was blurry. Psychiatry was still being established as a valid field of expertise, thus all manner of physicians, obstetricians and spa doctors alike weighed in on the nervous conversation (Shorter, 1997; 2013). Perhaps this reflects both the blurriness between medical domains at the time but also the liminality of the nervous which was being positioned as both mental and physical, albeit with a preference for the physical.

Nerves, the nervous and their treatment had become increasingly popular with clinicians and the public from the eighteenth century onwards, housing a panoply of diagnostic maladies from dyspepsia to paralysis that all seemed reducible to the nervous system (Ishizuka, 2010). However, the nervous coalesced into the formal diagnosis of neurasthenia in 1869 when American physician, George M. Beard endorsed the diagnosis in various medical journals and addresses to fellow clinicians (Gijwijt-Hofstra, 2001). While the diagnosis functioned almost synonymously with that of previous ideas of nervous irritability and fatigue, it served to cohere and formalise the concept of the nervous into a diagnostic syndrome (Shorter, 2013). Neurasthenia fore-grounded the symptom of nervous exhaustion, resulting from day-to-day toils and strains, and located it in both body and mind. However, it was explicitly defined as organic and thus differentiated from madness (Schuster, 2011). Neurasthenia’s clinical validation rendered the discourse of nerves and nervous as old-

fashioned. ‘Nervous breakdown’ as a term was nowhere to be found in this official diagnostic lexicon, except as a popular anecdotal expression for moments of nervous collapse that precipitated a diagnosis of neurasthenia (Barke et al., 2000).

Nonetheless, despite its position as organic illness, neurasthenia and the nervous complaints it housed were located between the mind and the body, between psychiatry and an emergent psychoanalysis and the general physician. This is precisely because the symptoms that the nervous subject and his/her doctor described were located in both the tissues of the body and in the disposition, moods and emotions of the mind: organic and psychological (Loughran, 2008). The diagnostic category of hysteria suffered a similar predicament (Micale & Lerner, 2001). This ambiguity made it easy for the newly developing body of psy-practitioners to encroach on the nervous subject, rewriting him/her into their clinical discourses and eroding the grip of neurasthenia (Neve, 2001; Wessely, 1991). At the dawn of the twentieth century, many neurologists, outside of psychoanalysis, also began to dismiss neurasthenia’s nervous substructure, relocating its symptoms purely in the affective and psychic domains (Shorter, 2013). The diagnosis and the particularities of the nervous subject it constructed started to wane from the clinical and popular conversations.

The dilemmas that the treatment of World War I’s shell-shocked veterans posed acted to further dismantle the nervous foundations of the diagnosis. Western clinicians from all fields were rapidly forced to reconstruct their understanding of trauma and its treatment after 1914. They were forced to revisit their pre-war preference for locating nervous complaints in the soma over the psyche (Loughran, 2008). Many in the western clinical communities thus became more embracing of Freud’s contention that some features of neurasthenia were actually anxiety neuroses hallmarked by variants of anxiety, phobias and terrors, and a predominantly psychological aetiology (Stewart, 1967/2014). Freud re-worked his idea of these neuroses and the neurotic subject they described, divorcing them more and more from the somatic and conscripting them into the space of psychic and not somatic disturbance (Beer, 1996). The discursive overlap of nerves and psychoanalysis is firmly anchored in the use of the term neurosis and

the neurotic. Shorter (2013) makes the distinction between neurosis as a general adjective for the nervous subject, and one that has continued to be of use in neurology, and as a key concept of psychoanalysis. The concept has long since evolved in the psychoanalytic tradition, coming to denote all manner of things according to different theoretical schools, but crudely put, it denotes a psychological state or structure, hallmarked by a capacity for anxiety, worry and self-reflection (Sugarman, 2007). Psychological discourse, and particularly that of psychoanalysis, is pervasive in contemporary popular constructions of experience and personhood (Parker, 1997). It follows therefore, that the nervous subject, while constantly re-written and contextually fluid, remains sedimented in the western discursive reservoir.

1.2.1. ‘Nervous breakdown’ after World War I

Neurasthenia still exists as an ICD diagnostic classification (Buck, 2014). However, it has become increasingly marginalised in clinical and popular spaces after 1914. The trend to relocate distress from a somatic to a psychological space increased after World War I and neurasthenia and nerves were undercut by diagnoses of depression and anxiety (Neve, 2001). Yet, the nervous subject remained and as testified to by the likes of Loosmore (1921), the clinical literature of the time still reflected reports and diagnoses of nervous exhaustion and fatigue, which Shorter (2013, p. 49) contends functioned as synonym for the colloquial ‘nervous breakdown.’ The latter still seemed to be located in the popular-psy conversation in the first half of the twentieth century, and the public used it liberally to refer to their difficulties in managing of all manner of tensions, worries and social upheavals. Barke et al. (2000, p. 575) believe that this, like the inscription of nerves with the insignia of the Industrial Revolution, was a way of capturing the impositions of the “major innovations in the standards for emotion, appearance and personal function” that the modern era put upon the individual, and particularly, the competing demands they placed upon women. The authors suggest that in the mid-twentieth century to have a ‘nervous breakdown’ served the social function of being able to bow out of the pressures and contradictions of modern life, and to attribute it, much like the neurasthenic, to an embodied not a psychiatric malfunction. This resonates with the current position of Gove (2004) who believes

that the term serves the social function of allowing people to avoid diagnoses of mental illness and consequent hospitalization.

However, what emerges both from this literature review and those conducted by Barke et al. (2000) and Shorter (2013) are two things. Firstly, that ‘nervous breakdown’ never existed within the formal diagnostic literature, even during the zeitgeist of nervous afflictions between 1820 and 1914. It was used as an undefined colloquialism, a neologism, and a short-hand for describing a range of experiences. While it was used predominantly by the lay person, it was also used by clinicians of that era, particularly in their conversations with the public. Secondly, what emerges is that ‘nervous breakdown’ remained in psy’s conversation with the public for some time after the demise of neurasthenia and its translation from the somatic to the psychological. The writings of Loosmore (1921), Wolfe (1933) and Luce (1935) all attest to this.

While there is another spike in the psycho-medical literature specifically on the term during and immediately after World War II (e.g. Gantt, 1943; Gantt, 1953; Tooth, 1944), this work is aimed at fellow clinicians only. In Gantt’s case (1943, 1953), he borrows the term ‘nervous breakdown’ to describe a behavioural learning process much in the vein of Pavlov and Skinner. While this is anomalous in the literature as a whole, Gantt, like the arbiters of nervous disease, uses the term to describe an organic breakdown situated within nervous tissue. Tooth (1944, p. 358) uses the term, again without definition, to refer to the moment of “frank psychiatric collapse” of naval officers. He writes as a military psychiatrist for his peers, and like some of his contemporary academics such as Swindle et al. (2000), uses the term as an undefined short-hand in a conversation between psy-experts about lay people’s experiences. Simultaneously, in the mid-twentieth century, psychoanalysts and their cognitive behavioural opponents were both writing about and treating neuroses and the neurotic (e.g. Ellis, 1957; Eysenck, 1952; Fenichel, 1946; Horney, 1946/2001; 1950/1991), but do not appear to deploy the term ‘nervous breakdown’ in their texts. Access to the popular discursive terrain of the time is more difficult since there are no databases that

have captured the dinner table and corridor conversations. Yet, it would seem that the term, in contrast with the psycho-medical literature, remained visible in popular discourse. Barke et al., (2000) contend that it was widely-used by middle-class Americans from the 1920s to the 1960s, although their paper is scantily referenced in this regard. Shorter (2013) finds a few more citations of its popular use in this era, including in the accounts that American soldiers returning from World War II gave to their doctors.

The psycho-medical literature on ‘nervous breakdown’ diminishes after the meagre post-war offerings. References to it in the popular press also decrease after the 1950s (Barke et al., 2000; Shorter, 2013). The last stand seems to have been made by American doctor Frank Caprio (1969) in his self-help book *How to Avoid a Nervous Breakdown*. His work is resonant of that of Loosmore and his contemporaries, and offers tips on self-diagnosis and cure. Positioned as a doctor, Caprio gives ‘nervous breakdown’ a psycho-medical legitimacy, even though it still remained a popular term. Arguably he co-opted it into the realm of his expert interest and then fed it back, transformed by this expertise, to the public. As a self-help manual, it is debatable whether this text functions as part of the institutional literature or the popular literature. Again, this positions the term as somewhere between psy and popular spaces: in transit and liminal.

Barke et al. (2000) and Shorter (2013) contend that there has been a decline in both clinical and public popularity of ‘nervous breakdown,’ after the mid-twentieth century owing to two major changes in the landscape of western medicine and psychology. Firstly, the American Psychiatric Association began publishing its series of official Diagnostic and Statistical Manuals (DSM) from 1952. This served to render the polarities between psychiatric and public terminologies highly visible, denoting the former as expertly correct and the latter as, if not incorrect, then insubstantial (Barke et al., 2000). Many argue that the position of expertise that the DSM taxonomy espouses has been reinforced by subsequent editions of the DSM and that this language is prioritised as expert in both clinical and popular spaces (e.g. Parker, 1999;

Wilson & Beresford, 2002). ‘Nervous breakdown’ is nowhere to be found in the DSM I (American Psychiatric Association, 1952). It was therefore explicitly dumped in the 1950s by virtue of the DSM into a colloquial and inexpert position vis a vis the psy-institution, and vis a vis the public for whom expert language functions to convey knowledge and legitimacy (Lafrance & McKenzie-Mohr, 2013).

Secondly, at the same time, the diagnoses of depression and anxiety were taking centre stage. Psychoanalysts had introduced the term depressive as an adjectival precursor to neurosis and as such it had become firmly established in the prevailing psy-discourse of the time and its ripple effects into the popular domain (Shorter, 2013). As has been discussed, the shift from soma to psyche in explaining distress had gained momentum after World War I (Loughran, 2008). Non-analytic psychiatry had also begun to focus its attention on mood disorders, particularly hybrids of anxiety and depression, which they described as mental (and therefore not-physical) disorders (Shorter, 2009).

Thus, psy-experts began to diagnose and construct the once nervous public as anxious and depressed, leaving little room for the likes of ‘nervous breakdown’ in the socio-discursive space. The promulgation of the pharmacology for mood disorders, while re-introducing the physiological into the psychological, has augmented the hegemony of these diagnostic constructs by reducing them to a biological determinism (Leader, 2013; Shorter, 1997; 2009; 2013). Moreover, the re-introduction of a biological aetiology into the expert literature has not necessarily acted to diminish the stigma attached these diagnoses: while arguably less mad than psychotic diagnoses, they are still circumscribed by the stigma of a discourse of mental illness (e.g. Angermeyer & Matschinger, 2003).

However, the purported disappearance of ‘nervous breakdown’ from the psycho-medical literature after the mid-twentieth century is debatable. It has never been highly visible in this domain in the first place, except perhaps as a peripheral discursive accessory to the Victorian heyday of the nervous subject. Even then,

official clinical citations are limited to a handful. The literature that refers to it has always been scant, and yet always on the radar. This undermines the absolutism of disappearance that Shorter (2013) and Barke et al. (2000) refer to. In fact, Askanasy (1974) picks up on the trail that Caprio (1969) left a mere five years later. Omark enters the conversation in 1980, and again, while the conversation continues sketchily, it still continues. Shorter's (2013) book marks the latest academic entry into the psychology literature.

The conversation about nerves and the nervous subject has never waned. Willis's nervous subject of 1684, was transformed by the various Victorian clinicians and their patients who picked up on the term. It was never uniformly used nor uniformly understood within this era, even when coalesced around the diagnosis of neurasthenia (Gijwijt-Hofstra, 2001; Ishizuka, 2010). The nervous subject has been appropriated into psychoanalysis and its psychodynamic offshoots, again with huge discursive variability from Freud's early work on neuroses to more recent work that attempts to find common ground between psychoanalysis and neuroscience (e.g. Fonagy, 2010; Kaplan-Solms & Solms, 2000).

The nervous subject has also been taken up in different ways by the proliferation of specialities that mark the current medical landscape of expertise. For example, neuroscience, neurology and even neuropsychology lay claim to a biological substructure of the nerves and the brain, also with huge variability in what they mean by and do with nerves and the nervous (e.g. Biller, 2012; Heilman & Valenstein, 2012; Lundy-Ekman, 2013). Other medical specialists from endocrinologists to gerontologists also speak of the nerves and the nervous, once again, meaning and doing different things with these constructs (e.g. Lee & Notterpeck, 2013; Smith, Betancourt & Sun, 2005). Interestingly, some of this medical discourse even deploys the terms 'nervous' and 'breakdown' – never as a discrete term – but nonetheless, discursively resonating with it (e.g. O'Toole et al., 2009; Sharma, 2005)

The greatest overlap in the contemporary talk of nerves in the medical terrain comes perhaps from the discourse of stress. While a highly heterogeneous construct itself (e.g. Odgen, 2002), medical and health experts seem conceptually unified in extrapolating that stress has a corrosive effect on the body's nervous system, and that this nervous stress is highly predictive of physical and mental illness (e.g. Bennett, Rodrigues & Klein, 2013; O'Connor, Moynihan & Caserta, 2014; Vanltallie, 2002). This overlap is undoubtedly already present in the Victorian motif of nervous strain, but it has been reworked, with a high degree of contextual variability, in the contemporary discursive terrain (Brown, 1999). As discussed, the metaphor of breakdown, which the Victorian doctors borrowed from their engines, is still knocking about and not only under the microscopes of neuroendocrinology. Eminent British psychoanalyst, Christopher Bollas, released a book in 2012 entitled *Catch Them Before They Fall: The Psychoanalysis of Breakdown*. The language of breakdown has prevailed in the psy-discourse, with reference to a plethora of different subjects including self-control (e.g. Dewitte, 2013), relationships (e.g. Boden, Fergusson & Horwood, 2013), and foster care (e.g. Olsson, Egelund & Høst, 2012).

The nervous subject also takes centre stage in feminist theory in the social sciences. The nervous woman is invoked in studies on gender oppression and mental health, ranging from anorexia nervosa (e.g. Malson, 1998) to hysteria (e.g. Briggs, 2000; Micale, 2008). She is invoked in literary studies, including in the deconstruction of the post-colonial woman (e.g. Shaw, 2007) and the deconstruction of Victorian romanticism (e.g. Logan, 1997). The nervous woman is also found in academic writing on production and labour (e.g. McRobbie, 2007), sport (e.g. Hargreaves, 1994), and cyborgs (e.g. Balsamo, 1996) to name but a few more examples. Mainly, the ghost of the Victorian nervous woman is invoked in these texts but again, this in and of itself is not a homogenous and static construct, let alone when appropriated into other spaces, over a century later. Nonetheless, what this goes to show is that while references to 'nervous breakdown' may be scarce, the nerves and the nervous have been going strong. Unquestionably, the nervous subject and its permutations in locale

and form are closely related to ‘nervous breakdown.’ Yet, the official conversation on the latter term seems far less pervasive and mirrors its anecdotal status.

1.3. In summary: ‘Nervous breakdown’ and this research

What emerges from this review of the academic literature is that the academic literature on ‘nervous breakdown’ as a specific term is scarce. What there is, is both overwritten by and yet also created and legitimated by psy-discourse, and the use of the term waxes and wanes across this divide. It is intimately related to psycho-medical constructions of the nervous and stressed subject, and yet, not quite. It is given a status within this psy-discourse that is taken for granted by *both* the psy-researchers and public alike. It is used as an undefined short-hand, regarded as not only relevant to mental illness, but often indicative of it, particularly in the more contemporary research. Ironically, this same research (e.g. Rapport et al., 1998) tends to negate the label under the corrections of DSM taxonomies of depression, anxiety or schizophrenia.

In the literature, ‘nervous breakdown’ is positioned as a lay term, and in some cases, as a term used by cultures designated as other to the modern west (e.g. Askanasy, 1974; Cintrón et al., 2006). Yet, it is still rendered an object of interest to the authors of this research who, like the intrepid colonial anthropologist, go out to study it in situ but rush home to reclassify it according to a higher order taxonomy. Even when such authors do not do this, positioning it as a term with contextually-bound relevance for the folk, the lay, or the foreign, many of these emic endeavours are subverted by the lack of interrogation of the term itself, or its ultimate co-option into care-pathway recommendations or diagnostic recommendations (e.g. Jenkins, 1988; Nations et al., 1988).

Clinicians who have used the ‘nervous breakdown’ to sell self-help books have done so by subsuming it under their expertise while simultaneously positioning themselves as benign paternal figures in conversation with the public. This friendly duplicity is

arguably a more powerful appropriation of the term than that performed by those scientist-practitioners who do not pretend to be in dialogue with the public in the first place. These self-help authors appropriate the ‘nervous breakdown’ *from* the academic sidebar and the popular space into the realm of their expertise, re-selling it at a price, and imbued with the veneer of psy-legitimacy *back* to the public (e.g. Caprio, 1969; Musgrove, 1913). In most cases, they do not pause to signal to the reader that the term is not an official diagnosis, but neither do they pause to define it for themselves. Again, the term finds resonance with a popular taken-for-grantedness and legitimacy.

This anecdotal, undefined colloquial slipping and sliding of ‘nervous breakdown’ across the literature suggests that it is not akin to a fixed thing at all, but rather that it is a social construction. It is a construct that is contextually bound and which serves a socio-discursive function for its users. Gove (2004) begins to suggest that it functioned in an explanatory fashion to avoid diagnoses of mental illness and hospitalization in a small sample of people. Wolfe (1933) suggests that it serves a similar function. Davis and Whitten (1988) point to the term’s variable socio-historical discursive functions in a small Newfoundland community. Barke et al. (2000)’s social history of the term suggests too, that it served a purpose for the public who used it, particularly between World War I and World War II. They suggest it functioned to communicate individual difficulties in adapting to the contradictions of the modern era, but without suffering the stigma of a psychiatric gaze. Shorter (2013) explicitly suggests that it is a term, like the other nervous complaints, that avoids categorization into the crazy pole of the psychiatric diagnoses.

The mere fact that nervous complaints have had so many vagaries and re-appropriations since 1684 is all the more evidence suggesting they function as social constructs, and not as fixed things. Moreover, where they have functioned as reifications, they have often served the purposes of patriarchy and western colonization of the an-other (e.g. Appignanesi, 2008). For example, homosexuality functioned as a legitimate diagnosis of psychopathology until it was removed from the DSM in 1973 (Drescher, 2010). The racial, cultural and class-based biases in

psychometric testing have also had a longstanding role in lending scientific credibility to the perpetuation of discrimination against so-called others (Hudson, 1995).

1.3.1. An excursion: Towards exploring current and popular constructions of ‘nervous breakdown’

To return to where we started: the disparity in the use of, and interest in ‘nervous breakdown’ between the psy and popular domains is striking. It has currency for over nine million people on a Google internet search – more even, if I were able to count the number of people using it on forums, Twitter or Facebook. Perhaps it had the same or even greater currency a hundred years ago, but there was no space like the internet in which to capture a snapshot of its use. Since I started writing this chapter, actor Alan Cummings released his memoir, in which he, like Oprah Winfrey and Cheryl Cole, confesses to a ‘nervous breakdown’ (Cummings, 2014). Posters have gone up across London announcing the launch of a West End theatre production of Pedro Almodóvar’s *Women on the Edge of a Nervous Breakdown*. And yet, the latest offering from the meagre pickings of the psy-institution wants to reduce the term to a diagnosis of melancholia and thereby reintroduce it into the psychiatric taxonomy (Shorter, 2013). This not only reifies the term, nullifying its variable functions across space and time, but also remains deaf to the millions of people interested in and using the term.

Clearly, given that ‘nervous breakdown’ exists within the socio-discursive imagination of so many, including psycho-medical practitioners, even if as a neologism or a footnote, it warrants interrogation. This is particularly important because it is so imbued with the discursive legacy of psy-diagnoses and also because the literature that exists on it tends to co-opt the term back into this taxonomy. The psy-institutions have laid claim to diagnosing, treating, and in some cases withholding the personal freedoms of those whom they diagnose (Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995). They are supported by larger and more powerful institutions of knowledge, government and private sector business. This is an empowered cluster of institutions and the ways in which it constructs its patient-client

subjects has consequences for those people, who are arguably less empowered in interactions with these institutions (Crossley & Crossley, 2001; Foucault, 1965). Moreover, the discourses of these institutions carry clout in popular constructions of experience and identity, which emerge through dialogical, negotiated processes of discursive construction and re-appropriation at the psy-popular interface (Dineen, 2004; Speed, 2006; Rose, 1985). This is deeply resonant of the liminal position of 'nervous breakdown' that the literature has sketched out so far.

This relational and liminal nature of 'nervous breakdown' runs like a red thread throughout talk about it. As discussed, it is both part of and extra to a psy-lexicon. Flipped the other way, it is both owned by and not owned by the lay subject. It exists, like most discursive constructs, somewhere in the elision between institutions, histories, and social climates. The current trend in mental health-care has purportedly shifted away from an overt psy-hierarchy to one of greater collaboration with subjects or service-users in order to address the historical disempowerment of the mad, bad and sad by those laying claim to their construction and cure (Pilgrim & Rogers, 1999). Therefore, a counselling psychological research enterprise that aims to explore popular constructions of 'nervous breakdown' would be consistent with this discipline-wide aim (McLeod, 2001; Rennie, 1994).

Furthermore, there is an increasing awareness of the constructed and oppressive nature that psy-diagnostic categories and their consequences may hold for those subjects who are diagnosed (e.g. Cosgrove, 2005; Kitzinger, 1996). These critiques have pointed to the variability in constructions of mental illness over time and space (Horwitz, 2002). They have also emphasized the power imbalances and consequences thereof when certain subjects' constructions of their experiences are marginalised, silenced or co-opted for distinctly oppressive purposes (Appignanesi, 2008; Hansen, 2010). Those who are silenced are usually the patient-clients, not the psy-professionals. As such it makes sense for contemporary counselling psychologists to be alert to discursive constructions marginalised from the expert realm especially when these constructions, such as that of 'nervous breakdown,' seem to be salient to

their potential clients³. After all, ‘nervous breakdown’ is already situated on the discursive door-step of the institution, with one foot in and one foot out of the waiting room.

Thus disparities and relationships between the ways in which many would-be clients may be constructing their experiences of ‘nervous breakdown’ and the attention and credibility that psy-practitioners, including counselling psychologists, give to those constructions needs to be addressed. Speaking from a position within counselling psychology, this serves not only to understand those would-be clients better but also to intentionally *not* override their language and the social functions it performs for them with our so-called expert language (and the social functions this performs for us as practitioners). Moreover, even if those who use ‘nervous breakdown’ are not to be would-be clients, as the work of Gove (2004) and Barke et al. (2000) might suggest, this is of interest in itself. For if as these authors contend, ‘nervous breakdown’ performs the discursive function of avoiding being positioned in the psy-domain, then we need to ask ourselves why, and we need to ask this with discursive specificity: why are these people in this context wanting to avoid interfacing with psy-practitioners? This would offer us useful critical commentary on our profession and its limitations within specific sites of practice. It would also offer insight as to how people might resist psy’s all-seeing gaze, and the other spaces and discourses they might consult when in distress. This again, is not only of sociological interest, but has a direct bearing on how we might direct future psy-practice. It speaks to which domains might not be within our purview, but which might still be useful to people in mediating distress.

As such, this project aims to explore popular social constructions of ‘nervous breakdown.’ Given the paucity of research that is salient to this aim, the project is necessarily exploratory and modest. It is concerned primarily with how the subject navigates his/her way through the contemporary discursive terrain of ‘nervous

³ I use the word ‘client’ in accordance with counselling psychology’s preference for this nomenclature as opposed to psychiatry and psychoanalysis’ preference for ‘patient’

breakdown' and the implications of this for the subject and his/her relationships with psycho-medical practices, such as counselling psychology. This warrants a two-step research aim and process. Firstly, it necessitates a mapping of the contemporary popular discursive terrain of 'nervous breakdown' in order to have a sense of what discourses and positions are available to the subject. Secondly, in order to explore *how* the subject navigates this terrain, which subject positions he/she takes up, when and to what purpose, it is necessary to zoom in on subjective constructions of 'nervous breakdown' and the accounts of people who self-identify with the term. The nuts and bolts of this research process will be explained in detail in the following chapter on the methodology of this research. But for now, the Twitter feed is lighting up once again, and Google, through its all-seeing search engine, is advertising me a tonic called "Stress Damage Control," which somehow its algorithm has linked to my perpetual search term of 'nervous breakdown.' At this point, it is quite clear that I am also positioned as subject in this nebulous discursive hinterland of 'nervous breakdown.' I am even considering buying the tonic.

2. Methodology

I have divided this chapter into two main parts. The first part outlines the theoretical underpinnings that inform this thesis and situates the research within the conversation about discourse in psychology. It then elaborates on the main strands of discourse analysis that have contributed to the approach taken in this project, namely discursive psychology (DP) and Foucauldian discourse analysis (FDA). These, while distinctive, can also be understood as complementary in allowing for psychological research that is both critical and discursive in nature (e.g. Edley, 2001; Wetherell, 1998). From this contextual position, the second part of the chapter provides an overview of the specific methods used to carry out the research.

2.1. Situating the methodological approach

As has been discussed in the previous chapter ‘nervous breakdown’ is a discursive construction. It appears within text, language and symbol and its meanings, uses and consequences differ across institution, speaker and context. By extension, to have a ‘nervous breakdown’ is a meaning-making enterprise that requires one to draw upon a collective semiotic reservoir and is also socially, culturally and politically situated. The term can be appropriated, re-appropriated and also ignored by clients (would-be or would-not-be), psy-practitioners and institutions alike with variable consequences and purposes. Attempting to unpack moments when this happens *and* the implications of this for the subjectivities of people who self-identify with the construct and their concomitant relationships with psycho-medical practices, processes and institutions (not least of all counselling psychology) is the core aim of this research.

Therefore any attempt to explore the term must deploy more discourse *and* requires me-as-researcher to reflexively engage in this discursive unfolding. As such, this research is situated within a critical social constructionist epistemology, and aims to use critical discourse analysis to explore the use of the term (i) through analysis of a selection of popular media texts to gain a sense of the current constructions of ‘nervous breakdown’ and related subject positions that are made available in the

discursive terrain, and (ii) through the use of semi-structured interviews to explore how people who self-identify with the term accomplish this. The research is crucially engaged with the relationship between the discursive terrain of ‘nervous breakdown’ and how the subject navigates his/her way through, around, into and out of it.

This description of approach implies a particular epistemological lens informing the research: social constructionism. Since the late 1970s, psychology has begun to engage more with this philosophical position and has produced a buffet of research and methodologies informed by it (Blackman, Cromby, Hook, Papadopoulos & Walkerdine, 2008). I have chosen to approach data collection and analysis in this research by drawing on both discursive psychology (Edwards & Potter, 1992; Potter, 2012a) and Foucauldian discourse analysis (Arribas-Ayllon & Walkerdine, 2008; Hollway, 1984; Parker, 1992). I elaborate on the rationale for this choice later in this chapter. First, though, I provide an overview of the epistemological stance of this project.

2.1.1. Discourse, the critical and psychology

This research is concerned with problematizing the construct of ‘nervous breakdown.’ The mere act of problematizing a discursive construct puts the spotlight on discourse as the site of investigation. It foregrounds an intention to disrupt a taken-for-granted use of this term: a critical intention to look at what it does for the people who use it within the contexts in which they use it. Finally, the genealogy of the term ‘nervous breakdown’ locates it in psychological territory and when partnered with a critical aim, locates it in critical psychological territory. This trifecta can be dissected from a number of angles: discourse, critical enterprise and critical psychology. It is beyond the scope of this piece of work to pay adequate homage to each of these domains but I will attempt to expand on their inter-relationship and their relevance for this piece of work in terms of epistemology and subsequent methodology.

2.1.2. The crisis in social psychology

The latter half of the twentieth century has arguably been defined by a challenging of white, western and patriarchal hegemony and a concurrent exposing of practices and ideologies that act to oppress minorities. While this hegemony still continues in many ways, the challenges posed to it have demanded that institution and individual alike, not least of all psychology, re-think their relationships with those deemed as other (e.g. Gilroy, 2012). The disaffection for the oppressive practices of the western canonical status quo began gathering global visibility and velocity from the late 1950s onwards. It encompassed many sites of resistance including second-wave feminism, post-colonialism, the anti-psychiatry movement and the gay liberation movement (e.g. Altman, 1971/2001; Cooper, 1967/2001; Fanon, 1952/1967; Friedan, 1963).

The uneasiness with the way in which the psy-institution addressed the human being both individually and socially was echoed in psychology. Key theorists took issue with the potentially oppressive and reductionist nature of social psychology's preoccupation with quantitative science, its system of norms and its application of experimental methods to categorizing human beings. There was a call for a discipline that considered the impact of social, historical and cultural contexts on human experience (Armistead, 1974; Gergen, 1973; Reason & Rowan, 1981). This has been widely recognized as the crisis in social psychology (e.g. Parker, 1989; Potter & Wetherell, 1987).

This crisis led to a review of the methods of enquiry in social psychology by those concerned that the scientific method was missing out on the contextual nature of people's experiences and implicitly colluding with systems of oppression. Qualitative methods emerged as an alternative within social psychology and among them, social constructionist critiques of the discipline (Parker, 1999b; Smith, Harré & Van Langenhove, 1995). Psychology, now seeking alternative ways to theorize and research human experience, began borrowing ideas and methods from the other social sciences. This heralded psychology's turn to discourse (Potter, 2012b).

From the 1950s, philosophy, sociology and anthropology had begun to show an interest in language and symbolic systems. The approach to language shifted. Once conceptualized as a realist labelling of the speaker's internal world, the possibility that language might be a performative act that constructed versions of a *social* reality began to be explored. Social psychology, looking to revise its relationship with its subjects, began to work with language not as a direct route to discovering people's internal truths but rather as a social resource that people could use to construct versions of their realities (Taylor, 2001; Willig, 2013). This included thinking about language as a resource that psychology itself could and did use to construct its subjects, patients and practitioners (e.g. Henriques, Hollway, Urwin, Venn & Walkerdine, 1984).

As such, language, how people do language and the consequences of doing language became a legitimate focus for psychological investigation and critique. How this was done, though, depended on which epistemological paradigm theorists subscribed to and what they thought was important in re-writing psychological research. In this research, approaches to language informed by a social constructionist epistemology have been used. These are broadly termed discourse analysis. Before elaborating on these, I will briefly discuss social constructionism so as to flesh out the assumptions underpinning the project's approach to discourse.

2.1.3. Social constructionism

'Nervous breakdown' is a discursive construction. As argued in the introduction, its meanings have varied across time, space and context and have been negotiated and re-negotiated through language and symbol. Therefore an exploration of this construct and what it does for those who use it, must necessarily be located in a paradigm of knowledge that is also discursive, constructionist, social and to some degree, relativist. As such, this research is congruent with a social constructionist epistemology.

Social constructionism is a broad epistemological church and the methods it has informed in psychology are varied. However, those who draw on it share a critique of

mainstream psychology's presiding assumption that scientific methods of enquiry lead to the knowing of objective truths (Willig, 2013). Social constructionists argue that the ways in which we can come to know our world vary across history, society and culture. They contend that our knowing changes and is changed by context. This variability leads social constructionism to problematise the notion of truth. It suggests that what we may construe as truth at any given time depends on the historical, social, cultural and political contexts in which the truth-maker finds him/herself. This necessitates a relativist stance to reality: one that claims (at least theoretically) that there are as many versions of reality as there are subjects capable of constructing them (Burr, 2003).

Consonant with this, social constructionists claim that identities and categories of person are fluid and variable across context and are also socially constructed (e.g. Shotter, 1993). Therefore, a social constructionist approach focuses on the *processes* of constructing realities and identities (Durrheim, 1997). It looks to language as the key mediator of the process of social construction and contends that we can only construct our realities via the symbolic and language resources (oft termed discourses) available to us and suggests that language is therefore constitutive, not representative, of these (Gergen, 1985; Danziger, 1997). Since discursive resources are shared within a culture or society, constructions of realities and identities are understood as social acts of co-construction (Henriques et al., 1984).

Theorists occupying a more critical position contend that not all truths or identities are rendered equal or equally available at any given time. They argue that those truths and identities constructed and reified by powerful institutions are hegemonic and carry more socio-political clout than others and are entrenched in society as if they were real. This, it is argued, has important material consequences for the freedom and oppression of people (e.g. Burr, 1998; Parker, 1999a). For example, a person can be constructed as a patient, diagnosed with (constructed as) "x" and then *be treated with* (or subjected to) "y." This position alludes to an agenda for social change and

suggests that the work of deconstruction has the aim of drawing attention to the oppressive practices of hegemonic truth systems (Fairclough, 2001).

Given that the aim of this research is to examine not only the subjective construction(s) of ‘nervous breakdown’ by those who self-identify with the term, but also the implications of these constructions, it takes a position within social constructionism that acknowledges the relativism of truth constructs but situates these within relationships of power and aims to at least consider their more material consequences. Taking up this position situates my role as active in authoring this text. It demands that I be reflexive about my involvement in the interplay between constructing a version of knowing something about ‘nervous breakdown’ and doing this within the vanguard of a hegemonic institution: psychology.

2.1.4. Discourse and discourse analysis

Given that social constructionism foregrounds discourse as the site where we construct our-selves and our realities, discourse analysis of talk, text or image has evolved as the key methodology for research conducted in this paradigm. As Potter, Wetherell, Gill and Edwards (1990) discuss, defining discourse can be problematic. Definitions of discourse are variable by and within discipline. A definition can also be problematic because many discourse analysts are epistemologically opposed to fixing anything as inherently truthful. As Antaki, Billig, Edwards and Potter (2003) contend, adopting one definition of discourse over another is foremost an indication of one’s location in the theoretical terrain and one’s concomitant approach to research methodology.

Definitions of discourse used in discourse analysis tend to suggest that a discourse is akin to a grouping of statements, ideas or images which together can construct a version of an event, a person, or a thing. For example, Fairclough (1996, p. 71), cites his use of discourse as referring “to any spoken or written language use conceived of as social practice.” He points to its constitutive and intersubjective nature. Synonymously, Parker (1992, p. 5) opts for a working definition of discourse as “a

system of statements which constructs an object,” thereby suggesting that that discourses have a recognizable coherence. Burr (2003, p. 64) suggests discourse to be “a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events.” She points out the constitutive and variable nature of discourse. Burr, like Parker, also suggests some type of internal organization to a discourse.

Approaches to discourse analysis are as variable as definition. They invariably have common features but differ in focus (Van Dijk, 1997). Within social psychology, Wetherell and Edley (1999, p. 338) observe that it has become increasingly common to distinguish between two main “camps” in discourse analysis: those approaches more affiliated with the fine-grain style of conversation analysis and ethnomethodology and those that sit closer to a post-Foucauldian and more critical style of analysis. The former are generally accommodated under the umbrella term of discursive psychology and the latter under Foucauldian discourse analysis (Willig, 2013).

Notably, these approaches have been understood to differ in their theoretical foundations, the types of research questions they address (construct), and thus what they choose to focus on in the research process (Burr, 2003; Willig, 2013). They differ in how they understand and situate discourse and thus offer different possibilities for human agency and experience (Jorgensen & Phillips, 2002). Moreover, they differ in how they conceptualize discourse. For example, methods drawn from a Foucauldian discourse analytic tradition foreground the constitutive nature of discourse and its power to shape and regulate human subjectivity. They seek to deconstruct reified discursive constructions of identity, institution or thing in order to highlight the constraints and conditions that these put upon people (e.g. Parker 1992). In contrast, methods drawn from discursive psychology understand discourse to be the tool through which people actively construct versions of reality in situ. They focus on deconstructing the localized deployment of discourse and the ways in which

discursive actors might negotiate identity, meaning or experience within a specific social interaction (e.g. Wiggins & Potter, 2008).

To best address a research question that aims to gain some understanding of the construction of ‘nervous breakdown’ *and* what it does for those who identify with it, I have had to consider both the genealogical and regulatory nature of discourse and also the localized discursive agent. As such, this research draws on approaches from both Foucauldian discourse analysis (FDA) and discursive psychology (DP), and then moves into the realm of critical discursive psychology (CDP). CDP attempts to reconcile a discursive psychology with more a critical endeavour. I will briefly discuss these approaches individually before outlining the more synthetic approach to discourse analysis taken in this thesis.

2.1.4.1. Foucauldian discourse analysis

Foucauldian discourse analysis (FDA) is heavily influenced by post-structuralism and in particular, the work of Michel Foucault (e.g.1965/1988; 1969/2008). In the late 1970s, many social psychologists began to draw on post-structuralism as a way to respond to the crisis in social psychology. They used it to re-theorize subjectivity as socially constructed through discourse and began to change the gaze of psychology to critically considering its own processes of constructing truths about human experience (Henriques et al., 1984). Theorists drew on and developed critiques of psychology which highlight what Rose (1985, p. 9) calls the “psy-complex.” This describes how the self-referential system of psychology’s truths about human experience, legitimized by psychology’s institutionalized status and reified by its foothold in the scientific method, shape the possibilities of how people can be and what can happen to them (Arribas-Allyon & Walkerdine, 2008).

There is no one way to do Foucauldian discourse analysis and its theoretical foundations eschew essentialism. It can be best described as a cluster of approaches to deconstructing discourse which agree that discourses are constitutive, not representative, of our social realities and that we draw on them, as if from socially

available repositories of meaning, to make sense of our worlds, ourselves and one another. A discourse is understood to be the coalescence of systems of meaning that come together to construct a particular version of an object, experience or person (Parker, 1992).

Discourses are differently available to people across space and time, and enable or prohibit what can be said and experienced by whom *and* what can happen to that person as a result. In this way, discourses routinely act to position the speaker, author or institution in various, even conflicting, discursive spaces. These locations of the subject are referred to as subject positions and they signify sites-in-discourse or vantage points from which one can produce versions of reality and construct renditions of oneself, others and society (Davies & Harré, 1990). A subject position carries with it sets of rights, obligations and practices that are commensurate with reproducing and performing that position or point of view of reality (Harré & Van Langenhove, 1999). Therefore, when a person takes up a particular subject position or is located in one, it has implications for his or her subjectivity and experience. Consider, for example, how a person positioned as immigrant might be treated at the border of a country that defines itself as having an immigration problem, such as the UK or USA and how this might differ if the same person was to be positioned as citizen.

FDA is therefore particularly concerned with how discourses constrain, enable and thus “produce” the subjects of which they speak and the material effects of this (Carabine, 2001, p. 276). For Foucauldian theorists, discourses and the discursive positioning of subjects are intimately tied up with social practices that legitimize powerful institutions and promote their interests. Given that discourses offer the means for constructing social realities – among them versions of selves, others and norms – those espoused and endorsed by powerful socio-political actors become more dominant than those of actors and groups who are located on the margins. In this way, in a Foucauldian sense, discourses extend beyond the symbolic and into the institutional practices that organize and regulate social life. The more dominant

discourses often become hegemonic, that is to say they become reified and institutionalized as the truth and thus become very difficult to challenge (Willig, 2013).

Hence, the genealogical interest of FDA: a primary concern with the historic evolution of discourses and how the construction of subjectivities has changed over time. This allows one to begin to disrupt hegemonic, reified discourses by making explicit the shifting meanings, interests and practices on which they have been built (Carabine, 2001). This is what Foucault (2008/1969) meant when he brought the metaphor of archaeology to his work. He sought to show how things such as sexuality, madness and justice are not things at all but rather discursive constructions. He argued that the more hegemonic constructions of these so-called things have acted to normalize the interests of governments, capitalism, patriarchy, heterosexuality, Judeo-Christian morality and so on, by positioning those who challenge those interests as other. Those people and practices positioned as other to the norm are then able to be subjected to practices, discursive and otherwise, of exclusion, correction or punishment. FDA's understanding of the socially and historically constructed nature of hegemonic discourses allows for alternative discourses and alternative ways of constructing subjectivity to be explicated (Arribas-Allyon & Walkerdine, 2008).

FDA enables a socio-political theorization of subjectivity and reality. It allows one to explore the relationship between widely shared symbolic systems, that come together as discourses, to construct and thus regulate human experience. Theorizing human experience and subjectivity is arguably one of the core purposes of the discipline psychology. FDA offers a crucial challenge to the essentialist interiority of the a-political individual that psychoanalysis and cognitive-behaviourism have constructed.

However, FDA has been critiqued, among others, for the passivity it ascribes to the individual and his/her use of use discourse (e.g. Caldwell, 2007). By limiting the parameters for the production of subjectivity to pre-existing discourses in the socio-cultural milieu, it constrains the agency of the discursive subject. It offers little

consideration of situated language use or how people might use discourse in specific contexts to construct and re-negotiate identities and ideological positions to manage interests particular to that interaction. Discursive psychological approaches to discourse analysis explicitly address this limitation.

2.1.4.2. Discursive psychology

Instead of turning to post-structuralism to address the crisis in psychology, discursive psychology (DP) drew from the traditions of ethnomethodology and conversation analysis. Following these sources, DP's primary concern and challenge to cognitive science lies in its focus on the flexibility and action orientation of people's use of discourse in specific social contexts (Edwards & Potter, 1992; Potter & Wetherell, 1987). As opposed to examining the discursive terrain in which the subject is constructed (as in FDA), DP suggests that people construct versions of social reality by using discourse as a resource to manage and negotiate their personal investments in particular social interactions. Thus DP focuses on how the discursive actor accomplishes and performs social action with his or her talk in situ.

DP does not, however, suggest that people intentionally plot and plan ways in which to use discourse to achieve their interpersonal interests. DP does not seek out a motivation located behind talk. In this sense, it runs counter to the cognitivist and realist assumptions which dominate psychology and which understand language to be an accurate representation of a person's internal world. Rather, discursive psychologists posit that people draw on psychological constructions such as identity, experience or memory in their talk to help them make sense of the world and thus to construct versions of reality. DP thus offers a different way to theorize and study traditional sites of interest in psychology. DP reconceptualizes psychological activities such as justifying, persuading, blaming, justifying, rationalizing etc. as discursive strategies that help people further manage their interests in the microcosm of conversation (e.g. Edwards, 2006; Edwards & Potter, 1992; Potter, 2012a).

In order to interrogate *what* social actions people are accomplishing with their talk and *how* they are doing so, a discursive psychological analysis zooms in on the precise discursive and rhetorical devices people use in a specific conversational piece. Additionally, given its focus on situated and everyday language use, DP has a preference for using naturally occurring talk and has even come to opt out of the research interview itself (Potter, 2011). Such a situated approach forecloses the analysis to the specific site of the interaction in question and prevents it from considering its location within the wider discursive practices that constitute its speakers, the space in which they speak: the social, cultural, historical and political discursive macrocosm in which they are situated. The specificity of DP also makes the position of the discourse analyst problematic, for it is only his/her position within the wider discursive terrain that allows him/her meaningful access to the talk in the first place.

Notably, Parker (1999b) critiques DP for neglecting to address how structures of power have shaped the discursive resources that are made available or unavailable to the participants in the conversation under analysis. He contends that DP's silence about the broader discursive context of its analysis offers no platform from which to challenge oppressive discourses and potentially colludes in reconstructing the a-political reductionism of mainstream psychology that it seeks to challenge. Moreover, DP's preoccupation with situated language use also prevents it from theorizing subjectivity, arguably the cornerstone of the discipline of psychology (Willig, 2013). DP's molecular gaze allows for identities to be understood only as an immediate discursive accomplishment. The same micro-linguistic and situated focus of a discursive psychological analysis that allows it to foreground the discursive agency of its subjects also handicaps it from addressing how this agency is made possible in the first place.

2.1.5. A synthetic approach: Combining Foucauldian discourse analysis and discursive psychology

Several discourse analysts have suggested that the differences between FDA and DP are not incommensurate (Edley, 2001; Holt, 2011; Wetherell, 1998). Finding a way to synthesize these approaches, given their theoretical and methodological contrasts, is challenging. The tensions between FDA and DP include different understandings of the relationship between language and agency. DP suggests that people have a great deal of agency in their everyday language use which they use functionally to accomplish intersubjective interests. In contrast, FDA suggests that people are more constrained by what wider societal discourses make available to them and their subjectivities are consequently regulated and shaped by these discourses. As such they differ in their foci of discursive inquiry, with FDA looking to deconstruct broad-based discursive practices and DP focusing on the minutiae of situated language use and its immediate social functions. As a result of these tensions, FDA and DP tend to sit in separate methodological camps and are not generally combined (Wetherell, 1998).

However, both approaches share an epistemological position that aims to challenge the cognitive essentialism of psychology and which understands reality to be pluralistic and constructed by socially situated and socially pliable discourses. Both approaches are hallmarked by a shared interest in understanding how discourse does things in the social field and to what effect. In this sense, they can be seen as compatible, differing only in the degree of agency and flexibility they accord the individual in using discourse to construct versions of a social reality.

Wetherell (1998) and Edley (2001) have suggested that the differences between FDA and DP approaches to discourse analysis are reconcilable in the interests of responding more productively to a research question that wishes to address the interface between the social field that shapes a discursive construct and positions its subjects *and* the discursive agents who can and do repurpose that construct. Edley and Wetherell have since produced a number of research pieces which employ a more

synthetic methodology (e.g. Wetherell & Edley 1998; 1999; 2009; Edley & Wetherell, 1996; 1997; 1999; 2008).

2.1.5.1. Critical discursive psychology

Wetherell (1998) posits that a more flexible methodology that bridges micro and macro discursive approaches rather than one constrained by theoretical rigidity proves most useful for understanding the relationships between the individual, subjectivity and social practice. Wetherell (1998, p. 405) situates these synthetic approaches within the realm of critical discursive psychology (CDP) and contends that it “is a discipline concerned with the practices which produce persons, notably discursive practices, but seeks to put these in a genealogical context.” This approach argues that while people have the agency to construct and reconstruct versions of themselves and the world within particular social interactions and for particular interactional purposes, they can only do so by drawing on the discursive repertoires made available to them by their wider contexts (Edley, 2001). In other words, a person’s discursive agency is limited by the discursive resources on offer to him or her in a particular context, yet he or she has the agency to choose which of these resources to use and when and also has the power, perhaps, to re-negotiate them to a certain extent.

As such, CDP explores the dialogue between discursive practices which act to constitute subjectivity and the subjects who act to construct and reconstruct their positions in the discursive field. It posits that each informs the other and that the constructive use of discourse by an agentic subject impacts upon the discourses and institutions that also serve to regulate and constitute her or him. To serve this understanding of the two-way relationship between subject and discourse, Wetherell (1998) and Edley (2001) take an approach to discourse analysis that integrates three key foci. These are: interpretive repertoires (Gilbert & Mulkay, 1984; Potter & Wetherell, 1987), ideological dilemmas (Billig et al., 1988) and subject positions (Davies & Harré, 1990).

Interpretative repertoires were first introduced into social psychology by Potter and Wetherell's (1987, p. 138) seminal work which defines them as "a lexicon or register of terms and metaphors drawn upon to characterize and evaluate actions and events." They imply more flexibility for the speaker than a strictly Foucauldian definition of discourse through their bridging of macro and micro discursive sites: they are "drawn" by the speaker from the broader discursive field into the immediacy of situated talk for the purpose of constructing some sort of meaning. They allude to smaller and more fragmented bytes of discourse than the highly organized Foucauldian notion of discourse and thus offer more room for emergent spontaneity, creativity and variability in the agent's construction of meaning across different sites.

There is without a doubt significant conceptual overlap between discourse and the term interpretive repertoire (Burman & Parker, 1993; Holt, 2011; Parker, 1992; Wetherell & Potter, 1992). Even those who explicitly use interpretative repertoires in their discourse analyses admit to using the terms interchangeably (e.g. Potter et al., 1990). Both terms are constitutive of socially available symbolic reservoirs of meaning. However, they signal different approaches to discourse analysis where the use of discourse indicates an allegiance with Foucauldian approaches that are more preoccupied with the institutionalized nature of discourses and their power to regulate selves and social practices (e.g. Parker, 1992). In order to be able to introduce notions of the situated nature of discursive practice by a subject who has some discursive agency into the analysis, Wetherell and Potter (1992) consider the category of interpretative repertoire more useful.

Exploring the variability in constructions of subjects and objects across context is crucial to a critical enterprise seeking to destabilize the illusion of unitary truths. Wetherell (1998) and Edley (2001) suggest the identification of ideological dilemmas in a discourse analysis allows for this. Billig et al. (1988) use the term ideological dilemma to highlight the dilemmas inherent in our common-sense constructions of reality. They point to the plethora of contradictory and competing common-sense constructions of how the world is, and suggest that our daily navigation of these

dilemmas in the discursive field involves constant processes of reasoning and re-negotiation. This is particularly pertinent to this research as identifying ideological dilemmas allows some access to the different, even oppositional constructions of ‘nervous breakdown’ and the people who have them that are prevalent in the discursive terrain. In addition, as an analytic concept, ideological dilemmas allow this research to examine how these discursive tensions are negotiated in everyday interactions and thus in the situated talk of the discursive agent who draws on ‘nervous breakdown’ to construct versions of subjective experience.

The critical discursive psychology of Wetherell (1998) and Edley (2001) also draws on subject positions – a concept borrowed from the more Foucauldian approaches to analysis. Its use lies in its conceptual ability to connect broader discourses and interpretative repertoires with particular constructions of the individual (Edley, 2001). People take up particular positions offered up by interpretative repertoires: these repertoires delineate which positions are available to which subjects and thus offer but also constrain the possibilities for subjective construction and concomitant social action. In other words, the subject is positioned and can position him or herself within discourse. Subject positions are fluid and allow people to adapt their positions to some extent in order to manage the different contexts they regularly face (Harré, & Van Langenhove, 1999). As such, a person can draw on different subject positions made available to him/her to achieve a particular social function – perhaps to persuade another of competence or to justify an action.

Foucauldian discourse analysis, discursive psychology and the critical discursive psychology put forward by Wetherell (1998) and Edley (2001) have greatly influenced the approach I have taken in this research. However, I have prioritized addressing the research aim as fully as possible over methodological preciousness. Many discourse analysts advocate this pragmatic approach and recommend that methodology be tailored to research endeavour rather than shoe-horning the research into a particular approach (e.g. Jorgensen & Phillips, 2002).

2.1.6. Developing an analytical approach to explore ‘nervous breakdown’ and its subjects

In order to best answer a research question that aims to explore the discursive construction of ‘nervous breakdown’ but which recognizes it to be a construct situated both in the wider socio-historical field, and also within the talk of people who self identify with the term, I have had to find an approach that is sensitive to both sites and which supports a critical gaze. Neither FDA or DP alone is able to adequately accomplish this but used complementarily, they can. FDA informs an approach which considers how broader social, historical and political discursive practices shape what can be said about ‘nervous breakdown’ and by whom and thereby maps out a discursive terrain for ‘nervous breakdown’ and the subjects it constructs. I believe this process of mapping to be crucial to a piece of research that is exploratory and for which there is little precedent. As discussed, very little work on ‘nervous breakdown’ exists in the contemporary academic literature. Yet, it appears to be currently and widely used in popular discourse. This necessitates a consideration of the relationship between the wider discursive practices that have historically constructed ‘nervous breakdown’ and the contemporary subjects they, in turn, construct.

Adopting FDA's wide angle lens on the discursive construction of ‘nervous breakdown’ also allows this research to consider the relationship between the construct and the subjectivities of those who use it. It enables the research to explore the discursive field and concomitant subject positions that ‘nervous breakdown’ makes available for a person to construct versions of him or herself. This approach further allows the research to explore what having a ‘nervous breakdown’ might enable or prevent a person from doing in relation to the institutions in which she or he is located. For example, would that person be able to access psychological therapy? Would he/she even consider such therapy needed? And would that vary depending on how he/she could use the construct and thus his/her subject position relative to ‘nervous breakdown’?

However, given the contrast in the ubiquity of the use of ‘nervous breakdown’ between the psy-institutions and the popular field, it would seem that individuals have repurposed the construct out of its genealogical home. This suggests an agency in the individual’s use of the construct. Foucauldian discourse analysis cannot adequately address this agency but discursive psychological approaches can. DP allows the research to examine the very sites where the individual’s reconstruction of ‘nervous breakdown’ occurs. It also allows this research to ask what social function this reconstruction might serve for individuals. In combination with FDA, this research can extend this question out of immediate talk and into the realm of a social subjectivity – and ask what, at the site of interface between individual and institution, might motivate or compel a person to draw on a particular construction of ‘nervous breakdown’?

Wetherell (1998) and Edley (2001)’s synthetic CDP approach seems most aligned with addressing the research aims of this project. In its bridging of the macro and micro it considers the dialogical relationship between the discursive field and the agents positioned in it. It opens space for these agents to be both regulated by discursive practices but also to explore how they resist this regulation. For example, it would allow an analysis to consider how having a ‘nervous breakdown’ might construct a subject who is seen as unable to handle stress and also how the same subject could have a ‘nervous breakdown’ in order to justify a time-out from these same stressors.

Moreover, using an approach that can consider both the macro discursive field that constitutes and regulates ‘nervous breakdown’ and also the agency with which people re-appropriate the construct has a significant critical and reflexive function. This research is situated in the psy-domain whose discourses of expertise have often acted to mute the agency of the subjects they construct – rendering them passive patients awaiting diagnostic enlightenment. Furthermore, as discussed, ‘nervous breakdown’ originated in the peripheries of the psy-diagnostic terrain, and was allied to constructing all manner of subjects. In addition, the academic literature has tended to

subsume the construct under other psy-diagnoses, rendering it a marginal colloquialism. Therefore, a purely Foucauldian approach that renders the subject as relatively passive in the discursive field, risks re-producing this institutional silencing of the individual's agency in constructing his or her experience of having a 'nervous breakdown.' However, an approach that only pays homage to individual agency and does not acknowledge its constraints would be naïve to the power of institutionalized discursive practices, not least of all psy-practices (which include this piece of research), to shape people's experiences. It would thus risk re-locating the site of responsibility for 'nervous breakdown' with the individual only.

A methodological approach that transitions between these macro and micro discursive sites highlights the dilemmatic position of this research. It is both critical but also positioned within a psychological doctoral programme and thus capable of re-appropriating popular constructions of 'nervous breakdown' into the arms of psy-discourse. However, this liminal space can be a site of exchange. It brings popular discursive constructions of 'nervous breakdown' as a legitimate site of interest into psy-forums and foregrounds its significance for some of the people we purport to understand and assist. It also allows for reflexive consideration of the psy-institution's role in shaping their experiences. As psychologists we cannot help but construct subjects every time we speak, write or practice. However, we can do so in a more dialogical and less prescriptive fashion, allowing for the other's constructions of subjectivity and experience to hold relevance in the conversation. The aims of this research are modest but I believe that its position as critical but scripted by a trainee counselling psychologist allows for it to contribute to the body of work and practitioners that are facilitating a greater sense of dialogue between the psy-institution and the public.

2.1.7. Analytic approach

Many researchers advocate prioritizing the research question over methodological fealty. They endorse a pragmatic approach to methodology and therefore consider pluralism to be a strength (e.g. Frost, 2011). In this research, an approach that

combines elements of FDA and DP appears to offer the most productive scaffolding from which to explore popular constructions of ‘nervous breakdown.’ I have therefore adopted a combined methodological approach that draws significantly from the critical discursive psychology of Wetherell (1998) and Edley (2001). This understands FDA and DP to be compatible and able together to render a more holistic and reflexive account of discourse and its effects. As an approach that synthesizes DP and FDA, it addresses both the constitutive and constructive nature of discourse in the same analysis, looking at both interpretative repertoires that constitute the discursive terrain of ‘nervous breakdown’ and the ways in which these are deployed in situ by discursive agents constructing contextually-motivated accounts of ‘nervous breakdown.’ I detail the specific analytic method adopted in the discussion of research methods later in this chapter.

2.2. Overview of methods

Having outlined the epistemological and methodological position of the critical discursive psychological approach taken in this thesis, the rest of this chapter will consider how this approach has been applied in the practice of this research. It will supply an overview of the methods used for data collection and analysis and the rationale for their use. As discussed in the introduction, this research comprises of two studies. The first is a mapping of the discursive terrain of ‘nervous breakdown’ through an analysis of the ways in which it is constructed by the popular media. The second is an analysis of in-depth interviews with people who have self-identified with the construction of ‘nervous breakdown.’ A synthesis of the results of these studies is presented in subsequent chapters.

2.2.1. Media study

Mapping the discursive terrain of ‘nervous breakdown:’ An analysis of popular media

The aim of this study is to map out the discursive terrain of ‘nervous breakdown’ as constructed by contemporary popular media: to get a sense of the available discursive

currency for talking about ‘nervous breakdown’ and its subjects and the potential consequences of these repertoires and positions. This is intended to provide a wider discursive context in which to situate the following study which examines how people who identify with ‘nervous breakdown’ deploy the construct in situ. Given the limited scope of this project, the mapping will necessarily be a brief overview, and the focus of the research will be on the in-depth interviews where an analysis can consider more fully the interface between the discursive agent and the wider discursive field.

As discussed, there is a huge disparity between the popular and psy-sanctioned uses of ‘nervous breakdown.’ On 11 June 2014, a Google web search returned 9, 860, 000 results for ‘nervous breakdown.’ The same search on the PsychInfo database returned only twenty-two results for ‘nervous breakdown’ as the subject of a research title. For a term born and bred in the wings of psy-diagnostic discourses of the nineteenth century and then all but obliterated by the hold-alls of depression and anxiety in the twentieth century, its contemporary popular currency is as striking as the lack of literature on it. As such, this research is exploratory, and as with most exploratory work, reconnaissance of the unknown is the first step.

2.2.2. Methods used in media study

The popular media, because of its relative availability to all and its position as arbiter of social truths, is regarded as an extremely powerful regulator of social discourse (Silverstone, 2002). Its radical democratization by the internet has allowed local media to be accessed across borders and languages, and has also allowed the public to self-publish, dialogue with the institutionalized media and regulate the ratings and visibility of media stories (Deibert, 2000; Grossman, 1995). As such, an online media analysis seemed to offer the most scope for mapping out a popular and contemporary discursive terrain of ‘nervous breakdown.’

I considered including social media in this part of the analysis, given its increasing influence on social discourse (Kietzmann, Hermkens, McCarthy & Silvestre, 2011). However, it is a vast territory with rapidly shifting sites of influence and its

exploration was thus outside of the scope of this study and merits further study of its own. Although the lines between institutionalized media stories and those scripted by the public are blurry, research indicates that this can reinforce the illusion of veracity of big names such as The Times or CNN as their institutionalized position offers recognizable legitimacy in the sea of blogs and Tweets (Gunter, Campbell, Touri & Gibson, 2009). In order to access texts that would have the most far-reaching salience for as many people as possible, I turned to online articles authored by recognizable media institutions.

This choice of media also supports the more critical aim of this research as it examines texts produced by powerful institutions who persuasively deploy their brands and their rhetoric to position themselves and their texts as truthful and supported by rigorous evidence and experts. As such, they are crucibles of dominant discourses of ‘nervous breakdown’ and its subjects and warrant a critical gaze.

2.2.2.1. Sampling

I entered the search term ‘nervous breakdown’ into the Google search engine to find articles that cited this exact phrase. I used Google as it is currently the most popular and integrated search engine worldwide (Levy, 2011). I used the search term ‘nervous breakdown’ initially without any permutations as I wanted to access articles that would have had the most direct bearing on the discursive terrain of ‘nervous breakdown.’ As indicated, this search retrieved over nine million results in English. I filtered these to find articles by recognizable news brands, believing that as a subject also situated in the popular field, those brands that I recognized would hold valence for many other people. Such overlap can only ever be partial and the brands I recognized undoubtedly reflected my position as a media-aware, English-speaking, thirty-something academic. However, discourse analysis explicitly acknowledges that by also being a discursively constructed subject, the researcher is able to meaningfully access at least some of a shared discursive space (Jorgensen & Phillips, 2002).

In the search for articles on ‘nervous breakdown,’ Google threw up many related search terms, including breakdown and mental breakdown indicating significant overlap in the discursive field. Almost all the articles used ‘nervous breakdown’ and breakdown interchangeably, with some using mental breakdown as well. I decided to include these articles, believing that this interchangeability was significant in the construction of ‘nervous breakdown’ and would prove meaningful in the analysis. However, given that this research is on ‘nervous breakdown,’ I excluded articles that did not use ‘nervous breakdown’ at all as a discrete term within the text. Another significant feature of the search was that it was overwhelmed by reviews of Pedro Almodóvar’s 1988 critically acclaimed film *Women on the Verge of a Nervous Breakdown*. I did not include these reviews in this analysis as they were focused on reviewing the film, and not on ‘nervous breakdown’ as such. Analyzing the film itself was beyond the scope of this research, but I was curious about its title which signalled a gendered construction of ‘nervous breakdown.’

I continued to search for articles until the search was exhaustive: with new articles only repeating discourses and rhetoric of those articles already found. At this point, twenty articles had been collected for analysis (Appendix A.1). They came from a variety of online news sites and magazines. I included *The Huffington Post*, for although it is a blog, it uses journalists from big brand news media. Its online traffic is high and averages at 15.6 million pages views per weekday (Silver, 2011). All the articles reviewed were published between 2007 and 2014, with one outlier from 2000, situating them within contemporary discourse. The content ranged from news stories, celebrity gossip and confessionals, and political, lifestyle and health commentary.

The approach to analysis differed from traditional approaches to media analysis which are concerned as much with the content as with the political stances of the pieces. I acknowledge the articles range in their political persuasions and that this may affect the discursive terrain of ‘nervous breakdown’ made available to and taken up by their different readerships. However, the focus of this study does not lie with the different agendas of the media articles but rather with their discursive content and the

concomitant interpretative repertoires and subject positions they make available for the populace to draw on in constructing ‘nervous breakdown.’

I provide a description of the analytic procedure itself after supplying an overview of the second study as I have used the same method of analysis for both the media articles and the interview transcripts. The difference in emphasis of analysis in each study is also discussed. The results of the analyses of both studies are provided in subsequent chapters.

2.2.2.2. Ethics

Given that the media texts already exist within the freely accessible online public domain, City University’s Research and Ethics Committee advised that ethical approval was not needed for this study.

2.2.3. Interview study

Exploring subjective constructions of having a ‘nervous breakdown’

One might expect the interpretative repertoires identified within the popular media to be echoed in the talk of people who self-identify with the ‘nervous breakdown,’ given that subjective constructions of meaning both create and are created by the broader discursive field. However, the interpretative repertoires invoked by people who self-identify with the experience of ‘nervous breakdown’ may be very different and might be deployed in situ in different ways and to different interactional ends. As discussed, a situated exchange exploring subjective constructions of ‘nervous breakdown’ offers an opportunity to examine the impact that wider discourses of ‘nervous breakdown’ have on subjectivity. It also allows for one to explore the ways in which a person’s subjective constructions of ‘nervous breakdown’ in situ might be resisting or refashioning those discourses and offering them some challenge.

2.2.4. Methods used in interview study

2.2.4.1. Interviews

Semi-structured, in-depth interviews were considered the best qualitative method of accessing the situated and subjective accounts of people who self-identified with ‘nervous breakdown.’ Their flexibility enables the interviewer-researcher and participant to move around the topic with more freedom than in structured interviews. This allows for greater participant agency in shaping his/her account of ‘nervous breakdown’ than would be possible under a rigid interview agenda. This facilitates the emergence of something new in the interview space: constructions, subject positions etc. that may not have been considered by the researcher beforehand (Fontana & Frey, 1998; Kvale, 1996). The flexibility provided by in-depth, semi-structured interviews therefore facilitates an exploration of the meeting of the discursive field of ‘nervous breakdown’ and the discursive agent, as it allows him/her greater freedom in reconstructing ‘nervous breakdown’ and in negotiating related subject positions. It allows space for the researcher to follow emergent threads in the conversation. Semi-structured qualitative interviews thus provide a co-constructed discursive encounter between participant and researcher which must be reflexively addressed in the analysis (Potter & Hepburn, 2012; Potter & Wetherell, 1987). It must be noted that DA purists have opted out of using the research interview, considering it too contrived (e.g. Potter, 2011). They prefer the use of naturally occurring talk. However, both FDA and more synthetic discourse analytic methods regard the research interview as an appropriate and rich source of data (Edley, 2001; Parker, 1992; Wetherell, 1998).

However, the focus provided by broad pre-existing questions assisted the interviews to be productive in eliciting discourse about ‘nervous breakdown,’ given that this, not the free associations of the participant, is the focus of the research. Arguably, this semi-structured focus also serves a containing function for a topic that may have high emotional valence for the participants by providing some time and content boundaries to the experience while including sufficient flexibility for the participant to be able to share and shape his/her account.

I conducted a pilot interview with a colleague to see how the proposed interview topics held up in real-time, to check my use of materials and evaluate my interview style. This raised a few dilemmas for me. Positioned both as a researcher and as a trainee counselling psychologist with therapeutic training, negotiating a one-to-one encounter in which a person was speaking emotively about their experience proved tricky. On the one hand, therapeutic training made interviewing easier: facilitating rapport, curiosity and an ability to allow space for the creativity of the participant. It also made it harder not to adopt a therapeutic stance. Keeping a researcher's distance from unsolicited therapeutic invasion is ethically crucial (Brinkmann & Kvale, 2008) and also crucial for the integrity of the research methods.

The feedback garnered from the pilot interview and a subsequent one with another colleague allowed me to be conscious of the tensions in my approach to one-on-one interviewing and more able to monitor vacillations away from a research focus in my interview style. I was able to engage with the debates in the literature on the therapist-researcher, which are well summarized by Hart & Crawford-Wright (1999). Through a consistent process of reflexive evaluation of my position in the later interviews with participants, I was able to set a therapeutic style aside and recall my identity and position as researcher. This positional tension of therapist-researcher was also relevant to the process of analysis and I reflect on this where relevant.

2.2.4.2. Sampling

This research sought participants from a sample who self-identified with 'nervous breakdown.' This allowed for subjective accounts of having a 'nervous breakdown' to be fore-grounded as the act of self-identification suggested that 'nervous breakdown' held particular relevance for participants in their constructions of themselves and their experiences. There is little demographic information available as to who has 'nervous breakdowns', thus further defining a participant sample was difficult. However, given that this research is exploratory and situated in a paradigm aiming not to generalize but rather to engage credibly with 'nervous breakdown' as a social construction, it

matters less who does the telling, and more what in the telling, is identified as constructing ‘nervous breakdown’ (Parker, 1992; Potter & Wetherell, 1987).

The who is seen both as co-constructed in the situated interview and as constructed by the discursive field that surrounds it: thus offering critical commentary on the relationship between the people who say they have had a ‘nervous breakdown’ and the other subject positions they may occupy. This understanding enables the research to say something more about the who of the sample of participants at the stage of analysis. Other than a subjective identification with ‘nervous breakdown,’ any other explicit demographic delineation was considered too limiting for this exploratory piece of research and also not in keeping with its epistemological scepticism of predefined categories of personhood. This did not, however, prevent a consideration of wider discursive categories of identity and their relationships to power that emerged in the research: it simply positioned this consideration within the stage of analysis and within the processes of methodological and personal reflexivity.

Ethical considerations and the limited scope of the research did, however, shape the sample. The inclusion criteria were that participants self-identify with ‘nervous breakdown,’ be aged eighteen or above, and available for an interview in English within the Greater London area. Sixteen is legally and ethically regarded as valid in positioning the participant as able to consent in their own right to participating in research (British Psychological Society, 2010). However, given that the consensus on the age of majority and informed consent has been so widely debated (e.g. Waites, 2005), for ethical purposes and for ease of recruitment, the more conservative age of eighteen was chosen as the age criterion for inclusion. Availability in the Greater London area was an inclusion criterion imposed by the limited time and scope of the research. English-speaking is an inclusion criterion that signals my discursive limits. For us to understand one another, without the complication of an interpreter, the interviews needed to be conducted in English. Already, some landscaping of the who in the study was visible: English-speaking adults in the Greater London area – a discursive context in which I share.

2.2.4.3. Recruitment

I chose to use the internet as a site for recruitment because of its ubiquity and because it housed a multitude of pre-existing conversations between people who self-identified with ‘nervous breakdown’ on forums and social networking sites. I chose to target forums on ‘nervous breakdown’ first as they seemed the most publically accessible spaces. I contacted the hosts of forums I identified as UK-based and currently active. In total, I messaged seven forums asking the hosts for permission to advertise for participants. Three did not respond and the remaining four banned me from their forums. Two did not say why, but two of them cited “unwelcome invasion of privacy” and “breaking our safe space” as reasons for the exclusion. I have not provided the forums’ details out of respect for their insistence on privacy. I was struck by the construction of ‘nervous breakdown’ as private and its subject-agents as vulnerable.

I turned to my own social networks, a seemingly more private space, for recruitment. I used opportunistic sampling, asking friends if they could advertise for volunteers who self-identified with ‘nervous breakdown,’ were eighteen or older and available for an interview in English in London. I supplied them with a letter of introduction to the study to distribute to their chosen social networks (Appendix B.1.). This letter invited volunteers to contact me directly, enabling them to approach me privately and protecting their anonymity.

Such a localized and potentially homogenous site of recruitment is fitting for a qualitative study interested in the subjective discursive construction of ‘nervous breakdown,’ not in constructing a generalized demography of the construct. Moreover, it is particularly suitable for an exploratory study that relies on me and the participants being part of a shared discursive field. Greater commonality in the situations of participants has been observed to allow for in-depth analysis in small qualitative studies and to facilitate the coherence of the analysis and interpretation (Miles & Huberman, 1994; Patton 1990).

Eight participants volunteered for the study. All of them contacted me directly by email and we arranged for a follow-up phone call to discuss the interviews (Appendix B.2.). In this phone call I explained the research briefly (Appendix B.3.), clarified that the inclusion criteria were relevant to the participant and stressed the voluntary nature of participation. I also clarified that the interview was for research and not therapeutic purposes and that we would meet for a once-off encounter of about ninety minutes. This was to ensure that participants were informed about the limits of the encounter as the adjective psychological can foster confusion as to what type of encounter is being proffered. It also functioned to informally assess for risk and establish if the participants felt safe enough to talk about their experiences of ‘nervous breakdown’ in a once-off interview that offered no clinical support during or after.

This was a deliberate step into a more clinical position which was deemed crucial in order to meet the ethical requirements for the study. Given that the literature reviewed in the introduction explicitly associates ‘nervous breakdown’ with psychological vulnerability and crisis, I had to put aside the critique of this literature and its epistemological foundations and warrant it with some credibility. It was necessary therefore to ascertain whether the potential participant felt safe enough to share his/her experience of ‘nervous breakdown’ with me at that time, particularly given that I could provide no support for the participant during or after the interview and given that participants were not recruited via an institution or group that did offer them support. None of the prospective participants who contacted me seemed to be likely to be overtly unsettled by an interview about their experience of ‘nervous breakdown’ and at the end of our telephone conversations, we arranged to meet for an interview. Had the conversations indicated that an interview might have been too unsettling or risky for the prospective participant, he/she would have been sensitively excluded from the study and emailed a debrief sheet (Appendix E) of supportive resources to consult if he/she so wished. I discuss the debrief space and resources later in this methods section.

This step into the territory of potential risk assessment was a reflection of the tensions between my position within the discipline of counselling psychology, its ethical regulations and practices and my position in this research as critical of this diagnostic expertise. However, I could not, in any good conscience forgo my professional responsibility to prioritize the safety of the research process and the participants. Haverkamp (2005) stresses that this ethical responsibility for the safety of the research participants needs to trump other methodological concerns in the research process. Risk assessments, both formal and informal, are a key competency developed during counselling psychology training and are seen as a core ethical obligation of the practitioner-researcher (Shillito-Clarke, 2010). For the purposes of this research, I aimed to ask about potential vulnerability as sensitively, incrementally and non-invasively as possible, and to not use any overt psy-jargon, so as to limit its impact on shaping a subsequent interview space. Undoubtedly, it still did impact on the interview space and undoubtedly it positioned me as expert clinician, participant as vulnerable lay person and introduced some vestiges of a psy-discourse. However, again, this was trumped by the necessity of meeting the ethical requirements of the study. The tension inherent in the position of clinician-researcher is well documented in the literature, with many papers concluding that increased sensitivity to ethical obligations and participant safety is in fact a strength of this dual position (e.g. Bond, 2004; Long & Eagle, 2009; Morrow, 2007).

Although I had deliberately not pre-defined inclusion into the sample according to categories of person that I deemed significant (apart from those required by ethics), the sample was recognizable in its gendered homogeneity. I was struck that it was comprised only of women as my recruitment base was mixed in gender. As such, I wondered about the feminized position of shared self-reflection, and perhaps how my identity as a woman might have facilitated female participation and discouraged men. I wondered if gender would be significant in the interviews as part of a subjective construction of ‘nervous breakdown.’

Guidance on sample size in discourse analysis relates to the ability of the sample to meaningfully respond to the research question (Potter & Wetherell, 1987; Willig, 2013). In this case, the aim is to explore subjective constructions of ‘nervous breakdown’ in the situated talk of people who self-identify with the construct. When facilitated by the quality of data derived from in-depth, semi-structured interviews, a localized sample ranging from five to twelve is deemed capable of providing for a rich and cohesive qualitative analysis (Tracy, 2013).

2.2.4.4. Interviewing

Participants were given a choice of location and time for the interviews. We met in mutually convenient spaces that allowed for privacy and for the recording of the interviews. I chose to avoid spaces directly linked with psycho-medical institutions and universities to mitigate the inevitable power differential between researcher and participant. For the most part, we met in private study rooms of local libraries. With two participants, we met in private conference rooms at their places of work.

I had suggested to participants to allow for ninety minutes for the interviews. Many researchers believe this length is productive in allowing space for in-depth discussion and the emergence of the new, but also delimits the interview as an encounter that is manageable for both parties and which in its limits, provides focus to the discussion (e.g. Seidman, 2006). The interviews were based upon a loose interview schedule (Appendix C) which listed the main topics that I believed would facilitate the exploration of the participants’ choice of the construct of ‘nervous breakdown,’ allow for elaboration on its meaning to them and also examine the social consequences of drawing on this construct. Given its historical location in psy-discourses, I aimed to include some discussion of the personal and/or institutional resources the participant chose, was directed to or denied during ‘nervous breakdown.’ Given that ‘nervous breakdown’ is so intimately tied up with psy-diagnostic and treatment discourses and institutions, I felt this to be an important area to cover. I aimed to explore with participants who and where they sought help from during their ‘nervous breakdowns’ and whether psy-practitioners were relevant and/or accessible to them or not. If not, I

aimed to explore with the participants which other institutions and discourses were relevant to them in their constructions of their ‘nervous breakdowns.’

2.2.4.5. Informed consent

Before the interviews, I obtained informed consent from the participants in order to comply with the ethical requirements of participants being fully informed as to their undertaking and made aware of their rights within the research. I re-iterated the nature and aims of the research as explained during our phone conversation, their rights as a participant and the intentions for the data collected from them. I noted that participation was voluntary and that they had a right to withdraw at any time without reason or repercussion. I also clarified that participants were not obliged to answer all questions and could request for the discussion to move on. I indicated that the interviews would be recorded and transcripts used in the research. I stressed that participant identities would be anonymized and their data treated confidentially. Participants were asked to sign a consent form (Appendix D) acknowledging that they understood this and from this understanding, consented to participate in the study. I have kept these signed consent forms for my records.

After obtaining informed consent, I began recording with a digital Dictaphone. Recording enabled me to be attentive to the participant in the interview and allowed for full-text analysis. I indicated the loose structure of the interview and that participants should feel free to introduce anything extra they felt relevant to their account of ‘nervous breakdown.’ Throughout, I aimed to maintain rapport, and balance an attitude of curiosity with a focus on the research objective. The schedule proved helpful in re-focusing the conversation on ‘nervous breakdown’ and its implications for the participant. I tried to limit my introduction of new content, rather focusing on restating the participants’ talk. Willig (2013) contends that this allows for the researcher to signal to the participant that he/she is present to their accounts and also allows the participant to correct any misunderstandings.

2.2.4.6. Debriefing

At the end, I left time for participant questions and asked them how the interview had been for them. This allowed for a segue into debriefing. As indicated in the introduction of this thesis and the discussion about risk, the literature suggests that ‘nervous breakdown’ has been associated with difficult emotional experiences and crisis. As such, ethics dictated that I acknowledge the possibility that difficult material might have been raised for the participants which a one-off research interview was unable to adequately contain and process and which might not have been apparent at the time of the informal risk assessment. I therefore provided all participants with an information sheet during the debrief which listed resources they could consult if they felt unsettled after the interview (Appendix E). I acknowledge that all the resources I provided are within the psy-disciplines, thereby constructing appropriate help for the feeling subject as psychological. However, these are the resources that I am mandated to refer to by the research’s position in the psy-domain and its ethical protocols. Moreover, from my position as a trainee counselling psychologist, however critical of the institution, I share an ethical position that deems these resources as helpful in ameliorating distress. In addition, in order to maintain the ethical boundary between research and therapeutic interview, it was important to delineate the debrief from a site of psychological support. The provision of the information sheet and its explanation served to demarcate them as separate spaces. The debrief included a re-iteration of the aims of the study and what would happen next with participant contributions to the research. Participants were invited to ask any questions they had and to contact me at any point with further questions or if they wanted a copy of their transcript.

2.2.4.7. Anonymity, confidentiality and storage of data

Every effort was made to ensure that participant identity has remained anonymous. Informed consent assured participants that their data would be anonymized and stored confidentially. I have therefore allocated pseudonyms to all participants and kept the record of their correspondence in a locked filing cabinet accessible only to me. Other

identifying details such as place names, job descriptions, names of other people and particularly family, friends and partners were altered and the latter replaced with a label of relationship in square brackets e.g. [husband]. Participants were ensured that only me and my academic supervisor would see copies of their transcripts and that although direct quotations would be used in the research, identifying details would be anonymized such that a reader would be unable to recognize the participant.

Interviews were recorded using a digital Dictaphone. Informed consent was obtained for this from participants. After each interview, I downloaded the recording to two different password secured files (the second for back-up) on a password secured computer accessible only by me. I then deleted the recording from the Dictaphone. Participants were advised, in keeping with City University's research and data protection guidelines, that their data would be kept in the same secure storage facilities described above for ten years after publication of the research and thereafter confidentially destroyed by me.

2.2.4.8. Additional ethical considerations: Complexities and tensions

The study was granted ethical approval by City University's Research Ethics Committee (Appendix F). I have attempted to weave key ethical considerations into the description of the research process. Thus far, they have included a reflexive consideration of the impact of my dual identities as therapist and researcher, as well as considerations of informed consent, voluntary participation at all stages, participant anonymity and confidentiality of data storage, and the potential impact of interviews on the participant. With regard to the latter, pertinent because a research relationship carries a power differential between researcher and participant, I have discussed the attempts made to foster a more collaborative interview space and to facilitate an encounter where participants had some agency over the conversational terrain, and felt listened to and able to ask questions.

Many of the ethical considerations in this study were to mitigate risk to and exploitation of participants. However, some researchers contend that many

participants find the process of sharing a subjective account of experience within the constraints of a research interview to be beneficial (e.g. Frith & Kitzinger, 1998). It would be duplicitous to suggest that this research aims to give the participants voice in the stronghold of psy-discourses. The research is authored by me, situated as a psy-study albeit a critical one, and chiselled by discourse analytic approaches which are deeply rooted in a Barthian death-of-the-author stance. This challenged my therapeutic position which is embedded in discourses prioritizing client agency. However, it chimed with my therapeutic concerns about systemic pressures on clients and services and the limits of an individualized gaze. As such, an ethical consideration can be extended out of the immediate study to its context within the discipline. By contributing to the growing body of research that argues for the psy-institutions to attend more to the ways in which clients choose to construct their experiences and to develop more dialogical client-psy relationships (e.g. Boughtwood & Halse, 2008; Burman, 2007; Harper, 2013; Gibson & Cartwright, 2013; Speed, 2006), this study can in some small way address these as ethical concerns in the discipline. This enterprise is dear to counselling psychology, which urges practitioners to apply its client-centred and reflexive values to research as well as practice (e.g. Bury & Strauss, 2006; Kasket, 2012).

2.2.5. Data transcription and analysis

The final part of this chapter describes how the analysis itself was carried out and concludes the methodological discussion. The fusion between methodology and analysis is not as discrete as chaptered entries might suggest and where relevant I have included methodological considerations in the analysis.

2.2.6. Transcription

The articles in the media analysis study required transcription for ease of reading and analysis. Given that the content was already formatted as text, I copied the article text into word documents, standardized line length (highly variable in online media) and numbered the lines to facilitate analysis.

All eight of the interviews were transcribed in preparation for analysis. They were transcribed verbatim with basic transcription notions to give context to the analysis. Namely, I attended to vocal actions and attenuations which emphasized the function of the speaker's discourse including pauses, emphases, interruptions, whispering, laughing, inaudibility, crying, clapping and so on. I drew on the adaptation of the Jefferson transcription notion system used by Potter & Wetherell (1987). A full transcription notation is generally used in those discourse analytic approaches attending only to the minutiae of conversation. This level of detail is neither necessary nor appropriate for a more synthetic analysis as used in this project and interrupts a more global reading of the text. I have included sample pages of media article and interview transcription in Appendices A.2 and G respectively.

2.3. Analytic procedure

Having already broadly outlined the analytic stance of this thesis, I will now describe the process in more detail. The same approach was applied in the media and the interview studies, but differed in emphasis given that the interviews demanded greater exploration of the intersubjective function of discourse whereas media texts demanded greater consideration of wider discursive terrain. Many discourse analysts contend that providing a neat definition of the analytic procedure is obstructed by its iterative nature and the fact that methodological tools are abstracted from variable philosophical readings of the position of the research (Billig, 1997; Potter & Wetherell, 1987). This was particularly pertinent given the synthetic approach to analysis adopted in this research. The analysis was thus guided by immersion in methodological texts, and the statement of the analytic position of the project. Analysis was then informed by the conceptual categories I sought in the texts, and not the linear progression of stages, and was in keeping with the approach to analysis taken by Wetherell & Edley (1998; 1999) and Edley & Wetherell (1997; 1999). In the interests of transparency, I have retrospectively produced a list of key criteria that

informed the analysis to assist other researchers should they wish to replicate this approach to discourse analysis.

2.3.1. Familiarization and coding

For both studies, I read the transcribed texts without any attempt at analysis. This was to get a sense of the texts as a data corpus and enable a topographical gaze that would allow me to link parts with the whole at later stages of analysis. I believed that immediate analysis would interrupt this more global first sense of the data.

The next stage involved the start of a more active interpretation of the texts through a coding process. Re-reading each transcript or article, I made notes in the text's margins when a part of it seemed to relate to 'nervous breakdown.' As indicated by Potter & Wetherell (1987), the process erred on the inclusive, allowing for anything that struck me as relevant to be noted. The process included descriptive interpretations and also some abstraction to inferred meanings. Over time I noticed patterns and repetitions in my basic interpretative codes. For example, I noticed a pattern in the media and participants' descriptions of 'nervous breakdown' as a verge, an edge, and a dangerous place from which one can fall. This was denoted by a variety of descriptions which used mountaineering metaphors, descriptions of losing ground, horizons, and slipping and falling down, among others.

2.3.2. Key analytic concepts

Textual deconstruction then moved to an iterative process of identifying a discursive terrain that constructed 'nervous breakdown' and regulated its subjects; and also a process of examining how the discursive agents in the interviews and the media articles used the discourses this terrain made available to them to construct contextually-motivated accounts of 'nervous breakdown.' Analysis traversed these sites, looking to comment on the relationship between the two and the implications of this for the subject/agent of 'nervous breakdown' and the institutions that construct and are constructed by him/her. With regard to the latter, and given the genealogy of

‘nervous breakdown,’ I listened out for the implications for the subject-psy relationship.

Constitutive discourse

Firstly, the analysis addressed the constitutive nature of discourse through identifying interpretative repertoires. This allowed the research to examine the discursive currency made available for people to draw on in constructing ‘nervous breakdown’ and enabled a consideration of the subject positions that these repertoires make available for people in the discursive terrain of ‘nervous breakdown’ and their potential implications for subjectivity and social action.

Constructive discourse

Secondly, the analysis looked at the constructive nature of discourse, exploring the interface between the wider discursive terrain of ‘nervous breakdown’ and the individual discursive agent. Here it considered which repertoires were preferred or resisted and to what ends. It considered how people negotiated subject positions relative to ‘nervous breakdown’ and how they negotiated multiple, even contradictory positions and the social function of taking up or resisting a particular position. At this stage, the analysis attended to the localized deployment of discourse and the linguistic, rhetorical and symbolic devices that people used to construct their accounts and subject positions within the interviews, and as speakers in the media articles and interrogated the social function of these within the context of the account.

Variable discourse

Using the concept of ideological dilemmas identified by Billig et al. (1998) attention was paid to contradictions and variability within the texts. This was applied at all levels of analysis from interpretative repertoires identified in the discursive terrain of ‘nervous breakdown,’ to those drawn on by participants in the interviews and also to the related subject positions. A consideration of this variability enabled analysis to offer some deconstruction of a singular notion of ‘nervous breakdown’ and to

comment on some of the varied and even competing social functions that ‘nervous breakdown’ can hold for those who use it.

2.3.3. An integrated analysis

An analysis that considers the relationship between a constitutive discursive terrain and a constructive discursive agent needs to travel between the fine-grained and more global levels of discourse analysis throughout the analytic process (Wetherell & Edley, 1999). As such, a two-stage analytical approach is outlined above for explanatory clarity. In reality, the process, typical of discourse analytic approaches, is far more iterative with each moment of analysis constantly re-informing the whole, and changing the immediate conceptual focus. Edley (2001, p. 168) describes the discourse analytic process as a “craft skill” of coming to recognize the patterns that denote a particular discursive terrain and its subject-agents.

In the first instance, I used interpretative repertoires as defined by Potter and Wetherell (1987) as an exclusive analytic category. This was given its ability to facilitate an analysis that addressed both the wider discursive terrain and the agency of the people in it. However, during the process of analysis, I found that the more Foucauldian analytic category of discourse as defined by Parker (1992) fitted better when describing parts of the discursive terrain that were more hegemonic, and spoke of practices and legacies of power. I have therefore used both terms with interpretative repertoire denoting parts of the discourse of ‘nervous breakdown’ that are more partial, situated and malleable by discursive agents.

2.3.4. Ending analysis

Saturation or exhaustion is considered the point at which nothing new seems to emerge from analysis (Kelly, 1999). I stopped the analysis when I had gone over the texts such that the same patterns re-emerged repeatedly. Many contend that ending analysis is also guided by an ability to address the research aim in its complexity with conceptual abstraction that is well-grounded in the data corpus, and also in the debates

surrounding it (e.g. Antaki et al., 2003). I ended analysis when I sensed both saturation and a data-informed facility for discussing the meeting of the discursive terrain of ‘nervous breakdown’ and its subject-agents. The following chapters address the findings of the analysis, starting with the analysis of the discursive terrain of ‘nervous breakdown’ as mapped out by popular and contemporary online media.

3. Analysis

3.1. Media Analysis

Mapping the discursive terrain of ‘nervous breakdown:’ An analysis of popular media

3.1.1. Revisiting the Research Aim

The main aim of this study is to identify and explore the interpretative repertoires commonly used to construct ‘nervous breakdown’ in order to better understand what this construct might represent for people who invoke it and what the potential consequences are for the subjectivities of these people, and the institutions in which they are positioned and in which they choose to position themselves. A media analysis was conducted to map out the wider discursive terrain of ‘nervous breakdown.’ This was in order to see what interpretative repertoires are available for the construction of ‘nervous breakdown,’ thus providing a discursive mise-en-scene for the analysis of participant constructions of ‘nervous breakdown’ and grounding for a discussion of the relationship between the two discursive spaces that can construct ‘nervous breakdown.’

3.1.2. Reviewing Newspaper Articles

Following the analysis of twenty online newspaper and magazine articles using the search term ‘nervous breakdown,’ several predominant and even contradictory interpretative repertoires were identified.

This search term revealed that many texts used the terms ‘breakdown’ and ‘mental breakdown’ interchangeably with ‘nervous breakdown’ in the same article. The Google search engine that I used to perform the search also did this. After some deliberation I chose to give up a purist position dictating that I attend only to the construction of ‘nervous breakdown’ in favour of a more exploratory position that would allow me to engage with the construct as it is used in the public domain. I

believed that this slipping and sliding around a core tenet of breakdown would allow for a richer analysis. Moreover, while different semantically, all three terms were used as part of similar interpretative repertoires, suggesting that their functions-in-text were similar.

3.1.3. ‘Nervous breakdown’ constructed as a space on the edge

Many of the articles reviewed positioned their readers as unknowingly moving towards the verge or edge of a ‘nervous breakdown.’ For example:

On the verge of a nervous breakdown?

(Title from *The Mirror*, 22 March, 2007, no author cited)

And

So how do you know if you’re having a particularly stressful day – or if you’re about to have a nervous breakdown? Look out for these warning signs that a breakdown is on the horizon:

(Thapoung, 2013, Lines 12-14)

Both excerpts use a rhetorical device often found in advertising of asking the reader directly to evaluate whether he or she is in a dangerous position (often coupled with the selling of a restorative or protective product). In so doing the articles imply that the reader may be unknowing of how close to this danger (in this case a ‘nervous breakdown’) he/she is. This allows for the text to be positioned as expert in relation to the reader as it is the text and its authors who “know,” akin to the product-solution setup. It also constructs the verge of a ‘nervous breakdown’ as a risky place to be: terrain that requires “warning signs” and this implies that to fall off the edge or “horizon” is dangerous. Together, these discourses appear to construct ‘nervous breakdown’ as a *space* of impending danger for the unknowing public and seem to facilitate subject positions that vary relative to this dangerous space.

However, there is an imperative in this interpretative repertoire. It is an imperative for the reader, now alerted to this impending danger, to evaluate his or her own proximity to “the verge” *and* also take action to prevent him or herself from falling off the edge and into a breakdown. This is well demonstrated in the following excerpt:

Are you on the verge of a nervous breakdown? Here are a few signs you’re in the danger zone:

You’re having trouble concentrating.

You feel anxious, emotional or upset.

You worry about how you’ll get your work done.

You’re engaging with passive coping (drink, food, drugs).

You’re taking longer than usual to finish routine work tasks.

(Eurich, 2013, Lines 17-21)

This text is again asking the reader to evaluate his or her proximity (space) to the danger of ‘nervous breakdown.’ Once positioning the reader as unknowing of his/her peril, it then offers its seemingly expert opinion on how to self-diagnose one’s peril. This implies that a responsible reader-citizen, now in knowledge of warning signs, will undergo a process of self-examination for his or her proximity to a ‘nervous breakdown’ by filtering it through what reads much like a psycho-medical symptom checklist. The presentation of a symptom checklist is deeply resonant of the expertise of a medical text book and is strikingly similar to many DSM-5 checklists for mood disorders⁴. Arguably, the text has co-opted this discourse to add to its legitimacy.

This is further demonstrated in this excerpt from an article in *Forbes* (Casserly, 2011), the well-known financial newspaper, which includes advice from a “Robert Epstein, Ph.D, a research psychologist and former editor-in-chief of *Psychology Today*” (Lines 17-18):

⁴ For example, the DSM-5’s list of diagnostic criteria for Generalised Anxiety Disorder (DSM-5: 222) offers an excellent referent for comparison of tone, content and format with this excerpt

Epstein also suggests taking advantage of online resources, like doyouneedtherapy.com, a site he's developed with a series of questions that can help you better understand your mental state. "It doesn't diagnose you, but it indicates whether or not you should consult a therapist or counselor and what to tell them. It gives you a language to use.

(Casserly, 2011, Lines 70-74)

This excerpt locates 'nervous breakdown' within the domain of mental illness and the expertise of its institutions and practitioners. However, it also suggests that the reader become his/her own expert on diagnosing and managing him/herself through imparting some of this psy-expertise to him/her. As such it still positions the reader and his/her experiences in the gaze of the psy domain – quite significantly giving the reader the (hegemonically constitutive) "language to use." It also positions the reader within the evaluative criteria of the psy-institutions (for mental health or illness) by constructing a threshold (via self-diagnosis) at which one should or should not seek help from a "therapist."

However, the text implicitly locates responsibility for falling off the edge into 'nervous breakdown' with the reader, not with the expert other or the socio-political institutions in which the individual is positioned. It is the reader who must notice that his/her behaviour is "off" and the reader who must seek out and use resources psy and otherwise to correct this offness or risk falling off the edge into 'nervous breakdown.' This again suggests a spatial aspect to the construction of 'nervous breakdown:' potential subject positions for the everyperson-reader are then ways in which he or she can locate or be located relative to the space of 'nervous breakdown' and negotiate and re-negotiate these discursive locales.

3.1.4. Offness, stress or potential madness?

The interpretative repertoire constructing 'nervous breakdown' as a space of impending danger near an edge chimes well with the common phrase 'over the edge' which can be understood as a discursive construct that is invoked to refer to the

boundary between constructs of sanity and madness. It also suggests that over the edge in ‘nervous breakdown’ is an irrevocable state, much resonant of popular constructions of a descent into madness.

The image of edge and subjects’ spatial proximity to it appear extremely significant in the interplay between two seemingly competing discourses used to construct ‘nervous breakdown:’ discourses of stress and discourses of mental illness and madness.

3.1.4.1. The individual breaking down under too much stress

Almost all articles reviewed constructed ‘nervous breakdown’ using metaphors of a person breaking down, falling apart, collapsing, snapping, melting or being overwhelmed as a result of too much externally applied stress or pressure. This in turn constructs the edge associated with ‘nervous breakdown’ as a threshold space at which the individual succumbs to the stress and can no longer utilize inner resources to cope with it. This is well encapsulated in the following excerpt from *The Daily Mail* (Naish, 2013, Lines 41-47):

The renewed popularity of nervous breakdown as a term may reflect the nature of our highly stressed times. Last month, even President Barack Obama was rumoured to have suffered one, thanks to the combined strains of dealing with the Syrian crisis, the UN and the U.S. budgetary problems. The internet buzzed with rumours that the President had suffered a mental collapse in Washington and had to be sedated.

This excerpt constructs ‘nervous breakdown’ as a form of “collapse,” primarily owing to externally located “strains” and stressors becoming too much for President Obama. The use of the word “mental” situates ‘nervous breakdown’ in the domain of an inside mind. It implies that this inside mind has directly encountered the outside force of this stress. As such it positions ‘nervous breakdown’ at this encounter: where the outside world has breached an edge that separates it from the mind-inside-person and in so doing has caused the structure of the latter to “collapse.” The verb “collapse,” in

particular, suggests a force that is powerful enough to break down an existing structure in one foul swoop and draws on an engineering metaphor by invoking ideas of structure, force and collapse.

By locating stress and strain as external to President Obama: “the Syrian crisis, the UN and the U.S. budgetary problems” this text seems to mitigate his accountability for his (rumoured) ‘nervous breakdown’ and implies that external demands of such force could “collapse” or break down even one of the most powerful men in the world. This constructs stress as a dangerous external agent whose attrition of the edge of the inside mind can cause ‘nervous breakdown.’ The phrase “thanks to the combined strains of” in the above excerpt seems to locate blame for ‘nervous breakdown’ with stress, not with the Obama and suggests a powerlessness of the mental structures that are purported to constitute a coping subject to remain structured when under stress.

This discourse of mitigating blame for ‘nervous breakdown’ by attributing it to the inevitable force of external stress also serves to normalize the construct of a ‘nervous breakdown’ or at least move it into the terrain of discourses of laws of physics, work-related performance and embodied health and away from discourses of a mad other who is positioned as irretrievably broken down over the edge or constructed as never ‘normal’ in the first place. This is largely because stress constructs have become increasingly co-opted into discourses constructing normal daily life, and being stressed and managing stress can therefore be understood as routine discursive practices of a subject navigating his/her way through “our highly stressed times” (Brown, 1999; Doublet, 2000). This is well demonstrated in the following excerpt from *Women’s Health* (Thapoung, 2013, Lines 5-8 and 11-12):

But you don't have to have an Oprah-level to-do list to be on the verge of a breakdown. It's totally normal to feel overwhelmed and wonder if you're two annoying texts from your mom away from *completely* losing control of your mental facilities[...]Dealing with constant, overwhelming stressors – like working crazy hours with no downtime – is the most common cause of a breakdown.”

Once again, much like the Obama excerpt, it constructs a ‘nervous breakdown’ at the space of interface between “mental facilities” and “constant overwhelming stressors.” It suggests the power of these stressors to overwhelm the individual’s “control” and locates this control *within* the individual’s mind. This is resonant of the images used to construct Obama’s ‘nervous breakdown:’ a collapsing of his “mental” structures in the face of an onslaught of external stressors.

These texts position anyone as vulnerable to stressors, from Obama and Oprah to those subject-citizens working “crazy hours.” These subject positions of president, celebrity and hard-worker are arguably valued positions in our post-industrial, commercially driven and celebrity worshipping societies. This suggests that even powerful, hegemonic identities are able to be near the edge of ‘nervous breakdown’ by virtue of the very things that make them powerful: hard work and participation in many endeavours deemed worthy. These pursuits are constructed as agents of stress and stress is construed as determining one’s proximity to being on the edge of ‘nervous breakdown.’ Moreover since the individual is constructed as powerless in the face of the force of externalized and inevitable stress, blame for ‘nervous breakdown’ is attributed to stress, not the individual. In other words, (curiously, I think), this allows for and even normalizes a hegemonic subject position to be located close to the edge of ‘nervous breakdown’ and furthermore, allows it to act as a contemporary indication of success.

The deployment of stress discourse as a causative agent for ‘nervous breakdown’ acts to position the subject away from the terrain of madness (over the edge) while

simultaneously allowing for features of mental illness to be visible in the same position. This seems to be accomplished through the location of stress as external, an inevitable part of normal life and more powerful than the construct of a structured, internal mind which is positioned as the site of self-control and normative performance. Moreover, stress discourse has an embodied component which parallels the nervous in the term ‘nervous breakdown.’

Theories and constructions of stress are varied and longstanding. However, the interpretative repertoire of ‘nervous breakdown’ which positions the individual as helplessly passive in the face of the pernicious onslaught of external stress draws most on Selye’s (1956) theory of the General Adaptation Syndrome of stress. This theory draws on an engineering metaphor to construct a cause and effect relationship between organic life and the environment. It suggests that external events (stressors) can have a direct and damaging impact on our bodies because prolonged exposure to these events causes prolonged arousal of stress hormones, which are posited to lead to illness (Viner, 1999). By drawing on this stress discourse in the construction of ‘nervous breakdown,’ the media articles blur the lines between embodied illness and “mental collapse” and allow for the latter to be positioned more like the flu, and the subject more like a victim of exposure than an agent of contraction. Embodied illness that is caught rather than contracted by activity over which the subject is seen to have choice is rather more forgiving in the personal accountability stakes (Lupton 2012). In addition, subject positions in the realm of physical illness are generally more socially acceptable spaces than those in the terrain of mental illness (Pilgrim & Rogers, 2010). Thus, the use of discursive elements from Selye’s stress construct begins to accomplish a mitigation of personal responsibility for ‘nervous breakdown,’ and a mitigation of associations of mental illness when in ‘nervous breakdown’ – at least for Obama and Oprah and those occupying similar successful subject positions. In this interpretative repertoire of ‘nervous breakdown’ the subject becomes positioned as a victim of the stress of his/her success.

However, later theories of stress introduced the individual as the agent in his/her being stressed to a far greater extent. For example, the transactional model of stress suggests that a stress response is created through the individual's internal appraisals of the external stressor and of his/her coping resources to deal with it (e.g. Lazarus & Cohen, 1977; Lazarus & Folkman, 1984). More recently, dominant stress theories have diminished the role of the external in becoming stressed and increased the role of the individual's internal processes of self-management. These are believed to mediate the stress response, thereby rendering the individual wholly responsible for being positioned as stressed and if positioned as too stressed, as having failed in the enterprise of self-management (Brown, 1999; Ogden, 2002).

The constructions of 'nervous breakdown' as a spatial proximity to a dangerous edge which can and must be avoided by improved self-governance seem to draw more from these intra-subjective discourses of stress. The latter constructions are taken up by media articles asking the reader to self-diagnose and self-manage his/her proximity to 'nervous breakdown.' These articles rely on expert psy-sources and occupy a very different subject position from he/she who has had a 'nervous breakdown.' It follows that these articles, which sell on a danger-prevention pitch, and which arguably have an implicit institutional interest in constructing and regulating the self-managing subject – all deploy voices of psy-expertise – would draw on discourses of stress that are consonant with this position. It also follows, that individuals positioned as having had a 'nervous breakdown,' such as Oprah, would actively seek to avoid a position of failed self-management by drawing on discursive resources that mitigate personal responsibility, such as those which construct stress as an external and inevitable agent of damage to the relatively helpless individual. The avoidance of a seemingly more dominant position that equates a position of too stressed with failed self-management is augmented through references to the import of the stressors or the stress inherent in the subject's position of success. For example, one would have an uphill rhetorical battle to reposition the president of the USA who has been "dealing with the Syrian crisis, the UN and the U.S. budgetary problems" as a subject of failed self-management.

Yet, while mitigating responsibility for ‘nervous breakdown’ in this way, it was Obama who had to be “sedated” and therefore managed as a result of ‘nervous breakdown,’ not the UN, the US Treasury or the multiple agencies presumably also “dealing with” Syria. By constructing the site of “collapse” *within* President Obama’s mind the article implies that “collapse” is an uncomfortable *mental* deviance from normal performance and it is this which requires sedation (or perhaps silencing), presumably until a state of normal *mental* structure can be performed again.

3.1.4.2. *Mad but not mad*

I believe that this touches on one of the key contradictions in the interpretative repertoires constructing ‘nervous breakdown’ in the popular press. Many of the articles and voices captured therein go to great discursive lengths to construct a position within discourses of madness and mental illness while also avidly disavowing this position through the deployment of stress discourses. As Brown (2005) contends, the use of stress discourses can act to reposition the subject away from the sharp edges of distress, complexity or difficulty into seemingly more banal spaces of health and personal resource management. However, as is emerging, this is not accomplished completely in the construction of ‘nervous breakdown’ and allusions to mental illness and madness remain throughout. I believe this contradiction is also reflected in the slipping and sliding between ‘nervous breakdown’ which locates the site of breakdown in the body, ‘mental breakdown’ which locates the site of breakdown in the mind and ‘breakdown’ which seems to touch on both.

This interplay of contradictions is well encapsulated by Oprah Winfrey in constructing her experience of ‘nervous breakdown’ as cited in an article in *The Independent* (Walker, 2013, Lines 19-20):

“I mean, I wasn't ready to go run naked in the streets. Let's make that clear,” Ms Winfrey went on. “But I had reached a point where I couldn't take in any more stimulation. OK?”

Oprah seems to imply that some might regard the way in which she constructed her ‘nervous breakdown’ as the signs of someone who is going mad (moving to the space over the edge). The phrase “running naked in the streets” seems resonant with an interpretative repertoire of madness that pre-dates its co-option into the discourses and walled institutions of mental health and mental illness. It invokes a construction of over the edge as a space where individuals who disrupted consensual norms of Victorian Christian morality such as by “running naked in the streets” were construed as mad, unsafe and unmanageable (Appignanesi, 2008). The subject constructed as mad in this way is one that is positioned as othered, marginalized and at risk of losing liberties behind the restraints of the asylum or behind the ridicule and rejection of those positioned as sane (Sadler, 2004). This undoubtedly carries over into the interpretative repertoire of madness that Oprah touches on and understandably wishes to move away from.

As such, Oprah appears very resolute in telling the reader that this was not the case for her. This is not a subject position she chooses to take up or one that is consistent with her rags to riches story of success and self-empowerment. The phrases “let’s make that clear” and the suffix of “OK?” act as rhetorical devices that emphasize her position and do not enable the reader to easily interrogate it. Moreover, temporally, she admits to ‘nervous breakdown’ after the fact: situating her experience of it with a past subject position by using the past tense throughout. This implies that she is presently positioned back at a safe distance from the edge of ‘nervous breakdown.’ The article that refers to Obama’s purported ‘nervous breakdown’ also uses the past tense and thus also discursively accomplishes a present subject position that is no longer collapsed but repaired to a safer space away from the edge.

3.1.5. ‘Nervous breakdown’ constructing a liminal space: An edge

The discursive space of ‘nervous breakdown’ as constructed in the articles reviewed seems riddled with ambiguities. It is constructed largely as potential: an approach to a dangerous edge, and the everyreader-subject as proximal to but not quite in it. It is a

position on “the horizon” or “two annoying texts from your mom away” (Thapoung, 2013, Lines 14 and 7). It is a “verge” that is at least a “danger zone” away (Eurich, 2013, Line 16). Positions taken up in this approach to an edge might be said to be in the space of ‘not nervous breakdown,’ the more normal, even socially lauded space of stressed wherein one might still have a chance to maintain one’s position or navigate away from the edge through practices of self-management. Even for subjects who have been in ‘nervous breakdown’ and fallen off the edge, such as Oprah or Obama, the space of ‘nervous breakdown’ is constructed in the past, and the now-subject as repaired to the normality of before the edge. This too constructs ‘nervous breakdown’ as a space not-here-now: ambiguous and slippery.

By implication, ‘nervous breakdown’ is both the edge and the space over the edge. This is a problematic space structurally: how can it be both an edge and after the edge? It is also problematic because it is unclear whether or not a subject in ‘nervous breakdown’ can return to normal given the overlap with positions of madness which carry a heavy discourse of permanence and loss (Pilgrim & Rogers, 1999). Yet, some subjects like Oprah and Obama do return. They do so via discursive strategies that reject positions of madness, either actively, like Oprah who was “wasn’t ready to go run naked in the streets” or through the invocation of those stress discourses that allude to the more palatable landscape of an embodied breakdown of the helpless victim. They also accomplish a returned position via grammatical time, situating the subject in ‘nervous breakdown’ as not-now and the subject now as ‘not in nervous breakdown.’

‘Nervous breakdown’ is therefore constructed as a problematic space. It seems to position its subjects both as victims of the stress of success and as failures of the self-management of stress. It positions its subjects as stressed, not mad and as mad, not (just) stressed. It positions them as almost-there and having-been-there but not-there-now. ‘Nervous breakdown’ appears to problematise binaries on either side of the edge, referring to them and then tripping them up in the very same sentence.

As such, ‘nervous breakdown’ offers a liminal space: one that is not in the realm of sanity *or* madness, physical *or* mental illness, victimhood *or* agency, now *or* then, but one that allows for subject positions somewhere in between. This space is also one in which the hegemony of psycho-medical institutions is both represented but also can be resisted and re-appropriated. For example, while the texts locate expertise on defining this construct and the best way to manage it with psy-professionals, by their very nature as texts for the public’s self-diagnosis and as confessional spaces, they also suggest facility for the reader-subject to use and re-use the construct in negotiating his/her proximity to the edge of ‘nervous breakdown.’ To better understand this interplay, I turned to interviews with participants who self-identified as having had a ‘nervous breakdown,’ curious to see which interpretative repertoires they chose to construct ‘nervous breakdown’ and what this might accomplish for them.

3.2. Interview Analysis

Exploring subjective constructions of having a ‘nervous breakdown’

3.2.1. ‘Nervous breakdown,’ breakdown and break

Most participants used the terms ‘nervous breakdown’ and ‘breakdown’ interchangeably during the interviews. The interpretative repertoires they drew on to construct ‘nervous breakdown’ all used the verb stem ‘break’ in some way, and played on its multiple meanings to accomplish different positions relative to ‘nervous breakdown’ and within the interview space. These are discussed in the following analysis, as is the discursive function of including ‘nervous’ as an adjectival precursor to position the ‘breakdown’ as an embodied experience.

3.2.1.1. *Breaking*

The media analysis had identified that ‘nervous breakdown’ is often constructed as a space relative to a verge or edge. Similarly, in the interviews, many participants prefaced their constructions of ‘nervous breakdown’ with an approach to a dangerous edge. For example:

There seems to be this quality of lurching around – really just desperately
looking for ground
(Jackie, Line 98)

Later in the interview, Jackie described the time immediately preceding her ‘nervous breakdown’ as:

I felt on this edge and I felt y’know like I was gonna fall over the edge
y’know?
(Jackie, Lines 366-367)

Maria used a similar description:

It wasn't a sudden breakdown. I think things slowly started sliding and slipping and I started losing touch with myself – losing purchase
(Maria, Lines 62-63)

Both Jackie and Maria drew on metaphors of losing footing on firm ground: the usual preface to a fall. For both, this loss of a stable place on an edge was positioned as out of their control. Being “ungrounded” and “slipping...losing purchase” suggested that they started to fall owing to unstable terrain and not owing to a decision to fall. Jackie added that despite “desperately looking for ground” she felt as if she was going to fall. For many participants, the moment of ‘nervous breakdown’ was constructed as uncontrollable falling into a deep and frightening place:

It was like sinking down – you know a very very slippery slope – landing in a horrible dark place at the bottom
(Maria, Lines 250-251)

I was just falling down this hole. Just going down down down and it was getting darker and it was getting heavier
(Chantal, Lines 110-111)

A downwards movement uses an interpretative repertoire that constructs ‘nervous breakdown’ as falling over an edge and the subject as fallen down. Falling indicates a position of helplessness: a person who falls on unsteady terrain is not to blame, rather it is the fault of the terrain and the inevitable force of gravity. Moreover, a person who falls from a great height (over an edge), if not fatal, sustains serious injury and needs to be rescued by others. A fall also implies that the person is now in a space where others with firm footing are not: alone in a space no-one desires to be in. As such, by drawing on an interpretative repertoire of falling from an edge, indicating a

metaphorical breaking with the boundary of the edge, the subject positions him/herself in ‘nervous breakdown’ as victim (not to blame), injured, helpless, alone and in need of external rescue. Moreover, he/she is positioned as a victim of the (external) force of gravity. This resonated with the interpretative repertoires that emerged from the media analysis that constructed the subject in ‘nervous breakdown’ as a victim, felled or collapsed (as in Obama’s case) by external forces.

Some participants accomplished this position in a slightly different way. For example:

All of that started to come out, y’know? He [ex-husband] was very abusive...and I hadn’t really dealt with all of that and it was only in that moment at the end of August that it all literally came out. ‘Cause I just kept holding it, holding it
(Chantal, Lines 76-79)

That’s the beginning of everything I was always everything keeping in myself holding everything in[...]I think it started at the same time and happened after... it’s just like when you, when you can’t hold it anymore
(Ella, Lines 93-94 and 100-101)

This too, resonated with an interpretative repertoire that constructed ‘nervous breakdown’ as the result of powerful and inevitable forces. In this case the edge that is broken with is not constructed as a mountainous one but drawn from an engineering metaphor:

What happened over those two weeks [of nervous breakdown] was such that I couldn’t keep it in
(Rachel, Lines 203-204)

Later in the interview, Rachel referred to the moment of ‘nervous breakdown’ and noted that:

I saw a quote the other day saying it's about being too strong for too long
and at some stage the dam walls have to break
(Rachel, Lines 332-333)

Rachel also drew on an interpretative repertoire that constructed 'nervous breakdown' as the surpassing of an edge: the breaking of a dam wall. Such walls usually break apart from an overload of water pressure suggesting that Rachel was constructing her 'nervous breakdown' as a breaking apart of her wall, her edge between inside and outside, owing to there being too much on the inside, much like Chantal saying that "all came out" after "holding it, holding it" and Ella saying 'nervous breakdown for her was "when you can't hold it" in anymore. These constructions are resonant of the force of gravity used in the interpretative repertoire that constructs 'nervous breakdown' as a fall from an edge and is similar to the interpretative repertoire that was used to construct the 'nervous breakdown' of Obama, as "mental collapse" (Naish, 2013, Line 46) directly because of forces of external stress. They do, however, differ in the site and direction of the force that causes the edge to break. The force in this instance is located within the individual and its pressure felt in the direction of inside to outside, not outside to inside as for Obama and for the subject pulled down by gravity. The break with the edge occurs when internal pressure is construed to be too much for the individual to keep "holding," which results in it all "literally [coming] out."

Rachel's metaphor which likens the moment of breaking apart to the bursting of a dam wall suggests that the moment of breaking apart was fairly cataclysmic. A burst dam wall is considered akin to natural disaster and can devastate surrounding areas. In addition, this metaphor suggests that in breaking apart Rachel was no longer functional as a holder in some way, for a burst wall renders a dam no longer functional. By invoking a position of having one's edges no longer hold, the subject is constructed as broken apart and therefore is rendered not functional. Moreover, the subject is also positioned as not particularly accountable for this inability to function.

The breaking of the edge is constructed as a force majeure and as happening *to* the subject *by* forces which put pressure on an edge and which cannot be resisted by the subject. For example, Chantal noted that “it all came out” not that she let it out.

This is deeply resonant of Freud’s intra-subjective hydraulic metaphor which constructed the individual in terms of a build-up of inside psychological pressures, which had to find release in an expressive way. In the original model, the amount of libidinal build-up was correlated with the force of release and the process generally considered to be out of conscious control (Freud 1923/1961). As Parker (1997) contends, the contemporary discursive pool is saturated with Freudian idiom and metaphor and it has become a culturally dominant way of constructing relationships, individuals, groups and even perhaps largely constitutive of the self-reflexive subject. It is therefore unsurprising that the language of participants holds the discursive residue of Freud’s marriage of hydraulic engineering with the individual. Particularly, given that an interview space is implicitly set up for the discursive practices of self-reflection: I had asked participants to tell me about their experiences of ‘nervous breakdown.’

Chantal, Rachel and Ella all prefaced their breaking apart with descriptions of external events that were constructed as both difficult and ongoing. For Chantal, these were years of abuse by her ex-husband. Rachel prefaced her account of ‘nervous breakdown’ with an account of emotional abuse by her partner, while Ella prefaced hers with childhood abuse and neglect. All three of them constructed these events as external but as having had some effect on them internally: a pressurised effect that they had had to keep holding in or manage over a length of time. Thus, they situated the cause of their breaking apart both with these external forces and with a failure in their internal ability to hold in the pressure evoked by these external forces.

The latter makes reference to an internal process of stress or distress management: a process that requires the individual to hold in, and/or deal with the effects of outside forces. This seems to borrow from discourses of stress, distress and pain that position

these constructs as within the control of the individual's internal processes of self-management (Brown, 1999; Ogden, 2002). This differs from a Freudian hydraulic model wherein an overwhelming cathartic expression is constructed as largely unconscious. However, they do overlap in constructing an individual as holder of internal forces of pressure that have the potential to overwhelm him/her – breaking things apart – if not worked-through or dealt-with by *internal* resources. The common phrase of 'holding oneself together' is immediately brought to mind.

However, while acknowledging failure of this internal holding in as a possible subject position, Chantal, Rachel and Ella, along with most other participants, moved the site of failure to hold from one in their control to one out of their control. They accomplished this through the minutiae of the grammar and metaphors describing their breaking apart. For example, through Rachel's invocation of the burst dam wall metaphor and Ella's use of a passive "you can't hold it anymore" not an active "you don't hold it anymore."

They also accomplished a mitigation of personal responsibility for holding in through their accounts of the external events that caused the build-up of internal pressure and thus precipitated the breaking apart. These events, such as prolonged abuse or neglect invoke a socio-discursive position of victim. For example, Chantal described ongoing abuse from her ex-husband as the external force she had to hold in or deal with. The battered wife is a discursive position that often invokes a position of helpless victim. This is a similar discursive manoeuvre to that used in the media description of Obama's 'nervous breakdown' where the severity of the "Syrian crisis, the UN and the U.S. budgetary problems" were constructed as acceptably severe enough to allow for Obama to "collapse" as a victim of success, not a failure of self-management (Naish, 2013, Lines 44 and 46). For Chantal, Rachel and Ella, their descriptions of the difficulty and complexity of the external forces causing the build-up of overwhelming internal pressure allowed them, mostly, to break apart as victims of uncontrollable force. These forces, both external and internal, are constructed as severe enough to

mitigate the subject's responsibility to hold it in and position the subject as helpless victim.

Other participants accomplished a position of helpless victim by drawing on slightly different interpretative repertoires to construct the surpassing of an edge in 'nervous breakdown.' For example:

It [nervous breakdown] happened incrementally...and then just – it almost like hit a wall. Like if you run a long distance and your body hits a wall when you stop but my brain, my emotions, my life just hit this wall and suddenly went oh my god how does this work?

(Sophie, Lines 202-206)

Instead of drawing on falling or engineering metaphors, Sophie drew on the discourse of runner's wall. This is a construct borrowed from marathon runners and is used to refer to a sudden loss of energy while running. It is attributed to the toll that long-distance running takes on the body's glycogen reserves and denotes an embodied edge of ability to continue moving forward (Noakes, 2001). Sophie constructed her moment of 'nervous breakdown' as one of hitting this "wall" implying that the edge of her ability to continue had been surpassed. Similarly hitting a wall also implies a crash after which the subject-object that has crashed is unlikely to continue functioning, much like a car that crashes into a wall, or the body of a runner who hits runner's wall. Sophie did not use the pronoun 'I.' Instead she constructed a system of brain, emotions and life which crashed into the edge of the wall. This functioned to mitigate personal choice in and responsibility for the crash. Anna used a similar discursive strategy, noting:

It kind of felt like my head just popped one day. It just, it just stopped. I kind of felt like – if I remember rightly – I was rapidly getting to the point where I felt like my head was going to explode but instead of my head exploding it just kinda stopped

(Anna, Lines 93- 96)

Anna continued this description, noting:

I was floored. I mean it was like literally being broken down. Like not having the energy or capacity to do much physically or mentally
(Anna, Lines 102-103)

Anna constructed the moment of ‘nervous breakdown’ as her head “just stopping” after reaching a “point” where she was “floored.” This too implied that an edge of embodied ability to keep functioning had been surpassed, much like Sophie’s runner’s wall. The embodiment of the stopping of functioning, as discussed in the media analysis, is a discursive strategy that mitigates agency or choice. Anna’s head stopped, not her. Anna takes the embodied metaphor further, drawing on a boxer’s discourse of being “floored” which suggests that she was rendered unable to move and to continue the fight – the fight of staying on the edge of ability perhaps? A head that stops could be akin to being in a coma, where the subject is unable to do but is not dead. Anna also drew on the mechanical discourse of engines breaking down to augment this position, noting that being “broken down,” she could not move or function as expected. “Broken down” invokes the metaphor of an engine, particularly that of a car, that suddenly stops working and renders the driver or operator unable to use it.

Being “broken down” denotes that a mechanical system has surpassed the edge of its ability to keep functioning. Drawing on this interpretative repertoire accomplishes two key functions. Firstly, for Sophie and Anna, constructing themselves as embodied mechanical systems mitigates their agency in the ‘breakdown’ and shifts an attribution of blame. An embodied malfunction falls under the realms of physical illness, commonly constructed as *happening to* a subject and not his/her fault. It also constructs illness as system malfunction and thus suggests it may be fixable, like parts of a machine. Similarly, a car that is broken down is something *happens to* the car and the driver. Neither is to blame. A broken down car can also be fixed. As Jackie noted:

It almost feels like if you have a breakdown you can be fixed or, like, or and that sounds like you need to be fixed by another but y'know like if a car breaks down, the AA come and they, y'know put jump leads on and y'know off you go
(Jackie, Lines 273-276)

All participants drew on one of three interpretative repertoires that constructed 'nervous breakdown' as the breaking with or of an edge. Namely, interpretative repertoires that rendered the subject as broken after a fall, broken apart by pressure, or broken down after running out of embodied reserves. In all cases, accountability for 'nervous breakdown' was somewhat mitigated and the subject positioned as victim in an uncontrollable experience or force and subsequently rendered unable, injured or helpless. This also implies that the subject is unable to restore him/herself to a position of 'not nervous breakdown' on his/her own and requires the assistance of external agents such as "the AA." However, these three interpretative repertoires that construct 'nervous breakdown' as the breaking with or of an edge all leave some suggestion of the possibility of the repair of the position of the broken subject. In all cases the subject is rendered unable but alive, akin to the coma-like state invoked by Anna's construction of her head stopping.

3.2.1.2. Taking a break

Being positioned in 'nervous breakdown' rendered participants as helpless victims and also as unaccountable for this inability to exercise the agency that they might otherwise be expected to demonstrate. For example:

I literally spent two or three months in bed and my mum nursed me back to health. I know it sounds silly but I remember... I don't remember a great deal because it was really like my head just switched off and went on holiday but I remember my mum coming and feeding me like warm Weetabix like mashed up with it was the only thing I could eat... I... physically, physically I was absolutely battered and broken and mentally as well

(Anna, Lines 113-119)

Anna continued this description noting:

It was literally like my body and head went on holiday...just kind of physically I was there in bed but my mind was taking a break like it needed to

(Anna, Lines 122-126)

Anna, like most of the other participants, constructed 'nervous breakdown' as a time spent in a passive position and in bed. This drew on an interpretative repertoire of recovery from physical illness to construct 'nervous breakdown.' Anna constructed it as a time when she was "nursed" back to health from a position of "battered and broken." What is striking is that she explicitly constructed this time as one of "holiday," particularly for her head which was "taking a break like it needed to." She began to draw on a different interpretative repertoire to construct 'nervous breakdown' in this instance: one that used the noun 'breakdown' in the sense of break and holiday as opposed to broken.

Chantal drew on a similar interpretative repertoire:

[The GP was] saying 'you just need to stop' y'know and explaining to me what I had been through and that I needed some time out for me

(Chantal, Lines 178-179)

She continued talking about that interaction with the GP later in the interview, saying:

I went to the doctor [GP] and he gave me the sick note and then I rang work and then I knew I had closed that bit so I thought right I don't need to deal with that

(Chantal, Lines 357-358)

She then described what she did after receiving the sick-note:

I literally I was like ok I have to just take one day at a time and just do what I need to feel – rather than, to get into that and y'know and to fall apart...I...y'know I've now got this opportunity to rest because that's what my body was asking

(Chantal, Lines 360-363)

Chantal, like Anna, drew on an interpretative repertoire of recovery from physical illness to construct 'nervous breakdown.' she consulted a GP and got a "sick-note" in order to take "time out" and to "rest." This also began to draw on an interpretative repertoire that constructed 'nervous breakdown' as a break, time-out from work and an opportunity to rest. Both Anna and Chantal justified their respective breaks by constructing them as types of enforced (not chosen) holiday and rest. For example, Anna said she was unable not to take a break because her head went on holiday and her body was unable to get out of bed. She qualified this as "needed." Chantal justified hers by drawing on the power of a medical diagnostic discourse which effectively prevented her from working via a sick-note. Moreover, she qualified this by constructing her break as a response to what her "body was asking." This positioned her as responsible caretaker to her vulnerable body. This touches on discourses which speaks to the value of self-care in our society and which positions the responsible subject as custodian-regulator of the body (e.g. Rimke, 2000). In both

cases, the break in 'nervous breakdown' is not constructed as a choice made by either party and is constructed as necessary, responsible and restorative.

Anna continued to construct her break in 'nervous breakdown' as restorative:

I feel there was something in me that was kind of put into a bubble with the nervous breakdown: a very safe, nourishing bubble and just kind of suspended out of my physical and mental being for a while. And I feel like that is what needed to happen at that time. And then certainly...kind of...when...and then when I'd got well again it was kind of when the bubble had done what it needed to
(Anna, Lines 286-290)

In so doing, Anna drew on the connotations of break that construct it as a "safe" and protective space of stopping, not unlike a fuse effect or circuit breaker which function to stop the flow of electricity in a circuit if there is danger of the circuit being overloaded and causing harm. A fuse can be replaced and a circuit reset once the fault is repaired. Again, this harkens to constructions of mechanical failure, and acts to invoke a position of enforced (not actively chosen), protective stopping from which one can be restored when fixed.

Anna also constructed 'nervous breakdown' as a "suspended" time of recovery. She noted that "when I'd got well again it was kind of when the bubble had done what it needed to" which constructed 'nervous breakdown' as temporary, not permanent and also reinforced her position of passive recuperation: the "bubble had done," not her. All the participants positioned their 'nervous breakdowns' as a temporary episode outside of the context of normal functioning. For example:

I came to what I would call say maybe a three to six month full stop because the following year I arrived back and did what I had to do
(Naomi, Lines 119-121)

It was like ok, you've had some time out now- it's time to take charge and responsibility and give yourself the life you deserve and y'know really make things happen for yourself and I remember that...I remember that moment so clearly 'cause that's when I got out of bed and I thought enough's enough now. I've had my break or breakdown but more of a break and it was like ok now things are going to change

(Anna, Lines 253-258)

Naomi constructed her 'nervous breakdown' as a time-limited episode from which she "arrived back." This, again, drew upon the interpretative repertoire of break to construct 'nervous breakdown' as a time-away from doing what one "has to do" that serves to restore one to doing what one "has to do" – to normal functioning. Anna did this too, indicating 'nervous breakdown' was "some time out" which ended when she had had "enough" of it. She demarcated the end of the passive position of patient that she had taken up when "suspended" in her "safe, nourishing bubble" with the introduction of a voice of personal choice and agency, saying "it's time to take charge and responsibility" This agency is positioned as internal to Anna as she referred to herself as "you" when speaking, as if speaking to herself.

This resonates with discourses of self-management that construct the functional subject as able to relate internally to him/herself and thereby exercise agency over life-events (e.g. Ogden, 2002). This discursive space constructs the subject as caretaker of him/herself, and one who needs to act to optimise his/her functioning (Rimke, 2000). It links with those discourses identified in the media analysis that suggest that the responsible citizen-subject can avoid falling off the edge of 'nervous breakdown' through the practices of self-management. This suggests that by drawing on an interpretative repertoire that constructs 'nervous breakdown' as a restorative but discrete break, participants can be positioned/position themselves as passive patient-tourist-victims on an enforced break and then have the potential to be restored/restore themselves to positions of agents of self-care and self-management at the end of the

break. In other words, avoiding those constructions of ‘nervous breakdown’ in the wider discursive terrain that suggest a potential for being irretrievably lost after parting with the edge of so-called normal, sane or functional.

3.2.1.3. Breaking through

This ultimate restoration to agency at the end of ‘nervous breakdown’ was reflected in the accounts of all the participants. For example:

I’m much more content, much more wholehearted in the way I’m living now[...]I mean I wouldn’t recommend anyone go through a nervous breakdown of course but if you’re like me and you’re so incredibly stubborn that you don’t want to change anything then to have something like this [nervous breakdown] that gives you a clean slate to rebuild something that’s more honest is a good thing

(Rachel, Lines 471-480)

Rachel’s account of ‘nervous breakdown’ earlier in the interview had drawn upon interpretative repertoires that positioned her as passive and unable to exercise usual agency for a discrete period of time. For example, when describing the start of her ‘nervous breakdown,’ she said:

It was this big black void. I didn’t know how deep it went. I didn’t know how high it was. I didn’t know how wide it was. It was just dark. It left me questioning everything and that was a situation I just didn’t have the tools to cope with

(Rachel, Lines 134-138)

In this construction of ‘nervous breakdown,’ Rachel positioned herself as a victim and without control who was falling into a deep and unknown “void.” Like many of the other participants, she used the interpretative repertoire to construct ‘nervous breakdown’ as an uncontrollable falling off an edge into a dangerous and unknown

space to accomplish this position. Rachel also indicated that she did not have the “tools to cope” and thus augmented her position as helpless. This contrasts with her later accounts of ‘nervous breakdown,’ as referenced above, where she moved into an active position. She was able to “rebuild” herself while in ‘nervous breakdown’ and positioned this as part of the process leading out of ‘nervous breakdown,’ and leading to a (current) subject position that is “more content” and “more honest” than before ‘nervous breakdown.’ The reference to a then-and-a-now constructs ‘nervous breakdown’ as a discrete break. Moreover, Rachel drew on an interpretative repertoire that constructed ‘nervous breakdown’ not only as a restorative break, but one which repositioned her-as-subject into an improved space than that she had been in before the ‘nervous breakdown.’ This move from passive to active and then improved was echoed by Sophie:

I look on it [nervous breakdown] now as a blessing and I didn’t when I was going through it. It’s taught me a lot about myself and how I can keep going and how I did keep going and how much inner strength I have
(Sophie, Lines 320-322)

She also described her ‘nervous breakdown’ in retrospect as:

So I really feel I’ve gone into the depths of Hades and now I can come out and shine even more light
(Sophie, Lines 341-343).

Sophie also drew upon an interpretative repertoire that constructed the start of ‘nervous breakdown’ as a low, lonely experience in a depth: “Hades.” She also juxtaposed it, like Rachel, with an interpretative repertoire that constructed ‘nervous breakdown’ as a process that had repositioned to an improved subject position than that which she had occupied before ‘nervous breakdown.’ She was able after ‘nervous breakdown’ to “shine *even more* light,” presumably when compared with before ‘nervous breakdown.’ Sophie positioned herself as a now-agent actively able to

“shine” and “keep going” and as having “inner strength.” The latter is often used to describe the individual who is held together, not breaking or broken apart and also arguably a key construct in the discursive terrain of successful self-management. Moreover, Sophie suggested that ‘nervous breakdown’ functioned to teach her about herself and thereby positioned ‘nervous breakdown’ in the discourse of learning experiences. This is a term that litters the self-help discursive terrain and it is used as a preferred label to reframe aversive or distressing life events. It links with the discourses, already discussed, that position stress, distress and pain as well as health, ease and happiness largely as the result of processes of intra-subjective appraisal and control (Ogden, 2002).

In situating herself in this discursive domain, Sophie was drawing on an interpretative repertoire that constructed ‘nervous breakdown’ as a breaking down of the individual for purposes of rebuilding an improved version, with renewed and perhaps even better internal processes of self-management. This speaks to discourses of breakdown to breakthrough often used in contexts of self-development or spiritual enlightenment, where an individual who is constructed as somehow inauthentic or flawed goes through a period of change or breakdown in order to be reconstructed as more authentic, capable or spiritually advanced. These are seen to be positions of internal improvement and greater agency (e.g. Caprino, 2008; Druck, 2012; Sutcliffe, 1993). It was only from this discursive vantage point, where she had not only returned from Hades but was “now” shining *more* light than before, that Sophie could acknowledge any features of agency while in the “depths.” Being in the position of having “come out” from ‘nervous breakdown’ as repaired and *even* better, enabled Sophie or even required her by virtue of its reconstitutive quality, to say that she “did keep going” in ‘nervous breakdown’ and to imply that her “inner strength” remained throughout. This contrasted with her earlier position of being rendered a passive, helpless victim after hitting an embodied “wall” (Sophie, Line 204).

Most participants drew on the interpretative repertoire of breakdown to breakthrough in order to construct their current relationship to ‘nervous breakdown’ in the interview

space. Having manoeuvred through positions of unable victim and patient-tourist on a restorative break, all participants arrived at a position of triumphant survivor, re-built for the better by their respective ‘nervous breakdowns.’ Rachel (Line 101) positioned herself as a veritable “Phoenix rising from the ashes.” Yet, as discussed, the latter position can only be accomplished when juxtaposed with the helpless victim-subject who is rendered broken, broken apart or broken down after breaking with an edge that acts as a border between not ‘nervous breakdown’ and ‘nervous breakdown’ – between able and unable, stable and unstable, or held together and fallen apart. This begins to suggest that ‘nervous breakdown’ acts as a disruption to these binaries and that participants are actively positioning themselves as disrupted, not as permanently in an-other discursive space to the norm who sit in variable locations to the edge.

3.2.2. Not mad or bad, just nerves

In each of the interpretative repertoires discussed above, participants accomplish a relationship to ‘nervous breakdown’ that avoids positions within the interpretative repertoires identified in the media analysis that construct ‘nervous breakdown’ as a potential failure of self-management or as madness, and its subjects as not coping or mentally-ill.

3.2.2.1. Not my fault

Being positioned as having failed to avoid succumbing to ‘nervous breakdown’ relies largely on discourses that premise ‘nervous breakdown’ on the build-up of external stressors and/or internal pressure that could have or should have been mitigated by internal processes of self-management at some point. While participants can and do construct their ‘nervous breakdowns’ as the result of too much external or internal force, consonant with the interpretative repertoires of breaking with firm ground and being pulled down by gravity, breaking apart under too much pressure, or surpassing an edge of internal reserves (depleted by external demands) participants deny personal responsibility for reaching breaking point. They achieve this, as discussed above, through discursive strategies that position them as helpless victim on treacherous

ground, or that construct ‘nervous breakdown’ as a cause and effect relationship of the physics of engineering or mechanics applied to an embodied system whose edge of capability is surpassed by uncontrollable forces. In this way, ‘nervous breakdown’ is constructed as happening to participants, not as happening because of their failure to act in prevention – their not coping.

This position also relies on the construction of the causative forces trumping any internal attempts at prevention. Implying, that what participants construct as the reason for their breaking with the edges of their stability, holding together or continued functioning, is positioned as more powerful than those precipitators of ‘nervous breakdown’ that the media constructs as warranting prevention. In the media analysis, articles that drew on constructions of ‘nervous breakdown’ as a verge whose sharp edge must be avoided tended to draw on discourses that constructed stress as the precipitator of ‘nervous breakdown.’ They constructed stress largely as the result of difficulties of not coping well with competing work and personal demands and were thus located in a more transactional and intra-subjective discourse of stress⁵. These discourses contend that a responsible subject would know when the edge was being neared and take preventative measures or help them cope.

For example:

Bring some balance and routine into your life – take days off, make time for relaxation, try to eat regular meals, and get to bed early. Avoid alcohol, caffeine and sugary junk foods.

(*The Mirror*, 22 March 2007, Lines 94-96, no author cited)

Participants in the interview study constructed the precursors to their ‘nervous breakdowns,’ or the forces pushing them off and through dangerous edges, as other than work-life stressors. For example, as discussed, Ella prefaced her ‘nervous breakdown’ with a long history of family difficulties and Chantal with an abusive

⁵ See Ogden (2012) for a comprehensive overview of the discursive terrain of stress

relationship. Similarly, Maria prefaced hers with the loss of a long-term partner, immigration and a miscarriage:

The start of it all was leaving [country] and the life I had with [ex-partner]
(Maria, Lines, 13-14)

Later, again describing the build-up to her ‘nervous breakdown,’ Maria noted:

Then there was the pregnancy and the miscarriage that happened, oh that was a...that was a massive sort’ve...started the real degeneration
(Maria, 49-51)

No participants constructed failure to cope with work-life balance as precursors to ‘nervous breakdown.’ The forces they constructed as pushing them towards the edge, such as abuse, neglect or loss, position pre-emptive treatments of “daily relaxation” or the avoidance of “sugary junk foods” as facile and inappropriate. This would suggest that participants avoided being positioned as having failed to spot and prevent ‘nervous breakdown’ by constructing their ‘nervous breakdowns’ in a different discursive terrain from the media articles that would position them as having failed to cope with or manage their stress. Rather they drew on discursive terrains which constructed ‘nervous breakdown’ as other than work-life stress, and as the result of greater forces whose propulsion towards or attrition of an edge of embodied capability or stability could not be have been preventatively managed.

Nonetheless, despite circumventing unwanted positions of having failed to prevent ‘nervous breakdown,’ all participants suggested that they had been reluctant to use the construct in the public domain. For example:

There's people, people that I work with [who] have no idea I had a nervous breakdown because partially it's none of their business but there is still a stigma about mental illness
(Sophie, Lines 190-192)

Sophie constructed public disclosure of 'nervous breakdown' as having great potential for others to position her as "mentally ill" which she calls a position of "stigma" and therefore as unwanted. She also constructed 'nervous breakdown' as located in the private domain – it being "none of their business." One might infer that this is because of the fear of being positioned as mentally ill in the public discursive space whereas in a more private space, such as in the interviews, participants could construct a version of 'nervous breakdown' that could evade this position. This resonated with my experience of the internet web forums, which had constructed my accessing their conversations on 'nervous breakdown' as an "unwelcome invasion of privacy" and as "breaking our safe space." Perhaps, they too feared the discursive positions they might have been placed in by me (positioned as public domain), such as mentally ill, whereas in the privacy of an ongoing insider conversation, they would have been able to construct alternative positions in 'nervous breakdown' by drawing on other interpretative repertoires – as did the participants in this study.

3.2.2.2. *Not mad*

In the interviews, participants actively avoided being positioned in a discursive terrain of mental illness or madness. For example Anna noted:

I think that had psychological professionals been involved, my path from that point would have been very different. I think I woulda been section-able. I think I probably woulda got all sorts of diagnoses and be put on different medication and I feel I had a lucky escape from that but the way my parents approached the doctor was that I was ill physically
(Anna, Lines 150-155)

Anna was using her own knowledge of psy-discourses to construct her position in ‘nervous breakdown’ as relevant to its diagnostic gaze and treatment. She constructed her avoidance of the psy-institution as a “lucky escape” indicating if she had been co-opted within in it, she might have been positioned as prisoner – not only of a section, but also of the permanent markers of diagnoses and the material effects of medication. Anna said, shortly after this excerpt, that the presentation of a physical illness to her family doctor, a medical professional, was “safer” (Line 164) as if to imply that a non-physical, or mental construction would be dangerous. This, in turn, begins to position psy-institutions and practices as potentially dangerous for the subject who is rendered helplessly passive.

Even though Anna acknowledged the potential for her experience of ‘nervous breakdown’ to be constructed as mental illness and her to be positioned as “diagnosed” by psy-discourses, Anna deferred to a different construction that relied on ‘nervous’ as preface to ‘breakdown:’

I called it a nervous breakdown at the time because there’s no other words for it. I mean literally as a literal translation y’know I broke down nervously...I was a nervous wreck prior to that point. It was the utter extent of anxiety, living on nerves that just got to the point where it was just kind of enough’s enough and the shutters came down...literally just broke down (Anna, Lines 304-308)

Anna seemed to be connecting the psy-construct of “anxiety” with an embodied effect on her nerves. She indicated that she “broke down nervously” and situated the breaking down within her nerves, within her body. This again, relies on an interpretative repertoire that constructs ‘nervous breakdown’ as the trespass of an edge of embodied reserves, in this case located in the nerves, by a forceful agent, such as continuous “anxiety.” This draws on stress discourses, as discussed in the media analysis, which feature anxiety as part of stress and which link ongoing stress with physical attrition, collapse and illness (Abbott, 1990; Selye, 1956; Viner, 1999). It

also draws on the sediment of psy-discourses originating from the mid 1700s, which had begun to deploy constructs of nervous disease to explain an unable, restless or apprehensive subject (Shorter, 2013). Anna's amalgamation of these discursive terrains allowed her to draw on psy-discourses to construct herself as "anxious," but also to avoid a follow through positioning within the realm of psy-practices. It is unclear whether Anna was locating anxiety as external, internal or somewhere in between, but regardless of this, she was able to navigate into the terrain of physical malfunction, which as discussed, implies less accountability in onset or repair, greater possibility of audience sympathy and also suggests a temporary disruption to normal functioning. Most poignantly, as Anna suggested, she "escaped" a dangerous position as mentally ill.

It is at this point that participants' use of 'nervous' as qualifier for 'breakdown' becomes increasingly salient. Participants used 'nervous breakdown' and 'breakdown' interchangeably in their accounts, even erring towards a preference for the latter. However, when asked about why this descriptor for their experience and not another, participants re-invoked 'nervous' as explanation:

It's funny 'cause if you actually think about it a nervous breakdown is not quite correct. It's a mental breakdown but at the same time it's the nervous system that is going to buggery and is not functioning properly
(Sophie, Lines 372-374)

Sophie was quite explicit in capturing the potential for her to be positioned in the realm of "mental" not only in this excerpt but also in her talk about not why she chose not to use the construct of 'nervous breakdown' in the public domain. This alluded to a position within the realm of discourses of mental health and illness. Sophie also pointed to a contradiction in the premise that the construct of 'nervous breakdown' is either physical or mental, suggesting a disruption of this binary. Yet, she was keen to ultimately locate the breakdown within an embodied "nervous system" and render "going to buggery" as its malfunction, not hers. This resonates with other participants'

attempts to manoeuvre out of the realm of discourses that construct ‘nervous breakdown’ as a descent over the edge into madness. Rachel touched on this more explicitly when asked why she called her experience a ‘nervous breakdown:’

It’s purely because I think it [nervous breakdown] encompasses the entire experience[...]I think I hadn’t had enough exposure to mental health terms to call it anything else. It certainly wasn’t a psychotic break or anything
(Rachel, Lines 282-292)

Like Sophie, Rachel began positioning ‘nervous breakdown’ within the terrain of “mental health” thereby suggesting that for her, it was legitimately part of these discursive practices and she, a subject of them. She also brought the construct of “psychotic break” to the fore. This is a psy-construct used to denote a moment when the subject breaks with reality in some way. Leader (2011) contends that this is one of the most powerful constructions of madness in the contemporary discursive terrain. It is a break with an edge that results in a repositioning in the realm of mental illness, and carries with it the stigma of life-long psy-diagnoses, treatments and a position of exclusion from those who function normally. Rachel’s need to explicitly disavow her construction of ‘nervous breakdown’ as “psychotic break” confirmed the discursive connection between the two, consistent with the findings in the media analysis. It was as if she was telling me very clearly that while she had been rendered broken apart, unable to function and “everything [she’d] known had gone up in a puff of smoke” (Lines 133-134) – not unlike a break with an edge functioning as the border to a familiar reality – this was not to be construed as a “psychotic break.” This resonates with Oprah’s disavowal of madness in her media interview about her ‘nervous breakdown,’ where she had said: ‘ “I mean, I wasn't ready to go run naked in the streets. Let's make that clear” ’ right after she had positioned herself as having been unable to function as normal (Oprah Winfrey cited in Walker, 2013, Line 19).

Most of the participants constructed ‘nervous breakdown’ as a position in which they were unable to respond to external demands as they normally would for a period of

time. I have discussed their preferred interpretative repertoires to construct, explain and justify this position. The need to achieve an embodied breakdown for which they have limited responsibility can begin to be understood in terms of the fear of being positioned as mentally ill. The use of the interpretative repertoire of ‘breakthrough’ is particularly powerful in this regard as not only does it run counter to a position as mentally ill, it repositions the subject as even more able than before, discouraging any questioning or doubt of their current position in the discursive terrain of sanity. There appears to be a link emerging between demonstrating ability through practices constructed as coping or functioning and being positioned as sane. For example Anna noted:

Y’know you just get on with things and you don’t...you just cope and you just deal with things and I got to that point where I couldn’t cope and I couldn’t deal with things anymore so I remember feeling like that’s not ok
(Anna, Lines 324-326)

Anna continued reflecting on not coping not being “ok,” noting:

I think we do generally kind of y’know have a culture of kind of you just suck it up and get on with things. Perhaps that y’know not being able to do that is seen as a kind of weakness or some kind of psychological flaw
(Anna, Lines 357-359)

Anna constructed herself as unable to “to cope” when in ‘nervous breakdown’ and suggested that this was antithetical to a hegemonic cultural discourse of a coping subject who “just cope[s].” Moreover, she was implying that if positioned within this discourse, she would be constructed as having a “weakness” or a “psychological flaw.” To be part of a culture where *you* “just cope” and *you* “just deal” positions the subject as actively choosing to cope and deal. This in turn positions the subject who “couldn’t cope” as potentially accountable for this. As Rachel noted:

A little voice in my head went “you’re not coping” and I thought well
you’re gonna have to find some way of coping because this is your life. You
can’t book out of your own life
(Rachel, Lines 228-230)

In this excerpt Rachel was constructing her “not coping” as a choice both by suggesting that she “find” a way to cope and also by constructing her not coping as her actively “book[ing] out” of her life. This implies that there is a powerful discursive position in the wider terrain of ‘nervous breakdown’ that constructs not doing and not coping as the subject’s choice and therefore the subject’s fault. This implies that an inability to perform a coping self, as evident in all participant accounts of ‘nervous breakdown,’ needs to be justified for it to not be rendered as mentally ill, a failure of self-management or, crucially, as the choice and fault of the subject. Participants achieved this justification by constructing their not coping as a feature of temporary, embodied inability caused by uncontrollable forces that would overwhelm almost any individual. In addition, they emphasized that ‘nervous breakdown’ was not of their choosing or doing, but happened to them. Most importantly, participants constructed their not coping as repaired to even better coping as a result of ‘nervous breakdown.’

These discursive justifications for ‘nervous breakdown’ are a double-edged sword. They both avoid a position of accountability and blame for ‘nervous breakdown’ but also act to reinforce the power of this potential position by illuminating the extensive discursive measures one has to take to mitigate against this position. What begins to emerge is that participants are not only evading the stigma of mental illness but also the stigma of a person who does not cope. There seems to be a significant discursive overlap between the two positions in that to invoke one seems to require commentary on the other. The deployment of ‘nervous breakdown’ seems to function to mitigate against the stigma of both positions.

Permutations of 'breakdown' seem to allow access to interpretative repertoires and discourses that allow for more palatable positions of inability, particularly when prefixed with 'nervous.' The latter seems to allow for some constructions of a distressed subject to be borrowed from psy-discourses and then repurposed as an embodied malfunction. For example, in referring to "losing your reality" and "you're crazy" (Jackie, Lines 523-524), "depression" (Sophie, Line 64) and "section-able" (Anna, Line 152) these participants allowed sediments of these psy-constructs and their connotations of madness, stigma and distress to enter their constructions of 'nervous breakdown.' Yet, they lingered here but briefly, sidestepping and even disavowing these constructs, like Rachel saying "it certainly wasn't a psychotic break" (Line 292) and Sophie emphasizing that while "it's a mental breakdown" it is simultaneously "the nervous system going to buggery" (Lines 373 and 374). Participants showed a preference instead for those constructions of 'nervous breakdown' that emphasized its embodied location, its temporary nature and its largely external and unsolicited cause.

All participants claimed to have chosen the term 'nervous breakdown' themselves. For example:

Nervous breakdown is the only label I knew
(Naomi, Line 469)

Naomi went on to contrast her choice of label with that of her psychiatrist:

My perception would be that they would have a terribly high falutin jargon term of a more academic or whatever you would call it...they would have a very specific rather long word that was a bit complicated that the normal layman wouldn't understand
(Naomi, Lines 532-535)

Sophie said:

The doctor didn't call it a nervous breakdown, it was me
(Sophie, Line 9)

Sophie described her choice of label at a later point in the interview, saying:

At the time we [Sophie and family] needed a label to describe what I was going through so that it legitimised it rather than this is some kind of wobbly "poor Sophie can't stop crying." It gave it a legitimacy and a seriousness that helped us all cope because there is the opportunity for a person to think they're going completely mad
(Sophie, Lines 376- 380)

For Naomi and Sophie, even though they had both consulted psycho-medical professionals, they chose to name their experiences themselves and call them 'nervous breakdown.' Naomi explicitly indicated that her construction of her experience differed from the psychiatrist she had consulted. She appeared to show some disdain for his diagnostic terms by disparaging them as "high falutin," or perhaps as not relevant or accessible to her. Implicit in Naomi's construction of her account of self-diagnosis is a sense of distance between her and the psychiatrist and of an inability as a "layman" to participate in the diagnosis he might have used to construct her experience. Anna's "escape" (Line 154) from psy-diagnosis also places a distance between her and a psy-diagnosis. Similarly, for Sophie, she and her family chose 'nervous breakdown,' not her doctor. For them, this label accomplished a reassuring gravity by not dismissing it as a "wobbly," arguably a more facile construct, albeit one that draws on metaphors of being insecurely positioned and close to falling. However, the gravity bestowed by 'nervous breakdown' also served to mitigate a position of "going completely mad." For Sophie, it functioned to move her to a different discursive terrain: a legitimate break but not a mad break. Jackie, too, reflected on this discursive function of choosing the label of 'nervous breakdown:'

I don't want to be labelled as being ill, y'know, and in a way perhaps the idea of having a breakdown 'cause it almost feels like if you have a breakdown you can be fixed[...] If I've got depression it's kind of like this perpetual ongoing thing that I have or I am. Whereas a breakdown almost feels like a disruption
(Jackie, Lines 271-280)

Jackie reflected on the possibility of her experience being constructed as depression and situated in the psy-diagnostic terrain. She explicitly stated that she believed this position carried with it permanence and constructed the diagnostic label as intrinsic to personhood. She explicitly rejected this position, saying that she did not want to "be labelled as ill" within the psy-terrain. She indicated that for her, 'nervous breakdown,' constructed using the interpretative repertoire of mechanical breakdown, was preferable to a psy-diagnosis for it implied temporary "disruption," the possibility of being fixed by an-other and less accountability and blame for not coping.

What must be noted at this point is despite their use of 'nervous breakdown' as a self-owned label to construct their experience and going to great lengths to construct it as an embodied experience and re-purpose it out of discourses of mental illness, some participants chose to consult psy-resources, particularly talking therapies, while in 'nervous breakdown.' This appeared to be because they were unsure of where else to turn for an external agent of repair. As Naomi put it:

Where else would I have gone? I tried the health farm[...]If you're feeling disconnected and you're feeling disorientated and you're feeling out of yourself and not yourself and you don't have a temperature or physical things[...]I knew enough about psychological help because my aunt when she got divorced had been to see a psychologist , so I knew enough about it
(Naomi, Lines 434-446)

Naomi suggested she was faced with few external resources for help. The juxtaposition of “health farm” and “psychological help” is interesting for a spa alludes to the interpretative repertoire of ‘taking a break’ for purposes of restoration and alludes to treatments of the body. However, psychological therapy alludes to treatments for the mind and suggests that Naomi while having constructed ‘nervous breakdown’ as not her fault, embodied, and even transformative, also situated it within the wider socio-historical discourses that render a “feeling” subject appropriate for the hegemonic technologies of the mind. It also suggests a contradiction in her construction of an embodied experience. Nonetheless, it was Naomi, not the psychiatrist she saw, who chose the construct of ‘nervous breakdown.’ It was Naomi who chose to leave the psychiatrist’s diagnosis to his “high falutin jargon” (Line 533). This appeared to reflect an ambivalence in the relationship to psy-therapies for the subject of ‘nervous breakdown’ and an uncertainty of where to turn to for help during ‘nervous breakdown.’

Similarly, Ella saw psychologists while in ‘nervous breakdown.’ She noted that she was taken there by a concerned aunt who did not know where else to turn to for help:

She [aunt] said she can’t hold this anymore[...]they took me to the hospital
and then there was some people – psychologists – coming to me and talking
to me and stuff but I didn’t listen to them they didn’t help me at all
(Ella, Lines 771-778)

She compared the psychologists with the care she received from her aunt:

You [psychologists] don’t even know what’s going on in my mind and my
aunt she let me take me out all these things: what was going actually in my
mind, what I was thinking about
(Ella, Lines 835-837)

For Ella, like for Naomi, there was a turn to psy-institutions for help during ‘nervous breakdown.’ She positioned her aunt, like her, as helpless victim who could no longer “hold.” Interestingly, this might imply that Ella’s practices of not coping during ‘nervous breakdown’ were so difficult for her aunt to manage that she too could not “hold” and turned to the hospital for support in managing Ella. This emphasizes the extent of the deviance associated with a not-coping-as-usual subject position in the wider discursive terrain, so disruptive to normal that it could affect another almost as if by contagion.

However, Ella constructed psychological intervention as unhelpful. Ella, like Naomi, repositioned ‘nervous breakdown’ as out of the body and “in my mind.” Having also gone to great discursive lengths to construct an embodied experience and one which led to personal breakthrough, Ella blurred this position with one located in the mind. She thus positioned ‘nervous breakdown’ as both within the discursive terrain of psy but also outside of its reach. What begins to emerge is a sense that ‘nervous breakdown’ allowed participants to play with the discursive borders of psy: to navigate in and out of its territory and to dictate what parts of it they used as opposed to being constructed as its mad subject. Also emergent, is that ‘nervous breakdown’ functions to disrupt a binary of mind and body. Although participants went to great lengths to construct an embodied breakdown, they all alluded to features of mind, to the possibility of being positioned in psy-discourses and some even consulted psy-practitioners to help their minds.

3.2.3. A liminal space

It would seem therefore, that participants chose ‘nervous breakdown,’ even when faced with other discursive possibilities – even when positioned, like Naomi or Ella, within the purview of psy-practitioners. Participants appeared to choose the term to allow themselves a discursive space that could draw on some psy-constructs to make sense of their experience and themselves, such depression, anxiety or even speculating that they were losing a reality or going crazy but which allowed them to avoid the stigma and permanence of psy-diagnosis and circumvent positions in the space of

mental illness. It allowed some participants to use psy-therapies for support but, like Naomi and Ella, to take ownership of diagnosis and entry and exit from these therapeutic technologies.

The use of ‘nervous breakdown’ appeared to allow participants to construct an experience featuring both the body and mind at different discursive junctures thereby disrupting this binary. It allowed them to embody the mind at moments of not doing to avoid the dual stigmas of being positioned as not coping or mad. This suggests that the normal or valued subject needs to *choose* to perform practices of coping, which are intrinsically related to socially endorsed practices of a stable and held together subject who can continue doing-as-normal. The subject of ‘nervous breakdown’ is one who falls from unstable ground, who breaks apart and is not held together and who is “not functioning.” As Jackie puts it:

Breakdown seems to be characterised by not functioning and by that I don’t mean dysfunctional but I mean not functioning, y’know? Maybe there is a kind of, yeah going to bed or a, or a y’know, a not...not working
(Jackie, Lines 499-501)

Jackie was suggesting that the performance of a coping self is demonstrated through practices of functioning such as going to work and getting up in the morning. She was also constructing a self who in ‘nervous breakdown’ is “not functioning” but was clear in delineating it from a subject position of “dysfunctional.” This seems to indicate the difference between a not-coping subject rendered as such through acts and language of being unable or not doing – particularly work – and the mad subject. It would seem that the construction of ‘nervous breakdown’ allowed participants to carve out a discursive distinction between the two subject positions, again, alluding to the construct’s facility in its interplay with the boundaries of discourses of madness. The position of unable and not-doing and the position of mad seem nonetheless related:

People sort of think you're crazy [if you have nervous breakdown] that y'know that yeah I think it's just sort of this perception that people kinda think, well people kinda think well there's something wrong with you or something not right with you or...and...you know if can't hold yourself up high and walk, y'know get through the day then there's y'know, what's wrong with you? And actually it's ok to fall apart
(Chantal, Lines 487-491)

Here Chantal was referring to others' constructions of one not being able to "get through the day." Much like Rachel's construction of coping, Chantal suggested that the norm is to be actively holding oneself "up" and able to "walk." This active position implies agency and choice over "holding yourself up" and therefore, by implication, choice in not doing so. Chantal denies that this was a choice in 'nervous breakdown' by using the verb "can't." She indicated that this would cause others to position the unable subject who can't (or won't) as "crazy" or having "something wrong" with them and thus indicates a link between the not-coping subject and the crazy subject. Yet, she also ended by saying "it's ok to fall apart." This touches on what 'nervous breakdown' seemed to be able to accomplish for the participants: a way to be in a position of unable, even deploying constructions of mental illness, but for it to be constructed instead as an "ok" way "to fall apart."

The embodiment of falling apart in participants' constructions of 'nervous breakdown' seems crucial in this regard for it finds through the adjective of 'nervous' a legitimate way of rendering the body unable because of external forces of attrition, pressure or destabilisation that can also be positioned as acting on the mind (such as feelings of loss or anxiety). It allowed participants to deploy psy-discourses to construct these external forces and to construct their experiences of them but then to neatly manoeuvre into the realm of physical illness, which functions as a far more forgiving discursive space of inability (Pilgrim & Rogers, 1999). However, participants' blurring of the boundaries between physical and mental in their use of 'nervous breakdown' also allowed them to remain silent about the body when

deploying the interpretative repertoire of ‘breakdown to breakthrough.’ They situated constructs of personal breakthrough within spaces of feeling and thinking self: spaces of the mind. ‘Nervous breakdown’ therefore appeared to allow participants facility in disrupting the binary of body and mind in the interviews in order to achieve discursive positions that legitimised their ‘nervous breakdowns’ through forging positions relative to inability that were justified and positions relative to new-found ability that were within discourses of the accomplished subject.

However, by extension, this discursive freedom was not without limits. While allowing participants greater facility over how and when they engaged with psy-discourses and discourses of not coping in the construction of their ‘nervous breakdowns’ all participants *had* to engage with these discourses, even through discursive acts of disavowal, justification or silence. The wider discursive field that constructs ‘nervous breakdown’ is largely constituted by discourses of mental illness and concomitant psy-interventions. In addition, a not-coping subject is constructed in the wider discursive terrain of ‘nervous breakdown’ as a subject who has failed to manage and in this, a choice in managing and not managing is implied – for example, the choice implied in the media discourses instructing the responsible citizen-subject to recognise and prevent him/herself from reaching the edge of ‘nervous breakdown.’ This brings to the fore the interplay between the subject of ‘nervous breakdown’ and the discursive agent who constructs ‘nervous breakdown.’ For example, the facility to re-construct ‘nervous breakdown’ as an “ok” way to “fall apart” seemed more limited to private conversations, implying that in the public domain it was harder to escape positions of mental illness or chosen deviance. The ensuing discussion will expand on this contextual interplay.

4. Discussion

On accomplishing an ok way to fall apart

What emerged from both the media and the interview analyses was that subject positions within discourses of madness and discourses of self-management were the most readily available in constructing the subjects of ‘nervous breakdown.’ Constructions of ‘nervous breakdown’ seemed to invoke the possibilities of mental illness and/or of having failed to manage to hold oneself together. Subjects who self-identified with ‘nervous breakdown’ were therefore faced with a discursive terrain that foreclosed on their options to explain their experiences in language other than that of mental illness or failed self-management – replete with their associated stigmas. ‘Nervous breakdown’ seems to be an explanatory exercise in accounting for passivity, helplessness and distress: one that seeks to evade fixed positions within the discursive terrains of madness and failed self-management, albeit forced to refer to them, and to carve out another less stigmatising space for its subjects in their moments of not-managing.

4.1. Finding a place between not coping and mad

4.1.1. Failed self-management

The media analysis mapped out a discursive terrain of ‘nervous breakdown’ that was predominated by interpretative repertoires that constructed it as a dangerous position to be avoided *by* the alert, responsible and self-effective subject. He/she is called by this interpretative repertoire to diagnose his/her position relative to the danger of ‘nervous breakdown’ and then adopt prescribed practices of self-management such as eating “regular meals” or getting “to bed early” (*The Mirror*, 22 March 2007, Line 95). This implies that those who reach a position of ‘nervous breakdown’ have failed to self-diagnose and failed to self-manage appropriately and thus, ‘nervous breakdown’ is their fault. This is premised on the assumption that individuals hold internal processes and resources which are constitutive of their ability to cope or

manage and furthermore, that the individual holds him/herself together via these processes.

The self-managing subject who holds him/herself together in this way, constantly policing and preventing risk of falling apart is a hegemonic construction of the individual in the contemporary discursive terrain (Ogden, 2002; Rose, 1998). It is premised on psy's constructions of the individual as constituted by malleable, internal cognitive processes held in his/her mind that can create and moderate experiences of distress (e.g. Bandura, 1993; Beck, 1979; Gilbert, 2009). Thus, the mind of the individual is constructed as the seat of self-management. Hybrids of this discourse that have begun addressing the embodiment of the mind still attribute these same properties of agency and self-management to the mind-body and thus situate them within the control of the individual (e.g. Lakoff & Johnson, 1999). Given that within this discourse, processes of self-management and control are ascribed as constituting this individual mind, or mind-body, they can be said to also constitute the individual. As such, this discourse very clearly circumscribes the normative and successful individual as consistently agentic and responsible for creating his/her experiences. It locates contextual experience within the individual thereby stripping the social of its responsibilities for impacting upon the individual. Therefore, via this discourse, the self-managing subject becomes almost totally defined by attributions of responsibility for his/her state and fate that are internal to and even constitutive of him/herself.

This construction of the self-managing individual has infused almost all institutional spaces that constitute and regulate the individual, from the workplace where the employee's fitness is assessed through his/her internal ability to manage stress as far as domains of medicine where self-management, particularly of the constructs of external stress and health behaviour, is seen as causing or preventing illness (e.g. Bandura, 2004; Iwata, Ota & Duman, 2013; Lovelace, Manz & Alves, 2007; Oginska-Pulik, 2005). What is central to these constructions are the polarities of coping and not coping. They are construed as the polarities of a self-managing individual who is doing this self-managing well enough not to disrupt the systems of workplace, health,

family etc. and he/she who is not doing it well enough and causes disruption to these systems through visible indications of illness, passivity or distress (Snyder & Pulvers, 2001)⁶. These systems rely on and therefore continuously reconstruct and regulate the self-managing, agentic individual who is positioned by them as successful.

What 'nervous breakdown' seems to indicate is a moment where the subject has not managed to demonstrate adequate self-management or to cope. The discursive terrain of 'nervous breakdown' as mapped out in the media study is quite explicit in this regard: offering up an interpretative repertoire asking the subject to appraise and if need be upgrade his/her coping so as to not fall into 'nervous breakdown.' The participants in the interviews were not as explicit but they used positions of passivity, distress and helplessness to construct themselves in 'nervous breakdown.' These positions run counter to the hegemony of the self-managing agent. The interpretative repertoire of breaking that participants deployed to construct a start of 'nervous breakdown' in the interviews is a construction of the breaking with their positions on the edge, which is a space where self-management and coping are situated.

Moreover, participants deployed this interpretative repertoire of breaking to account for the moment when passivity, helplessness or distress became impossible to hide or contain: when Ella, for example, could no longer "hold it," (Line, 101) when Chantal could not get out of bed (Lines 66-67) or when for Rachel, the "dam wall" burst (Line 333). In this way, the participants constructed 'nervous breakdown' as a disruption to what is/should be managed on the inside and implied a disruption to processes of self-management. It would seem then that 'nervous breakdown' not only denotes a failure of the subject to self-manage or cope but also a failure of the subject to hide this on the inside, away from the gaze of others. As such, subjects who are/have been in 'nervous breakdown,' are almost immediately positioned as not coping, replete with its associations of failed self-management and personal responsibility for this failure.

⁶ Snyder & Pulvers (2001) provide a comprehensive overview of the coping theory-construct and its link to processes of self-management

4.1.1.1. *Not to blame: Using 'nervous breakdown' to avoid accountability for not coping*

In breaking

Understandably, this was a position that the participants who self-identified with 'nervous breakdown' worked very hard to avoid. However, it was not a position of not coping that they attempted to avoid but rather a position of being held accountable for it. Participants attempted to avoid being positioned as to blame for passivity, helplessness and distress and the disruption these positions posed to normal agency, such as going to work, getting out of bed or holding and managing distress. Running like a red thread through all the interpretative repertoires that participants used to construct 'nervous breakdown' was the mitigation of personal responsibility. This was also evident in the constructions of Obama and Oprah's 'nervous breakdowns' in the media analysis. For example, Oprah and all of the interview participants positioned themselves as helpless victims of 'nervous breakdown' not as agents who chose it. They accomplished this by constructing 'nervous breakdown' as a breaking whereby they were pushed into positions of helplessness and passivity *by* powerful forces that were positioned as external to them and out of their control. When these forces were positioned as internal to the individual, they were constructed as out of conscious control and still related to the pressures of external events.

These powerful forces were constructed as having the capacity to overwhelm the individual, much like a natural disaster, accident or attack. For example, participants drew on metaphors of falling from a high edge into a deep void. This positioned them as the victims of the force of gravity and victims of dangerous terrain, akin to being the victim of a dangerous mountaineering accident. They also drew on metaphors of hydraulic pressure bursting through and pouring out, thus breaking the inside-outside binary. This positioned them as victims of this uncontrollable internal pressure, akin to being the victim of the disaster of a "dam wall" bursting and also akin to being overwhelmed by a cataclysmic Freudian catharsis. Finally, participants drew on metaphors of mechanical breakdown, likening the body to a machine. In this

metaphor, the individual is rendered helpless because a part of the machine-body that is constructed as driving him/her has failed, much like a broken down car leaves the driver helplessly stranded or a broken circuit renders a building and its occupants as victims of the shutdown. In Obama's case, possibly because he is such an iconic example of the successful subject, it was the media (not him) who positioned him as helpless victim of the stressful forces of the current socio-political landscape. He was, in their construction of his purported 'nervous breakdown,' forced into a position of "collapse" by the corrosive effect of ongoing external stressors, akin to a building being collapsed by an overpowering attack or a surface structure being worn down by abrasive forces.

One is hard pressed to attribute personal responsibility to a helpless victim of overwhelming forces, natural disaster, or the breakdown of the machinery on which he/she is reliant. In constructing 'nervous breakdown' as a breaking of the subject's ability to cope by powerful agents that are out of his/her control, participants rendered themselves as not to blame for their not coping. They allowed themselves to display features of a position of not coping or failed self-management, *visible* and even ongoing passivity, helplessness and distress, but evaded the stigma of the subject who has failed to hold it together. Interestingly, throughout their accounts of 'nervous breakdown,' as participants traversed from breaking to break and then breakthrough, the evasion of personal accountability for positions of passivity, helplessness and distress remained a key accomplishment of the term 'nervous breakdown.' While positions of agency *within* 'nervous breakdown' varied, from the total helplessness in breaking to the agency that subjects took up in breakthrough, agency for *causing* 'nervous breakdown' was constantly and consistently mitigated.

In break

In the interpretative repertoire of break, participants accomplished the mitigation of personal accountability through the use of physical illness discourses, positioning themselves as passive and helpless patients on the enforced break of recuperation. As discussed in the analysis, dominant discourses of physical illness, when prefaced with

the metaphors of being struck down, position subjects as victim-patients and not to blame for their bodies being overwhelmed by the virus or germ that comes in from outside spaces (Lupton, 2012; Ogden, 2002). The taking up of this position of patient-victim is deeply resonant of the sociological discourse of the sick role, originally theorised by Talcott Parsons (1951/2001). It posits that in the sick role, the subject is exempt from the normal obligations of social roles, particularly work. Parsons added that this position is socially endorsed because the subject is seen as not accountable for taking it up. Becoming ill and recovering are construed as being completely out of the subject's control and thus the subject is obliged to seek medical assistance. Indeed, many of the participants consulted a GP while in 'nervous breakdown,' particularly to procure sick-notes for work and thus to lend credibility to their positions within a sick role discourse. Participants who consulted both a GP and a psy-professional, such as Chantal, still deferred to the GP's sick-note when accounting for their absence from work. Another key obligation of the sick role as constructed by Parsons is to take a period of recuperation. All of the participants did this during what they constructed as the break in 'nervous breakdown.' One might contend that Obama did this too, while "sedated" after "collapse" and furthermore that this period of recuperation is what participants constructed as time spent *in* 'nervous breakdown.'

This concept of sick role has infused medical discourse and informed doctor-patient positions, positions relative to illness and particularly positions relative to accountability, passivity and agency (Fahy & Smith, 1999). While it has been critiqued in many ways, largely for disempowering patients and rendering doctors as all-powerful and in this regard for even being out-dated, it remains a dominant discourse in constructing the patient and what he/she is allowed to do (Young, 2004). By drawing on this discourse of physical illness to construct 'nervous breakdown' as an enforced, recuperative break, participants evaded personal responsibility for their positions of helplessness and passivity, and even found legitimacy for their bed-rest and not working.

The sick role discourse ties in well with participant constructions of ‘nervous breakdown’ as time-limited, for a further obligation of the role is to recover and for illness and recuperation to be discrete and short-lived. A slight tension in the construction of both the sick role and ‘nervous breakdown’ arises here: the absolution of responsibility for becoming ill and for the means of recovery and yet a simultaneous responsibility to recover quickly. Given its time-limited nature, the sick role discourse is therefore less applicable to chronic conditions and to diagnoses of mental illness, for both invoke a greater permanence of positions that are seen as deviant from normal social roles (Crossley, 1998; Karp & Tanarugsachock, 2000). As such, it seemed crucial for participants to deploy constructions of ‘nervous breakdown’ as a time-limited, physical illness which happened *to* them and to avoid positions of permanent passivity or mental illness. These were positions that the media analysis indicated as readily available in the wider discursive terrain for the subject of ‘nervous breakdown.’

This is also deeply resonant of the Victorian constructions of nervous illness, which were positioned as counter to diagnoses of mental illness and madness (Shorter, 2013). It also speaks to the female nervous subject of that era, for whom the conservation of nervous energy through rest was seen as vital (Appignanesi, 2008). What is interesting in this study, is that ‘nervous breakdown’ is being deployed by female participants not only to counter to positions of mental illness, but also to counter positions of failed self-management. It would seem that positions of failed self-management and passivity in the contemporary discursive space are deemed as pejorative as those of madness. This suggests that the construction of the nervous as a largely physical complaint and thus a legitimate reason to forgo positions of normal coping is still being used in contemporary discursive terrain but to slightly different ends than in the Victorian era and early twentieth century. The bed-rest and passivity were deemed a necessary cure for women’s nervous complaints are no longer endorsed.

In breakthrough

Even in the interpretative repertoire of breakthrough, participants constructed 'nervous breakdown' as having happened to them, and not as their choice. This was striking because this interpretative repertoire featured the participants in positions of agency and empowerment, not positions of passivity and helplessness. Participants deployed the interpretative repertoire of breakthrough to construct the end of 'nervous breakdown' and to indicate a current position that was better than before 'nervous breakdown,' and one that was improved *because of* 'nervous breakdown.' Yet, even in this space, even when co-opting discourses of self-development and self-management to construct themselves and their renewed and improved agency, participants continued to take up positions of passivity with regard to the cause of 'nervous breakdown.' For example, Sophie constructed it as a "blessing" (Line 320) within this interpretative repertoire. While this is a positive construct when positioned as counter to a curse, it still designates a passive position. A "blessing" is constructed as given by a divine entity to an individual. In this interchange, the divine is agent and the individual is a passive recipient. Thus while having reconstructed 'nervous breakdown' as a positive experience, which allowed her to now deploy an active tense and to "shine even more light" than before it, Sophie still mitigated her personal responsibility for causing it.

This was echoed by most other participants and was also echoed in Oprah's confessional of her 'nervous breakdown.' This discursive manoeuvre of positive reconstruction of agency after an enforced position of victimhood borrows from survivor discourses and some discourses of personal transformation. Victim-survivor discourse is contemporarily pervasive in the construction of the subjects of abuse, gross human rights violations and some illnesses such as cancer (Thompson, 2004). Key to all subjects constructed by this discourse is their having been violated, struck down or attacked by a dangerous external agent, such as abuser, terrorist, Nazi or deadly virus, and positioned as innocent victim of this agent. The subject is then positioned as having survived this attack or violation and is thus accorded agency, and the positive attributes of courage, strength, will-to-live etc. He/she is often also

positioned as having greater knowledge, empathy or strength as a result of having survived (Leisenring, 2006). The position of survivor can be deemed as one of personal choice and runs counter to the position of victim who does not recover from attack and whose continued passivity and distress is often maligned (Dunn, 2005; Orgad, 2009).

As such the survivor discourse can be positioned within the discursive terrain of the self-managing individual. The use of 'nervous breakdown' seemed to allow participants to accomplish the same discursive feat as survivors. It allowed them to take up the position of victim of uncontrollable force or attack, who after a discrete period of passive recovery, could take up a position of renewed and improved agency within the discursive space of the self-managing individual. Most significantly, it allowed them to mitigate personal responsibility for being positioned as helpless, passive or distressed in the first place, while allowing them to take responsibility for the valued positions of recovery, restoration and renewal. However, this position could only be successfully accomplished *after* 'nervous breakdown' when the subject was no longer passive, helpless and distressed and when he/she was back on the right side of the edge.

Personal transformation discourses function in a similar fashion, but are found more in spiritual and self-help literature. They act to position the subject as victim of intrinsic flaws, particularly that of inauthenticity. These flaws are then positioned as causing personal suffering and/or preventing the realisation of personal potential (Caprino, 2008; Zweifel & Raskin, 2008). Breakdown is constructed as a period of being rendered the helpless victim of these flaws and/or helpless victim of the driving force of transformation. Breakdown is constructed as the process whereby the individual sheds these flaws through a destructive catharsis and is transformed into an improved subject imbued with greater agency, self-management and personal power (Abrams, 2007; Sharma, 1997). One could contend that this is quite assuredly part of a self-management discourse but only by virtue of the fact that passivity is re-appropriated after the fact as a necessary evil in the goal of improving one's position in the terrain

of self-management and agency. If the latter subject position were not to be taken up, and passivity not reconstructed as a temporary and transformative position of victimhood, the subject would be at risk of being positioned as somehow failed or permanently lost to a much stigmatised passivity.

Survivor discourse and personal transformation discourse parallel the demand for recovery inherent in the sick role discourse. Together, these discourses seem to indicate that positions of helplessness, passivity and distress are socially acceptable under some circumstances: when the subject is victim of embodied illness, severe and uncontrollable forces or a process of personal transformation, and as long as these positions of passivity are temporary, and not chosen by the subject. By drawing on these discourses in the construction of ‘nervous breakdown,’ participants were able to avoid the curse of taking accountability for their positions of not coping. As Rachel said, perplexedly reflecting on finding herself in a position of helplessness, “you can’t just book out of your own life” (Line 230). One could summarise the disclaimer that her account of ‘nervous breakdown’ issues to this, by adding, ‘except if it’s not your fault, lasts for a short time and you use it to transform yourself into a better, more self-contained agent.’ This disclaimer was manufactured in all participant accounts of ‘nervous breakdown’ and evident in Oprah’s account of hers. As such ‘nervous breakdown’ seems to function to explain positions of not coping in a more palatable, less stigmatised manner than as a failure in self-management and thus the fault, or choice, of the subject.

4.1.2. Mad

So what then of madness? This is the other discursive space that the wider discursive terrain makes so immediately available to the subjects of ‘nervous breakdown’ and which the Victorian construction of nervous illness attempted to counter. The articles reviewed in the media analysis are laden with terms referring to a potential madness of the subject who falls off the edge into ‘nervous breakdown.’ For example, they construct understanding one’s “mental state” as a particular site of interest in preventing ‘nervous breakdown’ (Casserly, 2011, Line 2). They also suggest that this

understanding be constructed through the lens of psy-diagnostic criteria by using symptom checklists that are deeply resonant of those found in the DSM and which, for example, refer to psy-constructs of feeling “anxious, emotional or upset” and “passive coping” (Eurich, 2013, Lines 18 and 20). In addition, these articles tend to cite psy-professionals as expert-authors of ‘nervous breakdown,’ and how to diagnose (construct) one’s position relative to it. By constructing ‘nervous breakdown’ within the domain of psy-expertise and its language, the media articles situate it within the terrain of mental health and mental illness.

Some of the media articles adopted the language of madness more explicitly in constructing ‘nervous breakdown,’ eschewing the more sanitised constructions of mental health. For example, deploying constructs such as “mental collapse” and “sedated” to describe Obama as the subject of ‘nervous breakdown’ (Naish 2013, Lines 46-47). These speak to constructs of the uncontrollable mad subject who needs restraint. They dig up the construct of the lunatic who is straight-jacketed or lobotomised in the asylum. Other articles speak of “completely losing control of your mental facilities” as indicative of being over the edge and *in* ‘nervous breakdown’ (Thapoung, 2013, Lines 7-8). Oprah attempted to position her ‘nervous breakdown’ as not being ‘ “ready to go run naked in the streets” ’ (Walker, 2013, Line 19). This also speaks of the construct of the mad subject running riot, visibly ridiculed and excluded, and disruptive to social norms. These constructions of the mad or deviant subject speak of an irretrievable position and have been feared, excluded and ridiculed throughout western history (Parker et al., 1995). As Micale (2008) notes, before they were the object of a psycho-medical gaze, these subjects were constructed as lost to demonic or supernatural possession and were feared by all who were positioned as not possessed as contagious vehicles of harm. Arguably, some of the residue of this demonic possession still seems to cling to the construction of the mad subject. This is evident in the stigma attached to the subjects constructed as mentally ill who are still feared, shunned and even blamed (Couture & Penn, 2003; Yang, Cho & Kleinman, 2010).

The spatial metaphor that the media constructs of ‘nervous breakdown’ as being over an edge is resonant of metaphors that construct madness as a movement of descent, much like a movement into hell (e.g. Donner, 2014). It also speaks to the permanence attached to the mad subject wherein he/she is seen as irretrievably lost to madness. This symptom of permanence is still attached to the discourse of mental illness and is one of the main critiques of diagnosis (Kvaternic & Grebenc, 2009). Thus the wider discursive terrain positions the mad subject and the subject in ‘nervous breakdown’ as very closely related, and even as synonymous.

Furthermore, as Yang et al., (2010, p. 492) note, public attitude surveys show that people associate the construct of mental illness with the adjectives of “dependent and helpless on the one hand and dangerous, different and unpredictable, on the other.” These words are virtually synonymous with those used for ‘nervous breakdown’ by both participants and the media alike. For example, the media constructed ‘nervous breakdown’ as a dangerous space and synonymous with a loss of control and participants spoke of being the helpless victim of ‘nervous breakdown,’ and of the concomitant positions of passivity and distress which they could not contain or control. These speak of the adjectives of helplessness and also of dangerous unpredictability. Participants also constructed ‘nervous breakdown’ as a moment when they were no longer able to meet normative social obligations in a consistent and predictable manner. This speaks particularly of the words of “dangerous, different and unpredictable.” In addition, participant constructions of ‘nervous breakdown’ alluded to a disruption of the binaries of inside-outside and private-public, wherein what should be managed within or kept in the private domain, such as distress, bursts out and becomes visible in the public domain. This can be associated with a disruptive difference or outburst which is dangerous and unpredictable. Moreover, constructs of madness or mental illness tend to feature a similar disruption to private-public and inside-outside as the moment of becoming mad (Leader, 2011).

4.1.3. Not mad, just ‘nervous breakdown’

As such, the wider discursive terrain is not only at the ready to position the subjects of ‘nervous breakdown’ as having failed at self-management but is also pressing to construct them as mad or mentally ill. Participants seemed to walk a tightrope by using some of the lexicon of psy and of madness to construct ‘nervous breakdown’ while simultaneously avoiding the permanence and stigma of being positioned as mad. The use of ‘nervous breakdown’ seemed to allow for this interplay.

For example, Anna was quite clear in saying that she might have been “section-able” (Line 152) in ‘nervous breakdown.’ She noted that her description of being in ‘nervous breakdown’ overlapped with descriptors of psy-diagnoses. A section is a psy-intervention of restraint and speaks of the danger that the subject might pose to him/herself or to others (Donat, 2005). Similarly, Jackie spoke of “you’re crazy” and of “losing your reality” (Lines 523-524), Sophie engaged with the discourse of depression (Line 64) and Rachel, albeit in referential disavowal, spoke of ‘nervous breakdown’ as not being a “psychotic break” (Line 292). As discussed, Rachel, Ella and Chantal deployed a Freudian hydraulic metaphor to construct the moment of ‘nervous breakdown,’ which they likened to a sort of bursting through of internal pressure into external and public space. Naomi consulted a psychiatrist for help while in ‘nervous breakdown’ while Ella, Rachel, Chantal and Sophie consulted counsellors and psychologists also for help – thereby indicating that at least in part, they constructed ‘nervous breakdown’ as relevant to the language, technologies and practices of psy.

In their consultation of psy-practitioners, participants showed a great deal more agency than one would expect of the rather put-upon Foucauldian subject of psy: entering and exiting psy-services when they chose, and taking up or resisting diagnoses. Naomi, for instance, rejected the “high falutin” (Line 533) diagnostic language of the psychiatrist she saw, preferring to call her experience ‘nervous breakdown.’ Ella engaged with psy-services and then left, preferring the care of her aunt. Chantal and Sophie consulted a counsellor and psychologist respectively, but

also consulted alternative therapies, such as angel healing and yoga (Lines 229 and 152 respectively), and they did this without the endorsement of their requisite psy-professionals. This indicated that they were not fully signed up to only being the subject of psy while in ‘nervous breakdown’ and that the term gave them some facility to engage with and co-opt other constructions of their experience. It would seem that ‘nervous breakdown’ allowed participants to use the constructions of madness, mental illness and in some cases, the psy-resources made available by these constructions, but on their own terms.

Why then use this language if it has the potential to position one as mad and stigmatised for being so? Well, firstly, it seems that the wider discursive terrain does not offer much alternative in the construction of passivity, aberrance from norms and distress. Moreover, as discussed in the analysis of the interviews, the contemporary individual is largely constructed by psy-discourse, and thus it follows that any individual’s account of his/her experience would be saturated with this language (Parker; 1997; Rose, 1998). Yet, participants were not passive subjects of this discourse, and it would seem that they were actively using the language of madness, mental illness and psy to construct a certain quality of experience in ‘nervous breakdown.’ In so doing they were able to imbue ‘nervous breakdown’ with the distress, danger and unpredictability of madness, and even access the socially sanctioned support of psy-therapies, while also eschewing a fixed position as mad.

4.1.4. Nervous: Mitigating blame and individualising distress

In this regard, the adjective of ‘nervous’ as a preface to ‘breakdown’ performed a crucial discursive function. As indicated in the introduction, the use of nervous as an adjectival precursor to describe individual affliction, discomfort or deviance can be traced back in western psycho-medical discourse to 1684, but gaining most momentum in the Victorian era. At that time, the mind and the flesh were all under the purview of a medical gaze, and many so-called deviances of normal expression were being reconstructed by medical science as having an embodied, as opposed to a supernatural, origin (Micale, 2008). The introduction of the nervous marked a major

discursive shift in reconstructing many positions of distress, particularly those hallmarked by worry, as different from madness by virtue of the fact that they were seen as embodied by the nerves and were thus deemed curable, much like any other organ.

The introduction of nervous indicated and seems to still indicate a crucial bifurcation in psy-discourse. The subject of nervous disease was originally constructed as distinct from the mad subject. Nervous disease was constructed as embodied, and therefore curable and time-limited. It was signified by the attributes of “dependent and helpless,” whereas madness was murkier and was signified by “dangerous, different and unpredictable” (to quote the distinction made by Yang et al., 2010, p. 492). In addition, one could contend that the mad subject still held/holds the discursive sediment of the terror of demonic or supernatural possession, whereas the nervous subject is the construct of the reasoned and sanitised clinics of medical science. Nervous diseases, signified more by worry, are arguably positioned as closer to the norm of the self-contained agent than the visible deviances, outbursts and psychoses that have been used to construct madness (Gove, 2004; Shorter, 2013). The former is seen as recoverable, and the latter as not. As discussed in the introduction, ‘nervous breakdown’ while a colloquialism, is imbued with this legacy of nervous disease – constructed as relevant to psy-discourse but positioned as distinct in its transience and as distinct from madness. This seems reflected in participants’ use of the term to construct a time-limited experience that is not mad per se, but that can use the language and resources of the mad.

‘Nervous breakdown’ by virtue of this legacy of embodied worry overlaps with some aspects of contemporary stress discourse which all posit, regardless of the agency accorded to the individual, that high levels of uncontrolled stress have a corrosive physiological impact. Stress and worry are often used if not interchangeably, then as very close constructs (e.g. Brosschot, Gerin & Thayer, 2006). Furthermore, stress, not unlike ‘nervous breakdown’ is located within the psy-domain but positioned as distinct from madness. It is a dominant construct of health psychology (e.g. Ogden,

2012) and thus sits quite a world away from the wards and waiting rooms of discourses of psychopathology. In fact, as Brown (2005) contends, stress discourse can function to mute distress, surrendering it up to the alternative blandness of the hold-all of stress and constructing it as an all together different thing – a more palatable form of madness, perhaps. It is no wonder, therefore, that the media analysis featured ‘nervous breakdown’ and stress as overlapping constructs. Many of the articles constructed unmanaged/unmanageable stress as the precursor to ‘nervous breakdown.’ They situated stress as pertinent to every reader, constructing it as an inevitability of living, and particularly, an inevitability of “our highly stressed times” (Naish, 2013, Line 42) . This resonates with the Industrial Revolution’s inscription of its clamour, speed and engine breakdown onto the nerves and bodies of its subjects.

I was therefore surprised that participants did not overtly deploy stress discourse to construct their ‘nervous breakdowns.’ The media analysis had indicated that it was a readily available discursive alternative to madness. I was, however, perhaps mistaken in thinking that a position of failed self-management was preferable to that of madness. While participants used similar engineering metaphors to those in stress discourse – of pressure, strain on edges, collapse etc. – they did not construct ‘nervous breakdown’ as caused by the stress of everyday living. As discussed, it would seem that they wanted to avoid the position of failed self-management incumbent in a position of breakdown from stress and perhaps regarded this as equally, if not more pejorative than a position in discourses of mental illness. Herein, as already touched upon, seems the biggest difference in the use of ‘nervous breakdown’ and the nervous from its Victorian roots where it was explicitly positioned as not mad (Shorter, 2013). The few pieces of academic literature that do suggest that it performs a discursive function, suggest that this is only to counter positions of madness and psychiatric diagnosis (Barke et al., 2000; Gove, 2004; Wolfe, 1933). They do not suggest that it simultaneously functions to counter positions of failed self-management. This indicates, perhaps, that the self-management of stress might be a newly dominant discourse, or one particularly pertinent to the participants and articles in this study.

For example, not unlike in the article constructing Obama's 'nervous breakdown,' participants went to great lengths to contextualise 'nervous breakdown' in their constructions of it. They all attempted to set the scene for it by speaking of a build-up which was constructed as the movement towards the edge of 'nervous breakdown.' However, they did not refer to a build-up of work-life stress as the media analysis might have suggested they would. Rather, they spoke of spousal abuse, childhood neglect and abuse, miscarriage, immigration, spousal infidelity, divorce, and loss of work and significant relationships, among others. For most participants, these build-up events were not constructed as once-offs and immediately preceding 'nervous breakdown.' Rather, they were constructed as multiple and cumulative and as extending back in time. For example, Ella constructed the abuse and neglect she experienced as a child as part of the build-up to 'nervous breakdown' in early adulthood.

Participants used these histories to construct the forces that rendered them helpless victims of 'nervous breakdown' and to imbue these forces with a social severity that would warrant them as other than everyday stress (that should be managed) and as other than mad. For example, Chantal spoke of years of spousal abuse as the precursor-force to her 'nervous breakdown.' This allowed her to take up a position of battered wife which carries with it a socially acceptable helplessness that engenders sympathy and care. This position also carries with it the legal and moral obligations that others have with regard to the subject (Leisenring, 2006). Chantal used this position of battered wife to explain 'nervous breakdown' as an appropriate and therefore not a mad response to her circumstances and thereby to mitigate personal responsibility for causing it. Surely such abuse, much like "the Syrian crisis, the UN and the U.S. budgetary problems" were for Obama, is severe enough to legitimately "collapse" the self-managing, self-contained individual? Yet, Chantal side-stepped a discussion of the social nature of abuse. It may have functioned, in part, to legitimate her 'nervous breakdown,' yet Chantal constructed the effects of her ex-husband's abuse as something she "hadn't really dealt with" (Lines 78-79). She went on to construct it as something that "just literally came out. 'Cause I just kept holding it"

(Line 80). This acts to position the abuse as something Chantal had to hold inside her and also something that she had to deal with. This strips the abuse of its social, moral and legal obligations, colluding with the individualisation of distress inherent in the self-managing, self-contained agent who must manage stress, distress and pain on the inside. It suggests that while Chantal was using the construct of abuse and the severity of corrosive force it implies to absolve herself from having failed to deal with it, she was still positioning the abuse as something that had to be dealt with *by her* and *inside her* at some point.

This was the case for all the participants. The severity of the social forces they used in constructing the build-up of ‘nervous breakdown’ served to legitimate its occurrence and to absolve the individual from the stigmas of madness and failed self-management. In addition, it would seem that this absolution was granted only for a brief and discrete period of time, much like the absolution granted to the individual in the sick role and survivor discourses. Should Chantal and the other participants not have dealt with or found resolution for the passivity and distress that ‘nervous breakdown’ denoted, they would have been likely to be held accountable for this and be pushed by the wider discursive terrain into positions of failed at self-management or madness.

Thus, while participants’ introduction of the social nature of their distress began to open up a space for some critique of the oppressive individualisation of distress that the construct of the self-managing, self-contained agent enforces, participants exploited this only briefly and only to explain that ‘nervous breakdown’ was the fault of these very powerful and corrosive external agents. It would seem that the imperative of the self-managing, self-contained agent was so compelling that it trumped any further discussion of the social attribution of responsibility and symptom. It was the participants who had ‘nervous breakdowns,’ not their spouses, families, legal teams or psy-practitioners. It was the participants who had to justify and manufacture socially sanctioned explanations for their ‘nervous breakdowns.’ This signals that the break with successful self-management and successful sanity that

'nervous breakdown' affords its subjects does not afford them an extended facility to critique these constructs, only a brief liberation from them. The onus is on the individual to return to a place well away from the edge as soon as they can and not go back.

This at once liberating and at once oppressive function of 'nervous breakdown' is very much an artefact of nervous discourse. Nervous functions to situate breakdown within the nerves of the individual thereby locating it as a disruption *of* the individual but one that is contained *within* the individual. Although acknowledging a relationship between the social and the individual's nerves, nervous functions to locate the nerves inside as the point of interest in nervous disease and thus deflects the gaze of treatment and cure away from the social. It is thereby available for the same critique as is often levelled most other psy-diagnoses: that they serve to relocate social injustices and inequalities in the holder of the individual (Crowe, 2000). For example, hysteria and its contemporary label of borderline personality disorder, have been critiqued for pathologizing the woman who is subjugated or abused in a patriarchal world and who through her inevitable showing of distress, is deemed by the gaze of this world to be mad (Shaw & Procter, 2005; Wirth-Cauchon, 2001). The psychiatric act of locating disruption/madness within the tissue of the individual exacerbates the manufacture of the madness *in* the individual and obscures examination of the potential social madness that construct the individual (Parker, 1999c). The same critique, unsurprisingly, can be levelled at discourses of stress, particularly those that err on the intra-subjective side. As I have touched upon already, these discourses function to locate the site of the stress-problem as within the individual and the site of solution as also within in the individual. This shifts scrutiny away from unreasonable management practices in the workplace, for example, and onto the success (or lack thereof) of the self-managing subject (Hepburn & Brown, 2001).

In the same vein, a gendered critique of nervous disease and its discursive progeny can also be made. As Appignanesi (2008, p. 7) contends in her comprehensive history of women's relationship to mental health, "contemporary statistics always emphasize

women's greater propensity to suffer from the 'sadness' end of madness". This touches on the bifurcation between psy-constructs that signify a helplessness and those that signify a danger, co-opting women into the former category and thus also co-opting them into 'nervous.' Moreover, the Victorian history of nervous disease is rife with references to women and to the dangers that deviation from the norms of the feminine, especially independence and an intellectual career, posed to nervous regulation (Russett, 1989). In addition to this, the diagnosis of hysteria in the Victorian west constructed a propensity for women to suffer from "nervousness" and "mental instability" simply by virtue of their organic reproductive processes, such as menstruation (Cayleff, 1988, p. 1200). As such, the nervous subject has a history of being constructed as synonymous with the inside-body of the female subject, and particularly, the female subject who disrupted patriarchal norms. This, again, locates the problem inside, and inside the woman, and hushes a questioning of patriarchal norms.

Interestingly, all of the participants who volunteered for this study, self-identifying with 'nervous breakdown' were women. Many of the subjects of 'nervous breakdown' in the media analysis were women, like Oprah, but not exclusively. They also included the likes of Obama, albeit positioning him as passive and collapsed which are historically the beta feminine counterpoints to the resolute strength of the masculine alpha. One can imagine, therefore, that it might be easier for women to find a position within 'nervous breakdown' than for men. Not only because of its discursive sediment as endogenous to the female body (be it nerves or womb) but also because it is associated with the more feminine positions of helplessness, passivity and visible distress. That is not to say that it is easy for women to occupy these positions. It is undoubtedly more difficult than it was in Victorian times when the woman was necessarily positioned as acquiescent and dependent (but preferably not distressed and totally helpless). In the contemporary west, at least, the feminine ideal-norm has become infused with the do-it-all agency and self-reliance put forward by second wave feminism (Sorisio, 1997; Wolf, 1991). As a result, it seems that the socio-cultural imperative of the strong self-managing agent still trumps a positions of

the battered wife, for example, for she must still breakthrough triumphantly as more agentic and more self-managing than before ‘nervous breakdown.’ Nonetheless, it does beg the question of why the gaze is shifted away from abuse of women and onto the battered wife’s self-management and her nerves. The same question, with some permutations of abuse into miscarriage or loss, for example, can be asked of all the participants. It can even be asked of Obama.

4.1.5. ‘Nervous breakdown:’ Discursive flexibility and constraint

Nonetheless, ‘nervous breakdown’ does rupture the seamless logic of the self-managing and self-contained ideal-subject who can and must alchemize distress or helplessness into an acceptable performance of coping and sanity. ‘Nervous breakdown’ seems to accomplish for its subjects a (somewhat) socially sanctioned period of passivity, helplessness and distress that manages to evade the stigmas of being positioned as mad or as having failed at self-management. As much as its discursive terrain consigns its subjects to account for their passivity and distress by referring to and dismissing these positions, this act of explaining also allows them a space to construct alternative readings of these positions. It allows them to use discourses of madness and mental illness to convey a certain quality of experience and to make visible in the public space what they were seemingly supposed to hold or hide such as abuse, loss or in Obama’s case, a feminized position of being collapsed. This offers an opportunity to ask what it is the self-managing subject is meant to manage and why and to begin to poke a few holes in this construct and the individualisation of distress it endorses.

Participants closed down this critical window by simultaneously constructing ‘nervous breakdown’ as an embodied collapse or malfunction *in* them and for which they were forced to take a recuperative break. One could contend that their reconstruction of ‘nervous breakdown’ as a breakdown to breakthrough is the ultimate closing of this critical window, for it constructs the whole experience as an superlative act of self-development. It constructs ‘nervous breakdown’ as creating a capacity for self-management and agency that surpasses what was there before falling off the edge and

even surpasses those others who have not yet fallen off the edge. It is also, I think, quite a brilliant triumph to co-opt the very same discourse that could potentially exclude and stigmatise one and use it to reposition one into a space that was better than before and even trumps most other self-managing subjects. This allowed the participants to seemingly fall apart not only with impunity, but also to benefit from the experience. In the case of celebrity confessionals of ‘nervous breakdown,’ such as Oprah’s, one might add that this benefit extends to their public relations and positions them as simultaneously more accessible to the public and even more successful than they were before⁷. I believe this constitutes something of a challenge to of the rigorously policed hegemony of normal sanity and self-management for it places some power in the hands of the subject to repurpose these discourses. It liberates them not only from the subjugation by these discourses, but also from being the passive subject who has no recourse from institutional regulation.

At the same time, one could ask what choice did they have? Could they have really found a permanent alternative for passivity, helplessness and distress that did not become mad or failed self-management? What would this have accomplished? Would they even have wanted to? I believe these are questions for future work and also as part of a continuous critical enquiry both in the therapeutic encounter and beyond. In this instance, ‘nervous breakdown’ offers a temporary alternative, albeit one that must be defended, explained and shored up at every corner. Its reprieve is not indefatigable as the discursive terrain’s foreclosures of madness and failed self-management are always near. For example, many participants were quite careful to whom they used the label of ‘nervous breakdown.’ Sophie was explicit in not using the term with work colleagues for fear of being positioned as mentally ill. The internet forums I attempted to contact in the first instance of recruitment were quite clear in policing the insider status of their conversations, positioning my contact as an unsafe intrusion. It would seem that ‘nervous breakdown’ might not hold up in all spaces as a more palatable explanation for not coping and distress. In this regard, I believe that my insider status

⁷ See Cohen (2013) for an excellent discussion on the discursive function of the publication of the private for the celebrity subject.

with participants from my own social networks, our shared identities as women, as middle class and professional, and perhaps my identity as a trainee counselling psychologist in a one-on-one interview space might have facilitated participants' use of the label to describe their experiences. It comments on a shared access to and interest in the term and highlights my role as researcher-author of this piece.

4.2. A personal grapple: Researching and authoring this construction of 'nervous breakdown'

Quite clearly this research is my own authorship. This extends as far as my very choice of 'nervous breakdown' as the subject of study for my professional qualification as a counselling psychologist. This in itself positions 'nervous breakdown' as a site of legitimate interest for a psychological gaze. The project occupies a very different space from Skinner's legacy of objective psychological science. This is purposeful, for the very epistemology that allows for me to map and question the socio-discursive functions of 'nervous breakdown' demands that the answer be confined to the articles and participants I consulted, their relationship with me and my relationship with the material. It also meant that I have had to openly grapple with questions that I might have avoided had I chosen to rather address the more realist question of 'what defines a nervous breakdown?'

I could not be in any but the former camp of discursive enquiry for this piece of work. I believe that adopting any other approach would have been to neglect the shifting sands of 'nervous breakdown' over time and space and a deliberate act of blindness. I enjoyed the creativity, curiosity and opportunity for critical thinking that working in a social constructionist paradigm afforded me. However, I found it difficult at times to reconcile the theory with a day-to-day life. My daily performance of myself relies on many assumptions of as-if-true. For example, while I accept in theory that my identity and experience are probably shaped by language, I identify with having an interiority. So did many of the clients I saw as a trainee. In the same vein, I found it difficult to explain to curious enquirers, in the grips of a modern realism, that the purpose of my

project was not to find out what ‘nervous breakdown’ was, but rather the opposite, that I didn’t think it was some-thing at all. Their looks of bafflement and slight disappointment tempted me to find a position within the reification of mainstream science that was about discovering the truth of a thing. I began to query the use of a non-generalizable and emic piece of work in a world where reified scientific truths hold such sway, including in my own worldview. Even my chosen profession of counselling psychology often operates on the assumptions of as-if-true diagnoses and interventions: at least when accounting to the HCPC, multidisciplinary teams and even to our clients themselves.

This project has asked me to evaluate where I stand with regard to the real, the critical and the socially constructed and moreover, how I navigate between them in different spaces. I am indisputably the product of hegemonic discourse: finding it difficult to consistently occupy positions that are alternative to it, such as the constructionist epistemology of this project. Discourse analysis is not even so controversial these days and has arguably become co-opted into mainstream psychology’s research repertoire (Parker, 2011). In this regard, I must make the point that it has not been difficult to apply a social constructionist approach from a purely academic position. No, that has been endorsed, even made quite cool by its Foucauldian, postmodern associations. It has been hard to apply this approach in other spaces. For example, in engaging with the participants in this project who believed that ‘nervous breakdown’ was a thing and a thing that happened to them. Even though I explained to them that I was looking at it as a label that served to shape experience, I felt a fraud in knowing that I was applying a lens to their words that might make them unrecognisable in hindsight. I consoled myself by saying that this was true of all attempts at meaning-making and that at least I was acknowledging it. I am not the first qualitative researcher to question the ethics of interpretation and the literature documents this debates (e.g. Willig, 2012). My engagement with these debates in this piece of research indicated to me that I am more inculcated in person-centred politics than I had thought: still believing, that the representation of others can function as interpretative “violence” (Teo, 2010, p. 296). I believe this not also reflects the

person-centred ethos of my counselling psychology training, but also reflects my background as a white South African whose formative years were spent negotiating a post-Apartheid society where having authority to co-author the truth` of another was constructed as a violation (e.g. Coombes, 2003; Lykes, Terre Blanche & Hamber, 2003).

The ethics of social constructionism in psychological research are also tricky. My following of the university's ethical guidelines for working with people meant repositioning as real the very same things the study was critiquing as constructed. It also meant explicitly constructing the participants as psy-subjects. Yet, to have dispensed with these protocols, especially the concept of risk, was unthinkable for me. My firm foot-hold in the discipline of counselling psychology, my belief in a human rights discourse, my sensitivity to the harms that psychology's authoritarian legacy has caused and also my fear of being held accountable for any harm to participants all came into play. I wondered how Margaret Wetherell or Ian Parker addressed concepts of risk in their research. I wondered if there could be an alternative conceptualisation of ethics that was more compatible with an enterprise that is both critical and psychological.

It is this same bric-a-brac background that drew me to considering social constructionism and discourse analysis in my research in the first place. My academic career was shaped by left-wing South Africans urgently rewriting the injustices of a post-Apartheid nation. Critical theory was introduced to me at high school through the medium of post-colonial literature and this continued in my studies at university where I supplemented psychology with modules in gender studies, sociology and sociolinguistics. As a woman, I have always been primed to issues of oppression and marginalization and it was not a far leap to extend this thinking to language. In this regard, constructions of the mad woman have always been in my peripheral vision: more so as my studies in psychology progressed and my work with clients began. The personal started to become political for me as I worked in an inpatient facility for young women diagnosed with eating disorders and other so-called disorders of

emotional regulation. I could see that really, the key difference between them and me was their visibility to a discourse of pathology, and my relative invisibility. I wondered what psychiatrists might have made of me at various junctures in my life.

‘Nervous breakdown’ always seemed quite nearby. One of its cultural permutations is the image of middle-class housewife replete with her mid-morning gin, valium and dressing gown. This is an image of a woman that I heard summoned by others throughout my life. Female friends and relatives would even joke about becoming her. I would even joke about becoming her. ‘Nervous breakdown’ is intriguing to me because I can identify with it. There have often been times in my life that I have been tempted to use the label. Times when my performance of coping was barely up to scratch, and I was afraid I was going mad. Times when the physical and mental became blurred but I preferred to keep this to myself and tell work that I had come down with a bad cold. Fortunately, these were of brief duration and I was able somehow, perhaps through the comforts of a middle-class position, to fake it ‘til I made it back to that haloed space called normal. I never actually used the label but I am sure I could have.

4.2.1. Considering the constraints that I placed on the work

Undoubtedly, my history has contributed to my interest in the term and shaped my authoring of the research. An-other researcher positioned differently in the social field would have without doubt interpreted the research differently. For example, a sociologist might have decided to look at race, culture, socio-economics and geography more deeply, being academically primed to those conceptual categories. A demographic construction of ‘nervous breakdown,’ was not only beyond the scope of this study but was also inconsistent with its epistemological premise. However, I think that asking the question of ‘who has/can have ‘nervous breakdowns?’’ is relevant, and one that this study does not address apart from a brief discussion of gender. It is also not incompatible with a critical approach for it speaks to who has access to this discursive reprieve from agency and self-management and who does not. This might be interesting to address in future work. A related examination specific to the

gendered nature of constructions of helplessness, passivity or distress would also be interesting. For although I have touched on the possible feminization of ‘nervous breakdown’ and the positions it invokes, it would be interesting to see if men use it, if they can use it, and what they might use instead. It would also be interesting to see which kinds of women and men use it: would it only be relevant to a middle-class position as reflected in this study?

In fact there are many aspects of ‘nervous breakdown’ and its subjects that this work could not address – partly because I as interpretative-researcher did not have discursive access to them and partly because of the study’s limited scope. One of the criticisms levelled at discourse analysis is its discourse determinism which can prevent a consideration of extra-discursive ways of constructing identity and experience (Brown, 2001). It is also criticised for its neglect of individual histories (Avdi, 2012). Arguably, this is the point of social constructionism but in so doing, it can become as dogmatic as those epistemologies it was set up to critique. As such, this study might have looked at ‘nervous breakdown’ as a more personal phenomenon and perhaps one that considered the extra-discursive. After all, participants went to great lengths to offer personal histories to their ‘nervous breakdowns.’ In addition, a crucial hallmark of ‘nervous breakdown’ is an embodiment. A psychosocial approach such as that espoused by Hollway and Jefferson (2000), would have allowed for more of a consideration of the relationship between the personal and the social. A critical realist discursive approach (e.g. Sims-Schouten, Riley & Willig, 2007) might have allowed the research to consider the embodied aspects of ‘nervous breakdown’ and to look at the material consequences of an embodied shutdown.

Another aspect of the discursive terrain of ‘nervous breakdown’ raised in this study but not addressed by it is the vast expanse of quasi-psy literature that seems to construct it as a legitimate diagnosis. These are largely internet-based and came up during my search for media articles. I excluded them from the study as I was unsure of their popular reach, believing that endorsed media sources were more likely to have permeated popular discourse more readily given that they are not only reliant on the

explicit search term of 'nervous breakdown.' However, an exploration of them would no doubt enrich a discussion on the space(s) of 'nervous breakdown' and offer some comment not only on its discursive function for subjects who identify with it but also offer comment on its function for those subjects who use it while positioning themselves as experts. By this I mean experts who exist in the self-help hinterland between the psy-clinic and the lay healer: a liminal space, not dissimilar to that occupied by Loosmore (1921) and his contemporaries in the early twentieth century. Exploring this was beyond the scope of this study and would have required a dedicated study of its own but my interest was piqued and I would like to follow it up.

In a similar vein, I chose to focus this study on the interaction between the wider discursive terrain of 'nervous breakdown' and the subjects of 'nervous breakdown' who identified with the term. I chose this in order to focus on what the term may accomplish for those who use it to describe their experiences. This related to my interest in the construction of the client-patient, my own position as a therapist and my understanding of 'nervous breakdown,' as a popular re-working of a psy-legacy: as an interesting disruption to the directives of the psy-subject. However, this can be critiqued for failing to turn the gaze back on the centre. This is a critique often levelled at critical studies that look only to how the other-subject is constructed by hegemonic discourse, and which neglect to observe the simultaneous construction of the hegemonic subject. Studies on the construction of masculinity, heterosexuality and whiteness are responses to this critique (Connell & Messerschmidt, 2005; Steyn, 2001; Wilkinson & Kitzinger, 1994). Similarly, this study might have turned the gaze onto psycho-medical practitioners and interrogated their constructions of 'nervous breakdown' and its subjects. In this context the discursive function of the term might have been very different and perhaps offered a more heterogeneous comment on the psy-institution which this study has tended to construct in a homogenously post-Foucauldian manner. There are a variety of approaches housed under the psy-umbrella and it would be a disservice to them to not acknowledge this and the different conversations they all have with ideas of diagnosis, social change and the language of norms, among others. For example, Harper, Cromby, Reavey, Cooke and Anderson

(2007) go to great lengths to spell out the diversity of approaches to mental health care that can be used in practice. They also attempt to foreground those that attempt to reconcile meaningful ways of working and a more critical enterprise, arguing that while there remains a psychiatric diagnostic hegemony, assumptions of a homogenous psy-institution are false.

The social constructionist stance that this research adopts can also be critiqued for the paralysis of its relativism, even if it aims to be critical (Burr, 1998). For if all is a discursive construction and nothing is truthful, real or better than something else, then how can one hope to effect change (e.g. Burman, 1990; Gill, 1995; Willig, 1998)? How can a social constructionist piece of research be of use except to a niche of like-minded intellectuals? An extreme relativism is only useful in shaking loose rigid reifications. Psy-practitioners, in particular, as gatekeeper-creators of deviance and normality, as Harper et al. (2007) contend have an obligation to do a bit more. We have to stick our necks out a bit and contribute to making these constructs more tolerant and this tolerance more visible.

4.3. In conclusion: What can this study of ‘nervous breakdown’ contribute?

What has emerged from the application of a social constructionist approach to the study of ‘nervous breakdown’ is a sense of the construct as a discursive accomplishment whose power lies in its liminal position. Its position in both psy and popular spaces gives it the facility to be used to talk about psy-constructs but also to play with them and resist them. Similarly its blurring of the mental and physical allows it to use both discursive spaces but avoid becoming fixed in either. It is only through its position in-between that ‘nervous breakdown’ can allow those who use it to have a brief reprieve from the constraints of must-have agency, self-management and sanity without permanent reprisal. It has never been an official psy-term and if it did become a psy-diagnosis, co-opted into the mainstream, it would lose this ability to flirt with psy-discourse with impunity. It would also lose the opportunity it makes

available for critical comment on the ideal-norms of self-management and self-contained sanity. In a parallel process, to steal a phrase from psychoanalysis, this piece of work reflects the liminal status of 'nervous breakdown.' It is at once part of a psy-institution as a mandatory act of my qualification for membership but is also critical of the institution and its realist assumptions. By treating 'nervous breakdown' as a discursive accomplishment and not as a diagnosis, this piece of work accords the subject an agency in the construction of experience that a purely scientific approach cannot. Through its use of a methodological approach that combines both Foucauldian discourse analysis and discursive psychology, this project is able to look at the discursive construction and constraint of the subject of 'nervous breakdown' and also the ways in which an agentic subject can re-fashion these constructions and resist these constraints.

In this sense, the project is a dialogical one. It does not pretend to regard the truth from the soapbox of science but neither does it pretend to be a virtuous radical picketing the institution from outside its gates. I do not believe that a critical exercise has much effect if it is not dialogical exercise. A psychologist is also a member of the public in many spaces: I would not have had access to the term of 'nervous breakdown' if had not straddled these two discursive terrains. Psy-discourse and its services, such as those provided by counselling psychologists, are by their very nature dialogical. They are positioned both as regulators of the self-contained agent and also as one of few social spaces that can tolerate people who are helpless and distressed, who are dangerous or deviant and not held together. Participants like Naomi had little idea of where else to turn in 'nervous breakdown.' I believe that this positions psy-services and its practitioners as able to play a significant role in redressing the oppressive imperatives of the norms of self-management and the individualisation of distress.

The subject of 'nervous breakdown' is so readily constructed as mad or having failed at self-management and has to work terribly hard to carve out an alternative. He/she is also held solely responsible for metabolising distress and helplessness. The gaze is

easily shifted by psy-practices away from the social nature of this distress, refocused as a failure or disruption of the individual. The subject can accomplish an alternative position by using ‘nervous breakdown’ as has emerged in this study, but it also offers psychologists an alternative. It offers us an opportunity to really think about what we are telling clients when our language locates the problem inside them and the consequences of this. To my mind, we need to find other ways of talking about coping and not coping that are less asphyxiating for the individual – that do not require a GP’s sick note to save face or save a job. We need to be more vocal in acknowledging the massive fictions of self-management and self-containment and point a finger back at the social. Or, at the very least, we could be more flexible with the binaries of coping and not coping or mad and sane. What the third space carved out by ‘nervous breakdown’ in this study seems to suggest is that these binaries are illusionary. Things are less clear cut. People wander in and out of them, even people like Obama and Oprah. Yet, even so, people are forced to hide their experiences of travelling over the edge or tie themselves up in knots justifying them for fear of being fired, ridiculed or diagnosed.

I believe that counselling psychology, the institution within which this piece of work is located, is particularly well-positioned to endorse multiple, even contradictory constructions of what is coping or sane and to co-construct these *with* its client-subjects. Counselling psychology’s core values include that of dialogical and reflexive practice which can play with and also critique essentialist truths (Kasket, 2012; McLeod, 2001). A therapeutic encounter informed by these values and which foregrounds the relational is therefore well situated for the co-construction of alternative subject positions relative to these constructs (Anderson, 1997; Avdi, 2012). This is made all the more relevant because it would seem that these encounters are some of very few socially sanctioned spaces that are accessible to people who are positioned as deviant from hegemonic norms – people like the participants in this study. In addition, the relational and reflexive nature of counselling psychology’s practice allows it to explicitly notice and even welcome being impacted upon by its clients. It allows, to some extent, for popular discourse to have an impact on

institutional discourse. The situation of this piece of work, therefore, does not necessarily close-down the challenges that the liminality of ‘nervous breakdown’ poses for psy-practices, rather it can be seen as a consideration of them.

Psy’s brushing off of ‘nervous breakdown’ as a popular colloquialism is what allows its subjects to accomplish something other than a psy-diagnosis, including a diagnosis of failed self-management, in the first place. However, by maintaining this boundary between psy and popular discourse, the subjects of ‘nervous breakdown’ as well as the psy-institution all collude in keeping the pervasive individualism perpetuated by the psy-complex intact. This contributes to the maintenance of the oppressive fictions of coping, self-management and self-contained sanity. As such, it is not such a violence for a piece of work *in* counselling psychology to look at what a popular term like ‘nervous breakdown’ might accomplish for its subjects and to ask why they might need or want to accomplish these things. Instead, I hope, with this non-generalizable, emic piece of work to have added, albeit modestly, to a critical interrogation of the ideal-norms that psy so readily peddles and which its subjects readily reconstruct. This is so that we might reconsider them, and use our influence not only in the therapy room but in the wider discursive terrain to offer alternatives to the one-size-fits-all expert opinions on how we as individuals can and must hold ourselves together. In the meantime, there is the alternative offered by ‘nervous breakdown’ – seemingly one of few ok ways to fall apart currently available on the market (and not only for sale to middle-class housewives in dressing gowns).

5. References

- Abbott, A. (1990). Positivism and interpretation in sociology: Lessons for sociologists from the history of stress research. *Sociological Forum*, 5(3), 435-458.
- Abrams, S. (2007). *No more drama: Nine simple steps to transforming a breakdown to a breakthrough*. New York, NY: Sepia.
- Altman, D. (2001). *Homosexual: Oppression and liberation*. St Lucia: University of Queensland Press. (Original work published 1971).
- American Psychiatric Association. (1952). *DSM I: Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Association.
- Anderson, H. (1997). *Conversation, language and possibilities: A postmodern approach to therapy*. New York, NY: Basic Books.
- Angermeyer, M., & Matschinger, H. (2003). Public beliefs about schizophrenia and depression. *Social Psychiatry and Psychiatric Epidemiology*, 38(9), 526-534.
- Antaki, C., Billig, M., Edwards, D., & Potter, J. (2003). Discourse analysis means doing analysis: A critique of six analytic shortcomings. *Discourse Analysis Online*, 1. Retrieved from <https://dspace.lboro.ac.uk/2134/633>
- Appignanesi, L. (2008). *Mad, bad and sad: A history of women and the mind doctors from 1800 to the present*. London: Virago.
- Armistead, N. (1974). *Reconstructing social psychology*. Harmondsworth: Penguin
- Arribas-Ayllon, M., & Walkerdine, V. (2008). Foucauldian discourse analysis. In C. Willig, & W. Stainton-Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (pp. 91-108). London: Sage.
- Ash, E.L. (1920). *The problem of nervous breakdown*. Oxford: Macmillan.
- Askanasy, A. (1974). *Attitudes towards mental patients: A study across cultures*. The Hague: Mouton.
- Avdi, E. (2012). Exploring the contribution of subject positioning to studying therapy as a dialogical enterprise. *International Journal for Dialogical Science*, 6(1), 61-79.
- Balsamo, A. (1996). *Technologies of the gendered body: Reading cyborg women*. Durham, NC: Duke University Press.
- Bandura, A. (1993). Perceived self-efficacy in cognitive development and functioning. *Educational Psychologist*, 28(2): 117-148.

- Bandura, A. (2004). Health promotion by social cognitive means. *Health Education & Behaviour*, 31(2), 143-164.
- Banks, S. (2011, March 12). Charlie Sheen isn't funny. *LA Times*. Retrieved from <http://articles.latimes.com/2011/mar/12/local/la-me-banks-20110312>
- Barke, M., Fribush, R., & Stearns, P. (2000). Nervous breakdown in 20th century American culture. *Journal of Social History*, 33(3), 565-584.
- Beatty, H. (2012). *Nervous disease in late eighteenth-century Britain: The reality of a fashionable disorder*. London: Pickering & Chatto.
- Beck, A. (1979). *Cognitive therapy for anxiety and depression*. New York, NY: Guildford.
- Beer, D. (1996). The dichotomies: Psychosis-neurosis and functional/organic: A historical perspective. *History of Psychiatry*, 7(26), 231-255.
- Bennett, J., Rodrigues, I., Klein, L. (2013). Effects of caffeine and stress on biomarkers of cardiovascular disease among healthy men and women with a family history of hypertension. *Journal of the International Society for the Investigation of Stress*, 29(5), 401-409.
- Biller, J. (2012). *Practical neurology* (4th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Billig, M. (1997). Rhetorical and discursive analysis: How families talk about the royal family. In N. Hayes (Ed.), *Doing qualitative analysis in psychology* (pp. 39-54). Hove: Psychology Press.
- Billig, M., Condor, S., Hook, D., Gane, M., Middleton, D., & Radley, A. (1988). *Ideological dilemmas: A social psychology of everyday thinking*. London: Sage.
- Blackman, L., Cromby, J., Hook, D., Papadopoulous, D., & Walkerdine, V. (2008). Creating subjectivities. *Subjectivity*, 22(1), 1-27.
- Boden, J., Fergusson, D., & Horwood, J. (2013). Alcohol misuse and relationship breakdown: Findings from a longitudinal birth cohort. *Drug & Alcohol Dependence*, 133(1), 115-120.
- Bollas, C. (2012). *Catch them before they fall: The psychoanalysis of breakdown*. London: Routledge.
- Bond, T. (2004). Ethical guidelines for researching counselling and psychotherapy. *Counselling and Psychotherapy Research*, 4(2), 10-19.

- Boughtwood, D., & Halse, C. (2008). Ambivalent appetites: Dissonances in social and medical constructions of anorexia nervosa. *Journal of Community and Applied Social Psychology*, 18(4), 269-281.
- Briggs, L. (2000). The race of hysteria: "Overcivilization" and the "savage" woman in late nineteenth-century obstetrics and gynaecology. *American Quarterly*, 52(2), 246-273.
- Brinkmann, S., & Kvale, S. (2008). Ethics in qualitative research. In C. Willig & W. Stainton-Rogers (Eds.), *The SAGE handbook of qualitative research* (pp.263-279). London: Sage.
- British Psychological Society. (2010). *Code of human research ethics*. Leicester: The British Psychological Society.
- Brosschot, J., Gerrin, W., & Thayer, J. (2006). The perseverative cognition hypothesis: A review of worry, prolonged physiological stress-related activation, and health. *Journal of Psychosomatic Research*, 60(2), 113-124.
- Brown, E. (2011, March 1). Diagnosing Charlie Sheen from afar. *LA Times*. Retrieved from <http://articles.latimes.com/2011/mar/01/news/la-heb-charlie-sheen-bipolar-20110301>
- Brown, S. (1999). Stress as regimen: Critical readings of self-help literature. In C. Willig (Ed.), *Applied discourse analysis: Social and psychological interventions* (pp. 23-43). Buckingham: Open University Press.
- Brown, S. (2001). Psychology and the art of living. *Theory & Psychology*, 11(2), 171-192.
- Brown, S. (2005). The worst things in the world: Life events checklists in popular stress management. In D. Bell & J.Hollows (Eds.), *Ordinary lifestyles: Popular media consumption and taste* (pp. 231-254). Maidenhead: Open University Press.
- Buck, C. (2014). *2014 ICD-9-CM: For hospitals* (Vols. 1-3). Washington, DC: American Psychological Association.
- Burman & I. Parker (Eds.), *Discourse analytic research: Repertoires and readings of texts in action* (pp. 1-13). London: Routledge.
- Burman, E. (1990). Differing with deconstruction: A feminist critique. In I. Parker & J. Shotter (Eds.), *Deconstructing social psychology* (pp. 208-220). London: Routledge.
- Burman, E. (2007). *Deconstructing developmental psychology* (2nd ed.). London: Routledge.

- Burman, E., & Parker, I. (1993). Introduction – discourse analysis: The turn to text. In E. E.
- Burr, V. (1998). Overview: Realism, relativism, social constructionism and discourse. In I. Parker (Ed.), *Social constructionism, discourse and realism* (pp. 13-26). London: Sage.
- Burr, V. (2003). *Social constructionism* (2nd ed.). Hove: Routledge.
- Bury, D., & Strauss, S. (2006). The scientist-practitioner in a counselling psychology setting. In D. Lane & S. Corrie (Eds.), *The modern scientist-practitioner: A guide to practice in psychology* (pp. 119-129). London: Routledge.
- Caldwell, R. (2007). Agency and change: Re-evaluating Foucault's legacy. *Organization*, 14(6), 769-791.
- Caprino, K. (2008). *Breakdown, breakthrough: The professional woman's guide to claiming a life of passion, power and purpose*. San Francisco, CA: Berrett Koehler.
- Caprio, F. (1969). *How to avoid a nervous breakdown*. New York, NY: Meredith Press.
- Carabine, J. (2001). Unmarried motherhood 1830-1990: A genealogical analysis. In M. Wetherall, S. Taylor & S. Yates (Eds.), *Discourse as data: A guide for analysis* (pp. 267-310). London: Sage.
- Cayleff, S. (1988). 'Prisoners of their own feebleness': Women, nerves and western medicine – a historical overview. *Social Science & Medicine*, 26(12), 1199-1208.
- Cayleff, S. (1992). She was rendered incapacitated by menstrual difficulties: Historical perspectives on intellectual and physiological impairment among menstruating women. In A. Dan & L. Lewis (Eds.), *Menstrual health in women's lives* (pp. 229-235). Champaign, IL: University of Chicago Press.
- Cintrón, J., Carter, M., & Sbrocco, T. (2005). Ataques de nervios in relation to anxiety sensitivity among island Puerto Ricans. *Culture, Medicine & Psychiatry*, 29(4), 415-431.
- Cohen, J. (2013). *The private life: Why we remain in the dark*. London: Granta.
- Connell, R., & Messerschmidt, J. (2005). Hegemonic masculinity: Rethinking the concept. *Gender & Society*, 19(6), 829-859.
- Coombes, A. (2003). *Visual culture and public memory in a democratic South Africa: History after Apartheid*. Durham, NC: Duke University Press.

- Cooper, D. (2001). *Psychiatry and anti-psychiatry*. London: Routledge. (Original work published 1967).
- Cosgrove, L. (2005). When labels mask oppression: Implications for teaching psychiatric taxonomy to mental health counselors. *Journal of Mental Health Counseling, 27*(4), 283-296.
- Coulehan, J. (2013). What the world needs now. *Patient Education and Counseling, 93*(3), 664-665.
- Couture, S., & Penn, D. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Mental Health Journal, 12*(3), 291-305.
- Crossley, M. (1998). 'Sick role' or 'empowerment?' The ambiguities of life with an HIV positive diagnosis. *Sociology of Health and Illness, 20*(4), 507-531.
- Crossley, M., & Crossley, N. (2001). Patient voices, social movements and the habitus: How psychiatric survivors speak out. *Social Science & Medicine, 52*(10), 1477-1489.
- Crowe, M. (2000). Constructing normality: A discourse analysis of the DSM-IV. *Journal of Psychiatric and Mental Health Nursing, 7*(1), 69-77.
- Cummings, A. (2014). *Not my father's son: A memoir*. New York, NY: Dey Street Books.
- Danee, M. (1975). *Stop running*. Oxford: Vantage Press.
- Danziger, K. (1997). *Naming the mind: How psychology found its language*. London: Sage.
- Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the theory of social behaviour, 20*(1), 43-63.
- Davis, D. (1989). George Beard and Lydia Pinkham: Gender, class and nerves in late 19th century America. *Healthcare for Women International, 10*(2-3), 93-114.
- Davis, D., & Whitten, R. (1988). Medical and popular traditions of nerves. *Social Science and Medicine, 26*(12), 1209-1221.
- Deibert, R. (2000). International plug 'n play? Citizen activism, the internet, and global public policy. *International Studies Perspectives, 1*(3), 255-272
- Dent, G. (2013, October 10). What I learned from having a nervous breakdown at 25. *Women's Agenda*. Retrieved from <http://www.womensagenda.com.au/talking-about/editor-s-agenda/what-i-learned-from-having-a-nervous-breakdown-at-25/201310103024#.VDO7nPk7ugw>

- Dewitte, S. (2013). From willpower breakdown to the breakdown of the willpower model – The symmetry of self-control and impulsive behaviour. *Journal of Economic Psychology*, 38, 16-25.
- Dineen, T. (2004). *Manufacturing victims*. New York, NY: Studio 9 Books.
- Donat, D. (2005). Special section on seclusion and restraint: Encouraging alternatives to seclusion, restraint, and reliance on PRN drugs in a public psychiatric hospital. *Psychiatric Services*, 50(9), 1105-1108.
- Donner, J. (2014). *Descent into madness*. Bloomington, IN: Abbott Press.
- Doublet, S. (2000). *The stress myth*. Chesterfield, MO: Science & Humanities Press.
- Drescher, J. (2010). Queer diagnoses: Parallels and contrasts in the history of homosexuality, gender variance, and the Diagnostic and Statistical Manual. *Archives of Sexual Behaviour*, 39(2), 427-460.
- Druck, K. (2012). *The real rules of life: Balancing life's terms with your own*. London: Hay House.
- Dunn, J. (2005). "Victims" and "Survivors": Emerging vocabularies of motive for "battered women who stay." *Sociological Inquiry*, 75(1), 1-30.
- Durrheim, K. (1997). Social constructionism, discourse and psychology. *South African Journal of Psychology*, 27(3), 175-182.
- Edley, N. (2001). Analysing masculinity: Interpretative repertoires, ideological dilemmas and subject positions. In M. Wetherell, S. Taylor, & S. Yates (Eds.), *Discourse as data: A guide for analysis* (pp. 189-228). London: Sage.
- Edley, N. & Wetherell, M. (2008). Discursive psychology and the study of gender: A contested space. In K. Harrington, L. Litosseliti, H. Saunston & J. Sunderland (Eds.), *Gender and language research methodologies* (pp. 161-173). Basingstoke: Palgrave Macmillan.
- Edley, N., & Wetherell, M. (1996). Masculinity, power and identity. In M. Mac an Ghail (Ed.), *Understanding masculinities: Social relations and cultural arenas* (pp. 97-113). Buckingham: Open University Press.
- Edley, N., & Wetherell, M. (1997). Jockeying for position: The construction of masculine identities. *Discourse and Society*, 8(2), 203-217.
- Edley, N., Wetherell, M. (1999). Imagined futures: Young men's talk about fatherhood and domestic life. *British Journal of Social Psychology*, 38(2), 181-194.

- Edwards, D. (2006). Discourse, cognition and social practices: The rich surface of language and social interaction. *Discourse Studies*, 8(1), 41-49.
- Edwards, D., & Potter, J. (1992). *Discursive psychology*. London: Sage.
- Ellis, A. (1957). *How to live with a neurotic*. Oxford: Crown.
- Eysenck, H. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16(5), 319-324.
- Fahy, K., & Smith, P. (1999). From the sick role to subject positions: A new approach to the medical encounter. *Health*, 3(1), 71-94.
- Fairclough, N. (1996). Technologisation of discourse. In C. Caldas-Coulthard & M. Coulthard (Eds.), *Texts and practices: Readings in critical discourse analysis* (pp. 71-83). London: Routledge.
- Fairclough, N. (2001). The discourse of new labour: Critical discourse analysis. In M. Wetherell, S. Taylor & S. Yates (Eds.), *Discourse as data: A guide for analysis* (pp. 229-266). London: Sage.
- Fanon, F. (1967). *Black skins, white masks*. (C.L. Markmann, Trans.). New York, NY: Grove. (Original work published 1952)
- Fenichel, O. (1946). *The psychoanalytic theory of neurosis*. London: Kegan Paul, Trench, Trubner & Co.
- Fonagy, P. (2010). Attachment, trauma, and psychoanalysis: Where psychoanalysis meets neuroscience. In M. Leuhzinger-Boehleber, J. Canestri & M. Target (Eds.), *Early development and its disturbances* (pp. 53-76). London: Karnac.
- Fontana, A., & Frey, J. (1998). Interviewing: the art of science. In N. Denzin & Y. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (pp. 47-78). Thousand Oaks, CA: Sage.
- Foucault, M. (1965). *Madness and civilisation: A history of insanity in the age of reason*. New York, NY: Random House.
- Foucault, M. (1988). *Madness and civilisation: A history of insanity in the age of reason* (R. Howard, Trans.). New York, NY: Vintage Books. (Original work published 1965)
- Foucault, M. (2008). *The archaeology of knowledge*. (A. Sheridan Smith, Trans.). London: Routledge. (Original work published 1969)
- Freud, S. (1961). The ego and the id. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 19, pp. 3-66). London: Hogarth Press. (Original work published 1923)

- Friedan, B. (1963). *The feminine mystique*. New York, NY: W.W. Norton.
- Frith, H., & Kitzinger, C. (1998). "Emotion work" as a participant resource: A feminist analysis of young women's talk-in-interaction. *Sociology*, 32(2), 299-320.
- Frost, N. (Ed.). (2011). *Qualitative research methods in psychology: Combining core approaches*. Maidenhead: Open University Press.
- Gantt, W. (1943). Measures of susceptibility to nervous breakdown. *The American Journal of Psychiatry*, 99, 839-849.
- Gantt, W. (1953). Principles of nervous breakdown – schizokinesis and autokinesis. *Annals of the New York Academy of Sciences*, 56, 143-163.
- Gergen, K. (1973). Social psychology as history. *Journal of Personality and Social Psychology*, 26(2), 309–320.
- Gergen, K. (1985). The social constructionist movement in modern psychology. *American Psychologist*, 40(3), 266-275.
- Gibson, K., & Cartwright, C. (2013). Agency in young clients' narratives of counselling: "It's whatever you make of it." *Journal of Counselling Psychology*, 60(3), 340-352.
- Gijwijt-Hofstra, M. (2001). Introduction: Cultures of neurasthenia from Beard to the First World War. In M. Gijwijt-Hofstra & R. Porter (Eds.), *Cultures of neurasthenia from Beard to the First World War* (pp. 1-30). Amsterdam: Rodopi.
- Gilbert, E. (2006). *Eat pray love*. New York, NY: Penguin.
- Gilbert, G., & Mulkay, M. (1984). *Opening Pandora's box: A sociological analysis of scientists' discourse*. Cambridge: Cambridge University Press.
- Gilbert, P. (2009). *The compassionate mind*. Oakland, CA: New Harbinger.
- Gill, R. (1995). Relativism, reflexivity and politics: Interrogating discourse analysis from a feminist perspective. In S. Wilkinson & C. Kitzinger (Eds.), *Feminism and discourse* (pp. 165-186). London: Sage.
- Gilroy, P. (2012). Postcolonialism and cosmopolitanism: Towards a worldly understanding of fascism and Europe's colonial crimes. In R. Braidotti, P. Hanafin, & B. Blaagaard (Eds.), *After cosmopolitanism* (pp.111-131). Abingdon: Routledge.

- Gove, W. (2004). The career of the mentally ill: An integration of psychiatric, labelling/social constructionist, and lay perspectives. *Journal of Health and Social Behaviour*, 45(4), 357-375.
- Grossman, L. (1995). *The electronic republic: Reshaping democracy in the information age*. New York, NY : Viking Publishing.
- Gunter, B., Campbell, V., Touri, M., & Gibson, R. (2009). Blogs, news and credibility. *Aslib Proceedings*, 61(2), 185-204.
- Hall-Flavin, D. (n. d.). *What does it mean to have a nervous breakdown?* Retrieved from <http://www.mayoclinic.org/diseases-conditions/depression/expert-answers/nervous-breakdown/faq-20057830>
- Hansen, J. (2010). Multiplicity and its discontents: Life on the counselling farm. *The International Journal for the Advancement of Counselling*, 32(4), 240-247.
- Hare, E. (1991). A history of 'nervous disorders' from 1600 to 1840, and a comparison with modern views. *British Journal of Psychiatry*, 159, 37-45. doi: 10.1192/bjp.159.1.37
- Hargreaves, J. (1994). *Sporting females: Critical issues in the history and sociology of women's sport*. London: Routledge.
- Harper, D. (2013). On the persistence of psychiatric diagnosis: Moving beyond a zombie classification system. *Feminism and Psychology*, 23(1), 78-85.
- Harper, D., Cromby, J., Reavey, P., Cooke, A., & Anderson, J. (2007). Don't jump ship: New approaches in teaching mental health to undergraduates. *The Psychologist*, 20(5), 302-304.
- Harré, R., & van Langenhove, L. (Eds.). (1999). *Positioning theory*. Oxford: Blackwell.
- Harris, P. (2011, September 6). Charlie Sheen, a star on the verge of a nervous breakdown, grips and revuls America. *The Guardian*. Retrieved from <http://www.theguardian.com/culture/2011/mar/06/charlie-sheen-public-breakdown-analysis>
- Hart, N., & Crawford-Wright, A. (1999). *Research as therapy, therapy as research: Ethical dilemmas in new paradigm research*. *British Journal of Guidance and Counselling*, 27(2), 205-214.
- Haverkamp, B. (2005). Ethical perspective on qualitative research in applied psychology. *Journal of Counselling Psychology*, 52(2), 146-155.
- Heilman, K., & Valenstein, E. (Eds.). (2012). *Clinical neuropsychology* (5th ed.). New York, NY: Oxford University Press.

- Henriques, J., Hollway, J., Urwin, C., Venn, C., & Walkerdine, V. (Eds.). (1984). *Changing the subject*. London: Methuen.
- Hepburn, A., & Brown, S. (2001). Teacher stress and the management of accountability. *Human Relations*, 54(6), 691-715.
- Hollway, W. (1984). Gender difference and the production of subjectivity. In J. Henriques, W. Hollway, C. Urwin, C. Venn, & V. Walkerdine (Eds.), *Changing the subject* (pp. 227-263). London: Methuen.
- Hollway, W., & Jefferson, T. (2000). *Doing qualitative research differently: Free association, narrative and the interview method*. London: Sage.
- Holt, A. (2011). Discourse analysis approaches. In N. Frost (Ed.), *Qualitative research methods in psychology: Combining core approaches* (pp. 66-91). Maidenhead: Open University Press.
- Horney, K. (1991). *Neurosis and human growth: the struggle toward self-realisation*. New York, NY: W.W. Norton & Company. (Original work published 1950).
- Horney, K. (2001). *Our inner conflicts: a constructive theory of neurosis*. Abingdon: Routledge. (Original work published 1946).
- Horwitz, A. (2002). *Creating mental illness*. Chicago, IL: University of Chicago Press.
- Hudson, J. (1995). Scientific racism: The politics of tests, race and genetics. *The Black Scholar*, 25(1), 3-10.
- Ishizuka, H. (2010). Carlyle's nervous dyspepsia: Nervousness, indigestion and the experience of modernity in nineteenth century Britain. In L. Salisbury & D. Shail (Eds.), *Neurology and modernity: A cultural history of nervous systems 1800-1950* (pp.81-95). Basingstoke: Palgrave MacMillan.
- Iwata, M., Ota, K., Duman, R. (2013). The inflammasome: Pathways linking psychological stress, depression and systemic illnesses. *Brain, Behaviour & Immunity*, 31, 105-114.
- Jenkins, J. (1988). Conceptions of schizophrenia as a problem of nerves: A cross-cultural comparison of Mexican Americans and Anglo Americans. *Social Science & Medicine*, 26(12), 1233-1243.
- Jorgensen, M., & Phillips, M. (2002). *Discourse analysis as theory and method*. London: Sage.
- Kaplan-Solms, K., & Solms, M. (2000). *Clinical studies in neuropsychanalysis: Introduction to a depth neuropsychology*. London: Karnac.

- Karp, D., Tanarugsachock, V. (2000). Mental illness, caregiving and emotion management. *Qualitative Health Research*, 10(1), 6-25.
- Kasket, E. (2012). The counselling psychologist researcher. *Counselling Psychology Review*, 27(2), 64-73.
- Kelly, K. (1999). Calling it a day: Reaching conclusions in qualitative research. In M. Terre Blanche & K. Durrheim (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 421- 437). Cape Town: University of Cape Town Press.
- Kietzmann, J., Hermkens, K., McCarthy, I., Silvestre, B. (2011). Social media? Get serious! Understanding the functional building blocks of social media. *Business Horizons*, 45(3), 241-251.
- Kitzinger, C. (1996). Speaking of oppression: psychology, politics and the language of power. In E. Rothblum & L. Bond (Eds.), *Preventing heterosexism and homophobia* (pp. 3-19). Thousand Oaks, CA: Sage.
- Kugleman, R. (1992). *Stress: The nature and history of engineered grief*. Westport, CT: Praeger Publishers.
- Kvale, S. (1996). *InterViews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage.
- Kvaternic, I., & Grebenc, V. (2009). The role of social work in the field of mental health: Dual diagnoses as a challenge for social workers. *European Journal of Social Work*, 12(4), 509-521.
- Lafrance, M., & McKenzie-Mohr, S. (2013). The DSM and its lure of legitimacy. *Feminism & Psychology*, 23(1), 119-140.
- Lakoff, G., & Johnson, M. (1999). *The embodied mind and its challenge to western thought*. New York, NY: Basic Books.
- Lazarus, R., & Cohen, J. (1977). Environmental stress. In L. Altman & J. Wohlwill (Eds.), *Human behaviour and the environment: Current theory and research* (pp. 89-127). New York, NY: Plenum.
- Lazarus, R., & Folkman, S. (1984). *Stress, appraisal and coping*. New York, NY: Springer.
- Lea, L. (2010). What's it like having a nervous breakdown? Can you recover? In T. Basset & T. Stickley (Eds.), *Voices of experience: Narratives of mental health survivors* (pp. 85-93). Chichester: John Wiley & Sons.
- Leader, D. (2011). *What is madness?* London: Penguin.

- Leader, D. (2013). *Strictly bipolar*. London: Penguin.
- Lee, S., Notterpek, L. (2013). Dietary restriction supports peripheral nerve health by enhancing endogenous protein quality control mechanisms. *Experimental Gerontology, 48*(10), 1085-1090.
- Leisenring, A. (2006). Confronting “victim” discourses: The identity work with battered women. *Symbolic Interaction, 29*(3), 307-330.
- Levy, S. (2011). *In the plex: How Google thinks, works and shapes our lives*. New York, NY: Simon & Schuster.
- Logan, P. (1997). *Nerves and narratives: A cultural history of hysteria in nineteenth century British prose*. Berkeley, CA: University of California Press.
- Loinaz, A. (2012, June 20). Charlie Sheen ‘fesses up about public meltdown: “psychotic break” left him in “total denial.” *EOnline*. Retrieved from <http://uk.eonline.com/news/324706/charlie-sheen-fesses-up-about-public-meltdown-psychotic-break-left-him-in-total-denial>
- Long, C., & Eagle, G. (2009). Ethics in tension: Dilemmas for clinicians conducting sensitive research. *Psycho-analytic Psychotherapy in South Africa, 17*(2), 27-52.
- Loosmore, W.C. (1921). *Nerves and the man: A popular psychological and constructive study of nervous breakdown*. New York, NY: George H. Doran Company.
- Loughran, T. (2008). Hysteria and neurasthenia in pre-1914 British medical discourse and in histories of shell-shock. *History of Psychiatry, 19*(1), 25-46.
- Lovelace, K., Manz, C., & Alves, J. (2007). Work stress and leadership development: The role of self-leadership, shared leadership, physical fitness and flow in managing demands and increasing job control. *Human Resource Management Review, 17*(4), 374-387.
- Luce, H. (1935). *The nervous breakdown*. Oxford: Doubleday Doran.
- Lundy-Ekman, L. (2013). *Neuroscience: Fundamentals for rehabilitation* (4th ed.). St Louis, MO: Elsevier Saunders.
- Lupton, D. (2012). *Medicine as culture: Illness, disease and the body* (3rd ed.). London: Sage.
- Lykes, M., Terre Blanche, M., & Hamber, B. (2003). Narrating survival and change in Guatemala and South Africa: The politics of representation and a liberatory community psychology. *American Journal of Community Psychology, 31*(1-2), 79-90.

- Malson, H. (1998). *The thin woman: Feminism, post structuralism and the social psychology of anorexia*. London: Routledge.
- McLeod, J. (2001). Developing a research tradition that is consistent with the practices and values of counselling and psychotherapy: Why Counselling and Psychotherapy Research is necessary. *Counselling and Psychotherapy Research*, 1(1), 3-11.
- McRobbie, A. (2007). Top girls? Young women and the post-feminist contract. *Cultural Studies*, 21(4-5), 718-737. doi: 10.1080/09502380701279044
- Micale, M., & Lerner, P. (Eds). (2001) *Traumatic pasts: History, psychiatry, and trauma in the modern age, 1870–1930* . Cambridge: Cambridge University Press.
- Micale, S. (2008). *Hysterical men: The hidden history of male nervous illness*. Cambridge, MA: Harvard University Press.
- Miles, M., & Huberman, A. (1994). *An expanded source book: Qualitative data analysis* (2nd ed.). London: Sage.
- Morrow, S. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist*, 35(2), 209-235.
- Musgrove, C. (1913). *Nervous breakdowns and how to avoid them*. New York, NY: Funk & Wagnalls Company.
- Nations, M., Camino, L., & Walker, F. (1988). ‘Nerves’: folk idiom for anxiety and depression? *Social Science and Medicine*, 26(12), 1245-1259.
- Neve, M. (2001). Public views of neurasthenia: Britain, 1880–1930. In M. Gijswit-Hofstra & R. Porter (Eds.), *Cultures of Neurasthenia from Beard to the First World War* (pp. 141-160). Amsterdam: Rodopi.
- Noakes, T. (2001). *The lore of running* (4th ed.). Cape Town: Oxford University Press.
- O’Connor, T., Moynihan, J., & Caserta, M. (2014). Annual research review: The neuroinflammation hypothesis for stress and psychopathology in children – Developmental psychoneuroimmunology. *Journal of Child Psychology and Psychiatry*, 55(6), 615-631.
- O’Toole, D., Grossman, A., Gross, D., Fave, G., Barkmanova, J., O’Connor, J., ... Plöckinger, U. (2009). ENETS consensus guidelines for the care of neuroendocrine tumors: Biochemical markers. *Neuroendocrinology*, 90(2), 194-202.

- Odgen, J. (2012). *Health psychology: A textbook* (5th ed.). Maidenhead: Open University Press.
- Odgen, J. (2012). *Health psychology: A textbook* (5th ed.). Maidenhead: Open University Press.
- Ogden, J. (2002). *Health and the construction of the individual*. Hove: Routledge.
- Ogden, J. (2002). *Health and the construction of the individual*. Hove: Routledge.
- Oginska-Pulik, N. (2005). Emotional intelligence in the workplace: Exploring its effect on occupational stress and health outcomes for human service workers. *International Journal of Occupational Medicine and Environmental Health*, 18(2), 167-175.
- Olsson, M., Egelund, T., & Høst, A. (2012). Breakdown of teenage placements in Danish out-of-home care. *Child & Family Social Work*, 17(1), 13-22.
- Omark, R. (1980). Nervous breakdown as a folk illness. *Psychological Reports*, 47(3), 862.
- Oppenheim, J. (1991). "Shattered nerves": Doctors, patients, and depression in Victorian England. Oxford: Oxford University Press.
- Orgad, S. (2009). The survivor in contemporary culture and discourse: A genealogy. *The Communication Review*, 12(2), 132-161.
- Parker, I. (1989). *The crisis in modern social psychology and how to end it*. London: Routledge.
- Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. London: Routledge.
- Parker, I. (1997). *Psychoanalytic culture: Psychoanalytic discourse in western society*. London: Sage.
- Parker, I. (1998). Constructing and deconstructing psychotherapeutic discourse. *The European Journal of Psychotherapy, Counselling and Health*, 1(1), 65-78.
- Parker, I. (1999a). Against relativism in psychology on balance. *History of the Human Sciences*, 12(4), 61-78.
- Parker, I. (1999b). Critical psychology: Critical links. *Annual review of Critical Psychology*, 1(1), 3-18.
- Parker, I. (1999c). Deconstructing diagnosis: Psychopathological practice. In C. Feltham (Ed.), *Controversies in psychotherapy and counselling* (pp. 104-112). London: Sage.

- Parker, I. (2011). Discursive social psychology now. *British Journal of Social Psychology*, 51(3), 471-477.
- Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing psychopathology*. London: Sage.
- Parsons, T. (2001). *The social system*. Abingdon: Routledge. (Original work published 1951)
- Patkin, T. (2011, December 2). 15 things I learnt from my nervous breakdown (and how they can start helping you live your best life now. *The Huffington Post*. Retrieved from http://www.huffingtonpost.com/todd-patkin/nervous-breakdown_b_1117215.html
- Patton, M. (1990). *Qualitative evaluation and research methods*. London: Sage.
- Pilgrim, D., & Rogers, A. (1999). *A sociology of mental health and illness*. Buckingham: Open University Press.
- Potter, J. (2011). Discursive psychology and the study of natural occurring talk. In D. Silverman (Ed.), *Qualitative research* (3rd ed., pp. 187-207). London: Sage.
- Potter, J. (2012a). Discourse analysis and discursive psychology. In Cooper, H. (Ed.), *APA handbook of research methods in psychology: Vol. 2. Quantitative, qualitative, neuropsychological and biological* (pp. 111-130). Washington: American Psychological Association Press.
- Potter, J. (2012b). Re-reading discourse and social psychology: Transforming social psychology. *British Journal of Social Psychology*, 51(3), 436-455.
- Potter, J., & Hepburn, A. (2012). Eight challenges for interview researchers. In A. Marvasti, J. Holstein, J. Gubrium & K. McKinney (Eds.), *The Sage handbook of interview research* (2nd ed., pp. 555-570). London: Sage.
- Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.
- Potter, J., Wetherell, M., Gill, R., & Edwards, D. (1990). Discourse: Noun, verb or social practice? *Philosophical Psychology*, 3(2 & 3), pp.205-217.
- Pryse-Phillips, W. (2009). *Companion to clinical neurology*. Oxford: Oxford University Press.
- Purdie, K., & McLennan, J. (1993). 'After my breakdown:' Implications for counsellors of accounts of change in self-understanding during recovery. *Counselling Psychology Quarterly*, 6(1), 17-26.

- Rapport, L., Todd, M., Lumley, A., & Fisicaro, S. (1998). The diagnostic meaning of 'nervous breakdown' among lay populations. *Journal of Personality Assessment*, 71(2), 242-252.
- Reason, P., & Rowan, J. (1981). *Human inquiry: A sourcebook of new paradigm research*. Chichester: John Wiley.
- Rennie, D. (1994). Human science and counselling psychology: Closing the gap between research and practice. *Counselling Psychology Quarterly*, 7(3), 235-250.
- Rimke, H. (2000). Governing citizens through self-help literature. *Cultural Studies*, 14(1), 61-78.
- Rose, N. (1985). *Psychological complex: Psychology, politics and society in England, 1869-1939*. London: Routledge & Kegan Paul.
- Rose, N. (1985). *The psychological complex: Psychology, politics and power in England 1869-1939*. London: Routledge & Kegan Paul.
- Rose, N. (1998). *Inventing our selves: Psychology, power and personhood*. Cambridge: Cambridge University Press.
- Rose, N. (1998). *Inventing ourselves: Psychology, power and personhood*. Cambridge: Cambridge University Press.
- Rosenhan, D. (1973). On being sane in insane places. *Science*, 179(4070), 250-258.
- Russett, C. (1989). *Sexual science: The Victorian construction of womanhood*. Cambridge, MA: Harvard University Press.
- Sadler, J. (2004). Diagnosis/antidiagnosis. In J. Radden (Ed.), *The philosophy of psychiatry: A companion*(pp. 163-179). Oxford: Oxford University Press.
- Salmán, E., Carrasco, J., Liebowitz, M., Díaz Marsá, M., Prieto, R., Jusino, C., Cárdenas, D., & Klein, D. (1997). "Ataques de nervios" (nervous breakdown): A study of its diagnostic characteristics. *Actas Españolas de Psiquiatría*, 25(5), 285-289.
- Schuster, D. (2011). *Neurasthenic nation: America's search for happiness, health and comfort 1869-1920*. New Brunswick, NJ: Rutgers University Press.
- Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (3rd ed.). New York, NY: Teachers College Press.
- Selye, H. (1956). *The stress of life*. New York, NY: McGraw-Hill.

- Sharma, H. (2005). Selective neuronal vulnerability, blood-brain barrier disruption and heat-shock protein expression in heat induced neurodegeneration. In S. Sarbadhikari (Ed.), *Depression and dementia: Progress in brain research, clinical applications and future trends* (pp. 97-152). Hauppauge, NY: Nova Biomedical Books.
- Sharma, R. (1997). *The monk who sold his Ferrari*. San Francisco, CA: Harper Collins.
- Shaw, C. (2007). "You had a daughter but I am becoming a woman": Sexuality, feminism and postcoloniality in Tsitsi Dangarembga's *Nervous Conditions* and *She No Longer Weeps*. *Research in African Literatures*, 38(4), 7-27.
- Shaw, C., & Procter, G. (2005). I. Women at the margins: A critique of the diagnosis of borderline personality disorder. *Feminism Psychology*, 14(4), 483-490.
- Shillito-Clarke, C. (2010). Ethical issues in counselling psychology. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of counselling psychology* (3rd ed., pp. 507-528). London: Sage.
- Shorter, E. (1997). *A history of psychiatry: From the era of the asylum to the age of Prozac*. New York, NY: John Wiley & Sons.
- Shorter, E. (2009). *Before Prozac: The troubled history of mood disorders in psychiatry*. New York, NY: Oxford University Press.
- Shorter, E. (2013). *How everyone became depressed: The rise and fall of the nervous breakdown*. New York, NY: Oxford University Press.
- Shotter, J. (1993). *Conversational realities: Constructing life through language*. London: Sage.
- Shotter, J. (1993). *Conversational realities: Constructing life through language*. London: Sage.
- Silver, N. (2011, February 12). The economics of blogging and the Huffington Post. *The New York Times*. Retrieved from http://fivethirtyeight.blogs.nytimes.com/2011/02/12/the-economics-of-blogging-and-the-huffington-post/?_php=true&_type=blogs&_r=0
- Silverstone, R. (2002). Regulation, media literacy and media civics. In A. Zerdick, A. Picot, K. Schrape, J. Burgelman, R. Silverstone & V. Feldman (Eds.), *Emerging media: Communication and the media economy of the future* (pp. 376-380). (R. Glasgow Trans.). Berlin: Springer.
- Sims-Schouten, W., Riley, S., & Willig, C. (2007). Critical realism in discourse analysis: A presentation of a systematic form of analysis using women's talk

of motherhood, childcare and female employment as an example. *Theory & Psychology*, 17(1), 101-124.

Smith, J., Harré, R., & Van Langenhove, L. (1995). Introduction. In J. Smith, R., Harré, & L. Van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 1-8). London: Sage.

Smith, R., Betancourt, L., & Sun, Y. (2005). Molecular endocrinology and the physiology of the ageing central nervous system. *Endocrine Reviews*, 26(2), 203-250.

Snyder, C., Pulvers, K. (2001). Dr Seuss, the coping machine and “Oh the places you’ll go.” In C. Snyder (Ed.), *Coping with stress: Successful people and processes* (pp. 3-29). Oxford: Oxford University Press.

Sorisio, C. (1997). A tale of two feminisms: Power and victimization in the contemporary feminist debate. In L. Heywood & J. Drake (Eds.), *Third wave agenda: Being feminist, doing feminism* (pp. 134-154). Minneapolis, MN: University of Minnesota Press.

Speed, E. (2006). Patients, consumers and survivors: A case study of mental health service user discourses. *Social Science & Medicine*, 62(1), 28–38.

Speed, E. (2006). Patients, consumers and survivors: a case study of mental health service user discourses. *Social Science & Medicine*, 62, pp. 28–38.

Stewart, W.A. (2014). *Psychoanalysis: The first ten years 1888-1898*. Hove: Routledge. (Original work published 1967).

Steyn, M. (2001). “Whiteness isn’t what it used to be”: *White identity in a changing South Africa*. New York: NY: State University of New York Press.

Sugarman, A. (2007). Whatever happened to neurosis? Who are we analyzing and how?: The importance of mental organization. *Psychoanalytic Psychology*, 24(3), 409-428.

Sutcliffe, S. (1993). *Children of the new age*. London: Routledge.

Swindle, R., Heller, K., Pescosolido, B., & Kikuzawa, S. (2000). Responses to nervous breakdowns in Americans over a forty year period: mental health policy implications. *American Psychologist*, 55(7), 740-749.

Synnott, A. (1992). Tomb, temple, machine and the self: The social construction of the body. *The British Journal of Sociology*, 43(1), 79-110.

Taylor, S. (2001). Locating and conducting discourse analytic research. In M. Wetherell, S. Taylor, & S. Yates (Eds.), *Discourse as data: A guide for analysis* (pp. 5-48). London: Sage.

- Teo, T. (2010). What is epistemological violence in the social sciences? *Social & Personality Psychology Compass*, 4(5), 295-303.
- Thompson, R. (2004). Trauma and the rhetoric of recovery: A discourse analysis of the virtual healing journal of childhood sexual abuse. *JAC*, 24(3), 653-677.
- Thraikill, J. (2010). Railway spine, nervous excess and the forensic self. In L. Salisbury and D. Shail (Eds.), *Neurology and modernity: A cultural history of nervous systems 1800-1950* (pp. 96-112). Basingstoke: Palgrave MacMillan.
- Tooth, G. (1944). Nervous breakdown in the navy: Domestic difficulties as a causal factor. *British Medical Journal*, 1, 358-360. doi: 10.1136/bmj.1.4340.358
- Tracy, S. (2013). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. Chichester: Wiley Blackwell.
- Van Dijk, T. (1997). The study of discourse. In T. Van Dijk (Ed.), *Discourse as structure and process* (pp. 1-34). London: Sage.
- Vanltallie, T. (2002). Stress: a risk factor for serious illness. *Metabolism*, 51(6), 40-45.
- Viner, R. (1999). Putting stress in life: Hans Selye and the making of stress theory. *Social Studies of Science*, 29(3), 391-410.
- Viner, R. (1999). Putting stress into life: Hans Selye and the making of stress theory. *Social Studies of Science*, 29(3), 391-410.
- Waites, M. (2005). *The age of consent: Young people, sexuality and citizenship*. Basingstoke: Palgrave MacMillan.
- Wessely, S. (1991). History of postviral fatigue syndrome. *British Medical Bulletin*, 47(4), 919-941.
- Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse and Society*, 9(3), 387-412.
- Wetherell, M., & Edley, N. (1998). Gender practices: Steps in the analysis of men and masculinities. In K. Henwood, C. Griffin & A. Phoenix (Eds.), *Standpoints and differences: Essays in the practice of feminist psychology* (pp. 156-173). London: Sage.
- Wetherell, M., & Edley, N. (1999). Negotiating hegemonic masculinity: Imaginary positions and psycho-discursive practices. *Feminism and Psychology*, 9(3), 335-356.
- Wetherell, M., & Edley, N. (2009). Masculinity manoeuvres: Critical discourse psychology and the analysis of identity strategies. In N. Coupland & A.

- Jaworski (Eds.), *The New Sociolinguistics Reader* (pp. 201–214). Basingstoke: Palgrave Macmillan.
- Wetherell, M., & Potter, J. (1992). *Mapping the language of racism: Discourse and the legitimation of exploitation*. London: Harvester Wheatsheaf.
- Wiggins, S., & Potter, J. (2008). Discursive psychology. In C. Willig & W. Hollway (Eds.), *Handbook of qualitative research in psychology* (pp. 72-89). London: Sage.
- Wilkinson, S., & Kitzinger, C. (1994). The social construction of heterosexuality. *Journal of Gender Studies*, 3(3), 307-316.
- Willig, C. (1998). Social constructionism and revolutionary socialism: A contradiction in terms? In I. Parker (Ed.), *Social constructionism, discourse and realism* (pp. 91-104). London: Sage.
- Willig, C. (2012). *Qualitative interpretation and analysis in psychology*. Maidenhead: Open University Press.
- Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Maidenhead: Open University Press.
- Wilson, A., & Beresford, P. (2002). Madness, distress and postmodernity: Putting the record straight. In M. Corker & T. Shakespeare (Eds.), *Disability/postmodernity: Embodying disability theory* (pp. 143-158). London: Continuum.
- Wirth-Cauchon, J. (2001). *Women and borderline personality disorder: Symptoms and stories*. New Brunswick, NJ: Rutgers University Press.
- Wolf, N. (1991). *The beauty myth: How images of beauty are used against women*. London: Vintage.
- Wolfe, W.B. (1933). *Nervous breakdown: Its cause and cure*. Oxford: Farrar & Rinehart.
- Yang, L., Cho, S., & Kleinman, A. (2010). The stigma of mental illness. In V. Patel, A. Woodward, V. Feigin, H. Heggenhougen & S. Quah (Eds.), *Mental and neurological public health: A global perspective*. San Diego, CA: Academic Press.
- Ying, Y., & Miller, L. (1992). Help-seeking behaviour and attitude of Chinese Americans regarding psychological problems. *American Journal of Community Psychology*, 20(4), 549-556.
- Young, J. (2004). Illness behaviour: A selective review and synthesis. *Sociology of Health and Illness*, 26(1), 1-31.

Zweifel, T., & Raskin, A. (2008). *The rabbi and the CEO: The ten commandments for 21st century leaders*. New York, NY: Select Books.

6. Appendices

Appendix A1 – Table of articles used in media analysis

1.	Angelova, K. (2013, November 13). The impossible choice that had Elon Musk on the verge of a nervous breakdown. Business Insider. Retrieved from http://www.businessinsider.com/elon-musk-tesla-spacex-near-fail-2013-11
2.	Beck, M. (2012, February 28). Time for a good old fashioned nervous breakdown? Wall Street Journal. Retrieved from http://online.wsj.com/news/articles/SB10001424052970204653604577249262618835188
3.	Burnett, D. (2013, April 24). A breakdown of nervous breakdowns. The Guardian. Retrieved from http://www.theguardian.com/science/brain-flapping/2013/apr/24/breakdown-nervous-breakdowns
4.	Casserly, M. (2011, April 11). Are you headed for a nervous breakdown? Forbes. Retrieved from http://www.forbes.com/sites/meghancasserly/2011/04/11/headed-for-a-mental-breakdown-charlie-sheen/
5.	Eurich, T. (2013, December 13). 3 Tricks to prevent a nervous breakdown at work this month. The Huffington Post. Retrieved from http://www.huffingtonpost.com/tasha-eurich-phd/stress-and-anxiety_b_4415956.html
6.	Evans, R. (2012, June 27). Europe on the verge of a nervous breakdown. New Statesman. Retrieved from http://www.newstatesman.com/world-affairs/world-

	affairs/2012/06/europe-verge-nervous-breakdown
7.	Gardiner, N. (2010, October 10). A presidency on the verge of a nervous breakdown: 5 key reasons why Barack Obama's future looks increasingly bleak. The Telegraph. Retrieved from http://blogs.telegraph.co.uk/news/nilegardiner/100058278/a-presidency-on-the-verge-of-a-nervous-breakdown-5-key-reasons-why-barack-obama%E2%80%99s-future-looks-increasingly-bleak/
8.	Hicks, C. (2012, March 12). Mark Rice-Oxley: How I survived a nervous breakdown. The Telegraph. Retrieved from http://www.telegraph.co.uk/men/active/mens-health/9133828/Mark-Rice-Oxley-How-I-survived-a-nervous-breakdown.html
9.	Kenny, U. (2000, September 10). Nervous breakdown. The Guardian. Retrieved from http://www.theguardian.com/theobserver/2000/sep/10/features.magazine37
10.	Lebanon is 'a nation on the verge of a nervous breakdown.' (2012, November 3). The Daily Star. Retrieved from http://www.dailystar.com.lb/Culture/Lifestyle/2012/Nov-03/193693-lebanon-is-a-nation-on-the-verge-of-a-nervous-breakdown.ashx#axzz35q5fCkZe
11.	Naish, J. (2013, October 15). Why the return of the 'nervous breakdown' could be a good thing! The Daily Mail. Retrieved from http://www.dailymail.co.uk/health/article-2459935/Why-return-nervous-breakdown-GOOD-thing.html
12.	On the verge of a nervous breakdown? (2007, March 22). The Mirror. Retrieved from http://www.mirror.co.uk/news/real-life-stories/on-the-verge-of-a-nervous-breakdown-460489

13.	Pattinson on the verge of nervous breakdown. (2010, August 6). Indian Express. Retrieved from http://archive.indianexpress.com/news/pattinson-on-the-verge-of-nervous-breakdown/656831/
14.	Paul McCartney says wife Linda saved him from nervous breakdown during Beatles split (2013, September 2). NME. Retrieved from http://www.nme.com/news/paul-mccartney/72404
15.	Quigley, R. (2011, September 28). Casey Anthony is ‘on the verge of a nervous breakdown and could end up in a psychiatric ward.’ The Daily Mail. Retrieved from http://www.dailymail.co.uk/news/article-2043001/Casey-Anthony-verge-nervous-breakdown-end-psychiatric-ward.html
16.	Singh, A. (2012, October, 31). Kate Moss: I suffered a nervous breakdown at 17. The Telegraph. Retrieved from http://fashion.telegraph.co.uk/article/TMG9643886/Kate-Moss-I-suffered-a-nervous-breakdown-at-17.html
17.	Thapoung, K. (2013, September, 26). Are you heading for a nervous breakdown? Spot the signs before you crash and burn. Women’s Health. Retrieved from http://www.womenshealthmag.com/life/are-you-heading-for-a-nervous-breakdown
18.	Walker, T. (2013, September 22). Oprah Winfrey admits to having a nervous breakdown last year. The Independent. Retrieved from http://www.independent.co.uk/news/world/americas/oprah-winfrey-admits-to-having-nervous-breakdown-last-year-8833066.html
19.	Woman kills her mother after suffering nervous breakdown due to bitter break up. (2014, January 15). Retrieved from http://www.dailystar.co.uk/news/latest-

	news/360657/Emma-Parr-strangles-mother-Carol-after-suffering-nervous-breakdown
20.	Zaretsky, R. (2013, February 1). France on the verge of a nervous breakdown. Foreign Policy. Retrieved from http://www.foreignpolicy.com/articles/2013/02/01/france_on_the_verge_of_a_nervous_breakdown

Appendix A2 – Sample transcription of media article

Note: transcriptions have been reformatted for ease of reading. The line numbering is consistent with that used in the thesis, but may differ from the original sources.

Kenny, U. (2000, September 10). Nervous breakdown. *The Guardian*.

1 According to Mental Health Foundation figures, one in 20 of us is likely to suffer from
2 'clinical' depression - that is, serious depression, a disabling disorder including breakdown. At
3 one level, 'breakdown' is one of those words that operates as shorthand; many of us routinely
4 refer to being on the verge of a breakdown when we want to convey just how put upon,
5 stressed and pressurised we are, without really meaning it at all.

6 At a deeper level, though, a nervous breakdown is generally understood to describe a crisis
7 situation; when someone has reached rock bottom and 'broken', in as much as they have
8 ceased to function in a normal way. The details are more difficult - how a breakdown
9 happens, why, and who it is likely to happen to are harder to pin down.

10 There is no textbook experience, as Dr David Bell, consultant psychiatrist and psychotherapist
11 at the Tavistock Centre, confirms. 'Breakdown is a general term that people use to describe a
12 very, very wide variety of experiences.' Still, he feels it is an 'appropriate' word. 'It captures
13 something of the experience,' he says. Despite the fact that, as Dr Massimo Riccio, consultant
14 psychiatrist and medical director of The Priory in Roehampton, points out: 'There isn't really
15 any such thing in medical terms - saying someone has had a breakdown means everything and
16 nothing, and we need a lot more information to fine-tune a diagnosis and make it manageable.'

17 Nevertheless, it is a helpful description for the layman. According to a study earlier this year,
18 more than a quarter of Americans (26 per cent) say they have felt on the verge of a mental
19 breakdown (relationship problems and being a single parent were most often cited as the
20 cause). The study, by a psychologist at Indiana University, represents an increase of 7 per cent
21 since the last similar study 40 years ago, which may not mean that any more of us are
22 suffering from major depressive episodes, just that more of us are willing to admit it's a
23 possibility. Whatever 'it' is.

Appendix B – Recruitment

1. Email of introduction to the study for prospective participants

Have you experienced a nervous breakdown in the past?

If so, would you willing to talk about it as part of a psychological research project?

If you are 18 years or older, live in/are able to easily access the London area, and feel comfortable talking about your experience in a short interview please contact Natalie Le Clézio <emailaddress>.

2. Initial email of response to participants

Dear <name>

Thank you for your interest in taking part in this research project. So that we can discuss the details of the project, please could you email me your telephone number and a time and day that would be suitable for me to phone you.

Warm wishes

Natalie

3. Information to be shared with participants on telephone call and re-iterated at start of interview

I am conducting research looking at the experiences of people who have had nervous breakdowns. There hasn't been a great deal of research done that looks at this and particularly from the perspective of those people who have experienced a nervous breakdown, yet it seems that more and more people are identifying with this experience. A better understanding of how people make sense of their own experiences of nervous breakdowns would be really helpful in informing not only the work of those in the mental health professions, but also the public understanding of the experience.

Appendix C – Interview schedule

- Introduction, informed consent, review confidentiality, and begin recording. Explain parameters: ninety minute interview about their experience of nervous breakdown for research aimed to understand this better.
- Probe why the participant chose to speak about this in this space? “What made you decide to participate in this research?” (Aimed to ease the participant in to the interview and also explore motives for the telling of the experience).
- “Can you tell me a bit about when you had your nervous breakdown? When did it happen?” Follow up with questions of how it unfolded, what happened, key actors, institutions, motives etc. (Expect this to form a large part of the interview).
- “What made you decide that what happened to you was a nervous breakdown down?” (Exploring choice of term, use of term).
- “Do you know where you first heard the term?” Follow up with prompts as to what he/she associates with the term, and possibly linking it to cultural texts/institutions.
- “What do you think of the term nervous breakdown? Does it explain what you went through?” Follow up with other prompts to see if the participant has alternative explanations. (Again to explore choice of discourse and possible alternatives).
- “How do you think your nervous breakdown was perceived by the medical or psychological community?” (Probing the gap in the use and credibility of the term).
- “How do/does your community understand or react to the fact you have had a nervous breakdown?” (Exploring the participant’s relationships and positioning(s) in discourse by other actors or institutions in his/her life).
- “How do you feel about telling this story of nervous breakdown now? How has it been for you?” (Exploring the process of the telling, the interview and our interaction. This will provide rich material for reflexive interpretation and also begins to draw the interview to a close).
- Thank you, debrief and ending.

Appendix D – Informed consent form

I understand the content and procedure of this study as explained to me by the researcher. I also understand that I am free to leave this study at any time, should I wish to. I agree for this interview to be recorded and for the transcript to be used as part of the research. I understand that my data will be treated as confidential and anonymous.

I hereby agree to participate in this study.

Name:
Date:

Signature:

Appendix E – Debrief resource

Thank you for participating in this study. Sometimes, issues that get raised in such research can be difficult, or arouse one's curiosity to explore further. This is a broad list of resources that might be helpful to you if you feel you require further support. These are resources that can be accessed at all times, not only at times of crisis.

- Your GP. He/she acts as a care co-ordinator for both health and mental health needs.
- MIND – a UK based organisation that provides support for people who have mental health concerns or difficulties for no or minimal cost <http://www.mind.org.uk> (website); 0300 123 3393 (Info line)
- SANEline - a national out-of-hours telephone helpline offering emotional support and information for people affected by mental health problems http://www.sane.org.uk/what_we_do/support/helpline/ (website); 0845 767 8000 (phone line open from 6pm to 11pm)
- Samaritans – a 24 hour source of support via phone, email, letter or face-to-face <http://www.samaritans.org/> (website); 08457 90 90 90
- If you're interested in longer term therapy, the best place to begin to look is at the British Psychological Society's register of chartered psychologists: <http://www.bps.org.uk/psychology-public/find-psychologist/find-psychologist> (website)

Appendix F – Ethical approval

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc M.Phil M.Sc D.Psych n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

What exactly is a nervous breakdown? Exploring popular constructions of "falling apart."

2. Name of student researcher (please include contact address and telephone number)

Natalie Le Clezio

3. Name of research supervisor

Prof. Carla Willig

4. Is a research proposal appended to this ethics release form? **Yes** **No**

5. Does the research involve the use of human subjects/participants? **Yes** **No**

If yes,

a. Approximately how many are planned to be involved?

8-10 (interviews)
Additional 10 if a
focus groups is

b. How will you recruit them?

Advertisements will be posted on internet forums, websites and social media sites where people are engaging in conversations about nervous breakdowns, and about experiences of mental health difficulties. Potential participants will be those who self-identify with the experience of nervous breakdown and would be willing to talk about it for the purposes of psychological research. They be provided with the core recruitment criteria and asked to email a given email address (see appended advertisement and recruitment criteria below).

However, should I not be able to recruit enough participants through this method, I would consider using my own social media networks to recruit participants. The same advertisement will be used. This in fact, might allow for my participation in the research to be safer, as participants recruited in this way might be more "known" to me.

c. What are your recruitment criteria?

(Please append your recruitment material/advertisement/flyer)

- Men or women over the age of 18;
- Who self-identify with the experience of a nervous breakdown in their pasts;
- Who are willing to talk about the experience as part of a psychological research project;
- Live within/able to travel to the London area.

As discussed in the proposal, criteria for participants have been deliberately kept as open as possible as very little is known about the potential demographics of potential participants and also because self-identification with the construct of "nervous breakdown" is the most crucial aspect for the research. However, aspects of risk both for participants and for me as researcher need to be carefully considered, as the idea of nervous breakdown might imply some kind of psychological or emotional difficulty. As such, the additional criterion of the breakdown being situated "in the past" has been included. Moreover, once the potential participants have made contact via email, they will be sensitively screened for potential risk (see 7c for more detail) and possibly excluded from the study as sensitively as possible should their current psychological and emotional vulnerability be deemed too high for it to be safe enough for them to participate in the study. If this is the case, they will be given information on resources where psychological help could be accessed should they feel they might need it.

d. Will the research involve the participation of minors (under 18 years of age) or

vulnerable adults or those unable to give informed consent? **Yes** **No**

d1. If yes, will signed parental/carer consent be obtained? **Yes** **No**

d2. If yes, has a CRB check been obtained? **Yes** **No**

(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

Each participant will be asked to participate in a one-on-one interview with me, exploring their constructions of their experiences of nervous breakdown (see appendix for guide to interview questions).

The interviews will last up to 90 minutes. Informed consent will be obtained before the start as will permission to tape record the interviews (attached in appended documents). Participants will be asked to travel to and from the interview location, which I will specify so as to ensure that the location allows for me to be as safe as possible, given that I will be meeting with people unknown to me (and vice versa for participants).

7. Is there any risk of physical or psychological harm to the subjects/participants? Yes No

If yes,

a. Please detail the possible harm?

There is no physical risk that is presented through participation in the research. However, the idea of nervous breakdown might imply an experience of psychological and emotional difficulty. As such, while potential participants will be screened by me for risk and current vulnerability, it is possible that the re-telling of such an experience might evoke difficult or painful feelings for participants. Given that this is a research enterprise and not a therapeutic one, such feelings cannot be addressed or necessarily contained within the research interview.

b. How can this be justified?

Without conducting interviews this research would not be able to be carried out. Since it aims to understand "nervous breakdown" as a popular construction, it is necessary to access popular discourse. Interviews with those who self-identify with the term are crucial in allowing such discourses to meet and challenge the more institutionalised psy-discourses. Without such critical enterprise, the skewed power dynamic between institution and "patient" remains unchallenged.

Furthermore, there is a fair amount of evidence that suggests that the opportunity tell one's story, such as holds benefit for the teller. See reference to Frith & Kitzinger (1998) in the proposal for more on this. Moreover, given that the interviews are designed to be exploratory in nature, with open-ended questions, and flexibility for the participants to lead the process, the experience thus allows the participants are fair amount of control over the interview experience, over what and how to speak and also how much they may wish to explore or reveal.

c. What precautions are you taking to address the risks posed?

All potential participants will be responding to an advertisement that acts as an invitation: they will be in way coerced. Furthermore, one of the recruitment criteria is that the "nervous breakdown" has happened in the past and is not current or ongoing. After responding to the advertisement, all participants will be asked to complete a risk assessment questionnaire (attached in appendix) and based on this, either invited to participate in the study, or sensitively excluded from the study, and emailed a debrief sheet of psychological resources that might be helpful to them (see appendix). For those who participate, they will do so under informed consent, and part of that is that they be able to stop the interview at any time and exit the process. After the interview, there will be a debrief question assessing the current emotional state of the participant and all participants will be given the appended debrief sheet of psychological help lines and resources that they might access should they feel the need.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as

Yes No

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes No

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

I will be tape recording the interviews on a digital recorder (with informed consent) and typing up verbatim transcriptions thereof. I will also be keeping field notes in diaries and on my computer. There will also be records of their details in email correspondence.

12. What provision will there be for the safe-keeping of these records?

All diaries and long-hand notes will not contain any detail that may allow for participants to be identified by a third party. They will be stored in a locked drawer in my desk. All digital recordings will be kept on my computer in a password protected file, and erased from the recorder once downloaded. Again, no directly identifying detail will be attached to the recordings. Transcripts will be kept in a separate file to recordings, also password protected. Finally, the email account I shall set up for correspondence will also be password protected.

13. What will happen to the records at the end of the project?

All recordings will be destroyed at the end of the project. I shall keep field notes and transcripts after the end of the research, as they may inform further research. However, as emphasised above, all identifying detail in these shall be omitted or changed to protect the anonymity of the participants, and they shall all be stored in a locked drawer. If they are not used within two years after the end of the research to inform further work, I shall destroy these notes and transcripts. I shall keep the email addresses of participants for a year after the research in the event that I wish to share a summary of the findings with them. Thereafter, I shall delete the relevant email account.

14. How will you protect the anonymity of the subjects/participants?

This has been partly addressed above. However, all identifying detail shall be anonymised or omitted in all records and write-ups, including the final dissertation. Records shall be kept in separate password protected files and locked drawers so that they cannot be cross-referenced by third parties. I shall be aware of this throughout the research, even when describing the recruitment process. On a more practical level, all interviews will occur in a private room, in a neutral location.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

After the interviews, I shall check in with participants to see how they are feeling. However, given that the interviews are for research and not therapeutic in nature, this will have to be managed in such a way that these boundaries are not blurred. In *all* interviews regardless of how "fine" participants might report feeling, I shall pass on a debrief sheet which will contain the details of psychological support resources that they can make use of, both for immediate crisis, and also should the interviews have raised their interest in exploring these narratives further. I have ensured in the list of resources that a range of resources is supplied.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher [REDACTED]

Date [REDACTED]

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal [REDACTED]
Recruitment Material
Information Sheet
Consent Form
De-brief Information

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? Yes No
If yes,

a. Please detail possible harm?

There are few risks that I can foresee. However, it is worth mentioning that I shall be meeting one-on-one with strangers and opening up a dialogue with them. There is very little way I can be absolutely sure of my own safety in the encounter. Moreover, I am not sure of the nature of the content that participants' may bring. Some it may prove traumatic, or difficult for me to process.

b. How can this be justified?

Without opening myself up to these possible risks, it would be impossible to conduct the research. Moreover, these risks are able to be managed throughout the process of the research.

c. What precautions are to be taken to address the risks posed?

The recruitment process is crucial in ensuring the mutual safety of me and the participants. Firstly, all participants shall be screened for risk and part of this will cover any previous history of violence towards others, and also assess for the nature of current psychological vulnerability. Potential participants will be discussed in supervision. Moreover, all interviews will occur in a space which I will choose, where my supervisor and colleagues will be aware of where I am, what I am doing and the time-frame of the interview. I will keep a mobile phone with me for safety. Furthermore, I will refrain from giving the participants my personal details aside from a telephone number and the research email address.

As I have specified in the proposal, however, if recruitment procedures in public forums and websites seem too risky at the time, I shall, in consultation with my supervisor, opt for more purposive, snowball recruitment methods, whereby participants are more likely to be within communities known to me and thus perhaps decrease risk to me in the interview encounter and the exchanges surrounding it.

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature -----

Date -----

Section D: To be completed by the 2nd Departmental staff member

(Please read this ethics release form fully and pay particular attention to any answers on the form where underlined bold items have been circled and any relevant appendices.)

I agree with the decision of the research supervisor as indicated above

Signature -----

Date -----

Appendix G – Sample interview transcription

Transcription formatting

(.)	micro pause
((pause))	longer pause
(inaudible)	
(other vocal actions)	
[]	overlapping.interruption speech from other speaker
—	interrupted speech
(?)	unsure if correct word
<u>underline</u>	emphasized word
[...]	Omitted speech
N:	Natalie
P(number):	participant

222 P5: Mmm. Er I think yeah, I think that would've been (.) y'know once I'd physically
223 healed from the abortion that I had (.) and:: (.) y'know once (.) y'know I suppose I just
224 after that I just really struggled to pull things back together again [mmm] and I felt
225 different. I felt like terminally wounded.

226

227 N: Mmm [and (inaudible)] like something wasn't quite the same

228

229 P5: Yeah yeah this kind of fear that would be (.) keeping me from (.) yeah from
230 engaging I think (.) that really kicked in then.

231

232 N: Mmm. When do you think you stopped and thought actually there's something going
233 on here?

234

235 P5: Round about yeah round about then round about May last year.

236

237 N: And and did you think at the time that it might be a nervous breakdown or did you
238 have other ways of understanding it?

239

240 P5: I just, I think, y'know it felt like I kind of, like my paradigm had shifted and that (.)
241 y'know the fight or y'know the (.) the gusto that I used to have in me the y'know the
242 audacity(?) that used to that I used to have or the force of (inaudible) had just
243 disappeared completely, and it's just that (inaudible) this is the longest I think I've
244 known I've (inaudible) cold(?) about something (inaudible) or sad about something
245 'cause the sadness pervaded everything and it didn't really (.) lift it kind of stuck with
246 me [mm] all that time.

Part B – Critical literature review

The immigrant, immigration and mental health care: A critical literature review

1. Introduction

This paper will attempt to explore the challenges that counselling psychology and psychologists face when working with clients who come from immigrant populations. More specifically, it will explore, firstly, why this is a salient question for us to be addressing at this time. Secondly, it will explore the difficulties in defining terms and experiences of immigration. Particularly, it will examine whether immigration is a subject that can be collapsed under the rubric of cross-cultural work or not, whether immigration is an experience that warrants scrutiny in and of itself, or whether it simply serves as a predisposing factor to categorically defined mental illness. The latter seems to be an assumption that runs throughout the current research and which warrants critical appraisal.

In exploring these debates, the tensions between theory and research that support context-bound pluralities and those that support universal human truths will be addressed. Finally, this paper will attempt to suggest that for counselling psychologists, it is a critical awareness of one's way of working, both in the room, and in the broader contextual framework of therapeutic intervention that might best address the complexities of working with immigrants, as opposed to either/or models or sets of assumptions.

2. Immigration: The current contexts

Immigration was a hot topic in the UK election of 2010. So much so, that apart from the recession and fiscal crisis, it was seen as one of the main problems that a majority of the populace wanted the new government to deal with (Carey & Geddes, 2010). In addition to this, the escalation of the complexities of the international discourse of

terror and terrorism since 9/11 has unquestionably impacted on the subject of the immigrant and his/her association with ideas of threat and safety (Huysmans & Buonofino, 2008). The UK has experienced an exponential spike in immigration over the last thirty years, particularly since the early 1990s (Manacorda, Manning & Wadsworth, 2012). This can be attributed largely to the expansion of multi-national corporations, the creation of the EU and other cross-national identities and agreements, and an increased political consciousness of and stake in a global human rights culture (Hansen, 2000; 2003). Augmented by the increasing polarities between developed and developing worlds, immigrants to the UK vary greatly in their provenance. They come from former colonies, the wider EU, and from war-torn regimes seeking refuge and asylum, among others (Castles & Miller, 2003; Morris, 1997; Panayi, 2010).

As such, working with immigrants is crucial for counselling psychologists to consider. Firstly, because immigrants and people who have experienced immigration are becoming increasingly prevalent in the client groups with whom we work and will work. Secondly, as will be explored later in this review, the current research suggests a higher prevalence of mental illness in immigrant populations than the norm. And thirdly, the same literature suggests that working with immigrant populations might be more challenging to mental health professionals and psychologists than working with a so-called native population as they are seen to foreground issues of difference in the counselling context and process (Conwill, 2010; O'Mahony & Donnelly, 2007). Moreover, counselling psychology is defined by the fluidity with which it moves between the rigorously clinical, the critical, the social and the individual. The hallmark of the discipline is its scope and flexibility in applied practice (Strawbridge & Woolfe, 2010). As such, its practitioners are likely to encounter the immigrant-client-subject in all manner of domains of practice and ideology, and are likely to face the reflexive discomfort of conflicting understandings of the immigrant and his/her mental health while still finding a way to work (Eleftheriadou, 2010).

Recently, owing in part to the recession and in part to the prevailing discourse of international terrorism, the British public have become more vocal in wanting to keep Britain for Britons and the government has taken stringent measures to cap immigration (Blinder, 2012). This is a tricky balancing act, in the wake of the policies and politics of multiculturalism that have been prevalent following the Brixton race riots of 1981 and on the back of global black consciousness, feminist, and human rights movements that gained voice and momentum from the late 1960s onwards, along with the disenfranchised voices of former colonies (Gilroy, 2004; Samson, 2001).

The current British literature on mental health care and immigrants reflects this tension in the socio-political context. It seeks largely epidemiological evidence of psychopathology: the counting of which immigrants suffer from which types of mental illness. The research suggests that immigrant populations in the UK, by DSM taxonomy, suffer from more mental health problems than the norm. Claassen, Ascoli, Berhe and Priebe (2005) provide an excellent meta-analysis of trends in recent research on immigrants and mental health in the UK and their results confirm these trends in the literature.

Other trends in the research on immigration and mental health reflect the aim to come to some sort of universal understanding of mental illness by attempting to subsume immigrant or more emic descriptions of difficulties under DSM diagnoses (e.g. Fearon et al., 2006; Jarvis, 2001; Kirov & Murray, 1999) . Some literature, however, seeks to address how we (positioned as psychologists within a westernised developed world framework) might work with people positioned as different (e.g. Hassiotis, 1996; Laungani, 2002). This reflects at least some critical awareness of differences in power and identity within a counselling and care context, but speaks very much from a stance of us and them. Indeed, the NHS's current stance towards treating mental illness reflects this conflict between overt embracing of a more inclusive, collaborative approach with service-users, while at the very same time, attempting to

standardise care and situate itself within evidence-based practice medical practice (Hewitt-Taylor, 2006).

The landscape of Australian, American and Canadian literature on mental healthcare and immigrants is quite different in tone. This reinforces the idea that research and mental health practice which it informs cannot be distinct from the socio-political climate in which it operates (Dineen, 2004; Foucault, 1965; Rose, 1985). For example, a great deal of literature from Canada and the USA focuses on the difficulties immigrant populations might face in a new country and how best these populations might be assisted to access appropriate care. A great deal of the work is qualitative and delves into the experiences of specific immigrant populations, largely those that are perceived to be very different from native populations.

Indeed, while the respective American, Australian and Canadian governments have fairly stringent immigration laws, the political climate seems to welcome immigrants as potential workers and revenue streams. Moreover, perhaps it is these countries' new world legacies that might lend themselves better to these different discourses of immigration or perhaps, in the case of the USA, it was the hotbed of 1970s black consciousness movements and perhaps ideas of advocacy for the marginalised are still very prevalent. This is not to suggest that the lived experience of immigrants in these countries is free from discrimination and alienation: quite the opposite as the detail of the research would suggest.

This paper will discuss a saturated sample of the most recent literature on immigration, mental health care and psychological practice. The broad trends in the literature will be outlined, but most attention will be paid to key debates, tensions and assumptions arising from the epistemologies and contexts in which the relevant papers are grounded as opposed to micro-analyses of the research process of each paper itself. This is more useful in informing a critical perspective and for thinking about areas for new research, and tensions and assumptions that we may bring to evidence-based counselling practice and the institutions in which this practice operates.

3. Immigration and mental health

All the research in the sample reviewed for this study indicates that immigrants are more at risk for mental illness than the norms for native populations. The research seems to explore this link in several different ways.

3.1. Diagnosing immigrants

The bulk of peer-reviewed research aims to quantitatively assess specific immigrant populations for psychopathology using specific DSM-IV taxonomy. It compares this assessment statistically to the normal distribution of specific diagnoses within the home or native population, generally with a purpose of describing epidemiology of mental illness among immigrants and in some cases, recommending suitable pathways to care and types of care. This is especially prevalent for diagnoses of depression, psychosis and incidences of suicide (e.g. Harrison, Glazebrook, Brewin, Canbrell & Dalkin, 1997; Hassen & Sardashti, 2000; Neeleman & Wessely, 1999).

This type of research is useful in informing policy (for how can one make decisions without having a topographical sense of what might be going on), in allowing for care to be consistent across client-groups which is a corner-stone of current NHS best-practice policy, and in informing practice that might best facilitate access to care for marginalised groups of immigrants who seem to be at higher risk for certain mental health difficulties. It might even inform preventative measures for these migrant groups. The language of hard science in which this research is grounded constitutes the hegemonic psycho-medical discourse at present. It is the language and epistemology currently most persuasive to governments, funding bodies, and arguably the general public as it offers an idea of scientific proof and truth which seems to prevail as the most persuasive type of communication in our current context (Kuhn, 1962).

As such, this trusted and shared language and epistemology of science is useful in achieving several things. Firstly, in allowing for comparisons across studies and populations, the possibility of generalizability and replicability of studies, and of facilitating communication between researchers and clinicians. Secondly, it offers the idea that by finding factors which seem to definitively contribute to increased immigrant psychopathology, one might find definitive treatments or solutions for these. For a profession that has moved to a premise of evidence-based practice, it offers such evidence for counselling practice constructed as best. Furthermore, from a political point of view it makes a convincing case not only for psychologists, but for government and other political bodies to pay attention to the difficulties immigrants seem to be facing by sheer weight of sample numbers and the extrapolations made from these.

However, the work rests on some problematic assumptions. Firstly, almost all research in this category fails to address who counts as an immigrant for the purposes of study and when it does, there is little consistency across studies. For example, Harrison et al. (1997) do not unpack the very obvious confounding variable of generational differences in the Caribbean migrants in their sample. There is arguably a great difference in the experiences of first and second generation immigrants, for example. This lack of consistent definition in who is an immigrant makes for murky water when comparing across studies, and when using the evidence in an applied sense. Especially, as when one scrutinises the idea of a native population, it is far from a homogenous group. In many cases, it is full of the descendents of immigrants and marginalised groups, groups positioned as other, and socially and politically disadvantaged groups (Bhatia & Ram, 2001). Indeed, as Silveira & Ebrahim (1998) found in their study of social determinants of psychopathology, it was the variable of social disadvantage as opposed to other person-bound categories of difference, such as being an immigrant, that most strongly correlated with increased incidences of mental illness.

This research draws upon assumptions of universality: that both immigration and mental illness are definitive things that have common features true for all people and which can be accurately measured with standardised instruments. Silveira & Ebrahim (1998) employed measures created by and validated against DSM-based diagnostic categories, for example by using the Symptoms of Anxiety and Depression Scale (SAD) to find anxiety and depression. Haasen & Sardashti (2000) and Harrison et al. (1997) employ similar data collection strategies.

In so doing, this research imposes a westernised developed world's understanding of immigration and mental health onto the immigrant populations it studies. As such, it does not allow for nuances between immigrants to emerge, for immigrants' own understandings of their difficulties or mental health and illness to be heard. In many cases, fails to pay adequate attention to the socio-political factors that may trigger, exacerbate and maintain higher rates of mental illness among immigrants. This is problematic in an applied sense: for example, what happens in therapy when the therapy and the problem as understood by the therapist (informed by all this evidence-based, DSM imbued practice) does not gel at all with the client? Or perhaps when a stable home and a job might alleviate depressive symptoms better than any NICE recommended CBT? This is the crux of the emic-etic debate that has run through mental health discourse and particularly cross-cultural psychology for several decades. Do we prefer an etic westernized system that we can all apply, share and discuss? Or do we opt for an emic approach which offers situated understanding, acknowledges context and plurality and which is negotiated between researcher and participant or therapist and client (Bhatia & Ram, 2001; Flakerud, 2007; Littlewood, 1990)?

For example, as psychiatrist Derek Summerfield (1995) quite convincingly argues, it seems appropriate, not pathological that refugees who have experience the atrocities of war in their home countries appear more distressed than the norm! Indeed, this suggests value in turning the gaze of the research question away from the psychopathology in the immigrant and towards the experience of immigration itself.

3.2. Mapping the psychological process of immigration

The next subset of research reviewed aims to do just this, to map out, in the main qualitatively and from the point of view of the immigrant-participants, the experiences of immigrants. It generally indicates a high proportion of adverse experiences and life-events during and after immigration (Conwill, 2010; Djuretik, Crawford & Weaver, 2007). Within this subset, is research that aims to map out psychological processes of immigration. In many cases this is discussed within the ambit of acculturation theories (Berry, 1980; 1997; 1998). Some research likens the immigration process to a bereavement model (Hani, Stiles & Biran, 2010). In others, it is described as a distinctive process, which involves elements of mourning but which is unique to immigration (Khan & Watson, 2005; Shin & Shin, 1999). In all cases, however, a difficult and painful process is described, which has adverse effects on immigrant mental health and psychological and emotional development.

This research is useful in many senses. Firstly, it addresses some of the gaps in the more quantitative diagnostic type of research. In many cases it allows for more emic understandings of psychological distress and immigration to enter the discourse informing our professional practice. For example, Conwill's (2010) study aims to generate a phenomenological understanding of Senegalese mental health beliefs and practices because self-report measures had suggested that while this group of immigrants were experiencing many psychological difficulties after immigration, they felt excluded from mainstream mental health practices. Conwill (2010, p. 210) indicates that "their reluctance was not simply fear of being misunderstood, derided or misinterpreted [by western psychologists and counsellors]. They were more disinclined to disclose the deep structure of their world to those without the apparent tools to fathom it."

This is a consistent theme in the more qualitative, immigrant-centred research (e.g. Ahmad et al., 2005; Djuretik et al., 2007; O'Mahoney & Donnelly, 2007). It indicates

that for many immigrants, having a western approach to mental illness and therapy imposed upon them is alienating, frightening and disempowering and thus may exacerbate distress. This research allows for this voice to be heard, and allows for us to start grappling with the power dynamics, assumptions and shortcomings of a westernised system of care, premised upon (arguably self-confirming) evidence.

However, qualitative accounts examining the situated experiences of small pockets of immigrants cannot and does not aim to be generalizable at all. Thus while this type of research might better inform practice more appropriate to immigrant groups, it cannot tell psychologists definitively how to work with these immigrant groups, or how on earth to navigate the tricky terrain between the institutions in which we work and the specific needs of client groups whose difficulties we may be unable to understand, or indeed, for whom our type of intervention may be inappropriate. We are unable, for example to build houses, grant visas, address poverty and exclusion: well at least within the therapy room itself. Few papers suggest tangible policy or practice applications and all call out for a nebulous need for more research, with few suggesting what this entails and to what avail.

A handful of papers explore how psychologists might work with immigrants in practice. For example, Conwill (2010) does in fact suggest some ways in which therapists might work with Senegalese immigrants in the USA based on themes that came out of his analysis. Although, unfortunately owing to the politics of knowledge, it would be unlikely that qualitative work of this nature in and of itself would hold sufficient weight to convince policy makers, course directors, and regulatory bodies of the need for changes in existing systems that might allow for such immigrants (and arguably their therapists) to find a more meaningful way of engaging. Perhaps this is what the call for more research is alluding to.

Most of the papers that do suggest practice applications tend to collapse immigration under the rubric of cross-cultural difference and are centred on specific domains of difference, such as language or religious ideology. For example, Bowker & Richards

(2004) explore therapists' experiences of working in English with bilingual clients and very helpfully (and bravely) put forward suggestions for ways of thinking about and working with the differences in language proficiency and meaning systems between client and therapist. They identify their sample from immigrant groups and yet are almost silent about the experience of immigration itself. Furthermore, they do not reflect upon the differences between immigrants in their sample. This fails to take into account the role of immigration in constructing the immigrant and his/her experiences.

The few papers that examine the emotional and psychological experiences of immigrants explore how psychologists might work specifically with immigrant populations in an applied sense. This is excepting the case of refugee and asylum-seekers, about whom which a great deal has been written, in all epistemological frameworks (e.g. Ai, Peterson & Ubelhor, 2002; Kirmayer, 2003; Mann & Fazil, 2006). Arguably, refugee and asylum seekers, far from a homogenous group themselves, are more visible within the domain of research and policy because of the political landscapes that have fuelled their seeking asylum. War, genocide, famine and detention are highly visible and newsworthy. The understandably high incidence of trauma and distress which these individuals experience as a result brings them visibly and in high proportions into the remit of mental health care (Summerfield, 2003; Tribe, 2002).

3.3. Negotiating immigrant positions: A critical, post-structural exploration

Finally, within the current research output on immigrants and mental health is a subset of theoretical papers that overtly challenge the assumptions of the above research. They are critical of the imposition of a western psychological lens onto the experiences of immigrants and of either/or bicultural models and assumptions, which are very evident in most of the research reviewed above. These papers draw largely on the domain of cross-cultural psychology, where this tension between emic and etic and scientific truth and post-structuralism has been a key debate. More recent papers

call for the transcendence of the emic versus etic debate through understanding the individual as dialogically constructed, hybrid and in constant negotiation (Bhatia & Ram, 2001; Hermans, 2010; Hermans & Kempen, 1993). However, these papers are largely theoretical in nature, with very little primary empirical work fuelling them.

For example, Hermans (2001) argues that the increase in immigration as a result of globalisation has thrown into relief the need to work with ideas of plural and hybrid identities, as opposed to the fixedness of categories of immigrant or similarity and difference. He contends that immigration itself has served to highlight the shortcomings of universalist assumptions about psychological processes. Certainly, this seems to be supported by a great deal of the more qualitative studies of particular experiences of immigrants – such as Conwill's (2010) work on the experiences of Senegalese immigrants in the USA, and for example, the work of Wexler (2011) who explores the experience of cultural incongruity of Alaskan Native Communities in Euro-American mental health care services.

Hermans (2001) goes on to argue that the very idea of the individual is thrown into question when working with immigrants, much in the vein of Nikolas Rose (1996), who deconstructs the notion of singular and unitary personhood by tracing its history. Hermans (2001) suggests that post-structural conceptualisations of the immigrant and the therapist allow for these identity positions to be deconstructed and understood as in flux, impacting upon one-another and constantly negotiated. This seems to make theoretical sense and addresses many of the critiques levelled at the research that seeks to quantitatively or qualitatively locate mental illness in the immigrant, or indeed as an outcome of a process of immigration itself. It allows for the complexities of the immigrant and the processes associated with immigration to emerge.

However, how on earth to put this into practice within institutions or therapy rooms that must necessarily work with standardised or at least consistent processes, that are premised upon alleviating distress, and must treat groups and categories of people? Certainly, it raises a necessary critical awareness, and perhaps therein lies its merit: to

allow the practitioner or researcher to more fully question the assumptions he/she brings to therapy or research with immigrants and their experiences. However, while this point of view seemingly dismantles most established ways of working with and understanding immigrants, it does not suggest alternative workable practices and therein is the rub.

3.4. Somewhere in between: Models of cultural competence and integrating emic and etic ways of working

Ideas of cultural competence and culturally sensitive practice seem to be emerging from some of the more recent practice orientated literature as a way to begin grappling with how therapists might work with immigrant populations (Roysircar, 2009; Werkmeister & Smith, 2009). This seems to be premised on the assumption that it is cultural incongruities between therapist and client and between client and institution that seem to contribute more than any other factors to immigrant populations having difficulties engaging with systems of mental health care (Bhugra & Arya, 2005; Flaskerud, 2007; Griner & Smith, 2006).

What exactly this kind of competence or practice entails is inconsistently described across the literature. Whaley's (2008) meta-analysis highlights this inconsistency, but does extrapolate broad themes to inform practice. These include taking a stance between knowing and unknowing, examining one's own and institutional socio-cultural assumptions, and taking time to explore those held by the immigrant-client. When read through the more post-structural position explored in the previous section, consideration of these themes can allow for thinking about how same-ness and difference are being constantly negotiated between parties. This line of questioning offers a starting point for thinking about how one might work immigrant populations. Through its consideration of the mutuality involved in the construction of identity positions and assumptions, it cannot assume either an emic or an etic stance. Rather it begins a conversation between these approaches and offers an opportunity to integrate elements of both.

The work of Vikram Patel, on integrating western-based meanings, diagnoses and treatments for depression, with local systems, idioms and expression of seemingly similar distress among the Shona immigrants from Zimbabwe is an excellent example of this kind of integrative work that moves beyond theory and into practice. Furthermore Patel and his colleagues are open about their own assumptions in the work coming from a western psychiatric background, and have co-developed ways of working with immigrants and also their communities in Zimbabwe. Moreover they have tracked the efficacy of these integrated ways of working, finding them to be more effective than purely westernised interventions for depression, and also more effective than purely indigenous interventions (Patel, Mutambirwa & Nhiwatiwa, 1995; Patel, Simunyu, Gwanzura, Lewis & Mann, 1997; Patel, Abas, Broadhead, Todd & Reeler, 2001). This work lends some legitimacy to taking a more post-structural and critical stance – one which suggests that *both* the immigrant and therapist are impacted by and impact on the socio-cultural systems they encounter in the intersubjective space. It understands them as relational and mutually dependent. The same can be said of immigrant and so-called native.

Similar work has been conducted by Gone (2010a; 2010b) who has explored the process of integrating westernised mental health interventions and services with certain Native American cultural practices in a community substance misuse treatment centre in the north of Canada. The findings here too suggest that a collaborative, dialogical, integrated approach seems to have better outcomes on service access, use, interventions and outcomes. What is particularly interesting in this research is that integration is treated as an ongoing process as opposed to a fixed outcome. This again perhaps lends more credibility to thinking about working with immigrants within specific and situated contexts, and also to thinking about the identity positions of immigrants, therapists and indeed institutions as fluid, plural and dialogical.

Adding more weight to this way of conceptualising immigrants, immigration and their relationship with mental health care systems and practitioners is research conducted

by Rodriguez, Baumann and Schwartz (2011). This examines the process and outcomes of adapting a Euro-American premised mental health care service to the more idiosyncratic and emic understandings of health and mental health held by the Latino immigrant community it serves. The researchers note that prior to intervention, the service was operating purely from a westernised etic stance and failed to engage with the community it was set up to serve. They use mixed methods to inform their research, using secondary statistical data to gain an overview of service-engagement and changes in this. They also use in-depth qualitative methods to grapple with what both the immigrant-client and the therapists and mental-health care providers understood to be relevant to better and more meaningful service provision. Following on from this, they participated in and evaluated an organic process of integrating the results of these qualitative interviews and focus groups, with existing evidence-based westernised understandings of psychological assessment, intervention and service provision. Both qualitative and quantitative outcomes measures suggest an improved experience for both the clients and the therapists, and moreover, increased engagement with services and a decrease in mental health difficulties. Again, the merit of such research is in its situated, integrative quality and its ability to use both emic and etic points of view to understand and evaluate the needs and meaning systems of the key stakeholders in the service. It is also particularly useful in its tracking of the process and possible outcomes.

However, no perspective on understanding and working with immigrants and immigration seems without its shortcomings. Quite clearly, this work is contextually bound. Until sufficient studies are amassed to perhaps warrant some kind of meta-analysis, we cannot extrapolate any general conclusions about the virtues of adopting a situated approach that integrates both westernised understandings of mental health and its concomitant interventions and the more emic understandings of the immigrant groups these interventions are aimed to serve. Moreover, it might not even be possible to conduct a meta-analysis on such specific, situated studies without undermining many of the epistemological premises that have informed them in the first place: such an analysis would detract from the specific and situated nature of this work.

Also at play in this domain of more applied research on working with immigrants in mental health care settings, might be the specific investments of the researchers in the outcomes of the research. In all of the research explored, the researchers have occupied dual roles as clinician-researchers. They have sought both to develop more collaborative way of working with particular immigrant populations and to evaluate the processes and outcomes of such ways of working. While in no way undermining the merits of these studies, it would seem that the clinical reputations of the researchers might in fact rely upon producing effective clinical interventions that adhere to principles of cultural sensitivity and competence. Such a deep investment must undoubtedly affect a research process, especially its qualitative aspects where researcher interpretation and researcher-participants interaction are key in informing the outcomes of the research (Terre Blanche & Kelly, 1999).

3.5. Pulling these strands of research together: Questioning a few assumptions

A very glaring assumption that all of this research makes is that immigration is a traumatic or difficult experience for most or all immigrants, thus warranting investigation for psychopathology and distressing experiences. Perhaps this is not the case for all immigrants, and might be an interesting domain for future research to explore.

Furthermore, most attention in the research seems to be paid to the experiences of those immigrants who appear to the researchers to be markedly different from the natives of the countries to which they immigrate. This is understandable, as the research indicates that it is these groups that seem to be faced with more adverse challenges when immigrating and subsequently, suffer a higher proportion of mental illness. In addition, the research suggests that these groups impose more difference on the therapeutic encounter and this is assumed to be problematic to therapeutic alliance (Claassen et al., 2005; Constantine & Kwan, 2003).

However, it seems that merely paying attention to immigrants who are noticeably different renders those who might be a bit more similar invisible in the research enterprise. This resonates with the recent moves in the social sciences to turn the gaze towards exploring the experiences of more hegemonic identities. Research and theorising in this vein suggests that the difficulties of those perceived to hold more dominant identities are often overlooked in psychological research (Bonnett, 1997; Hopkins & Noble, 2009; Steyn, 2001).

It might be useful to explore the nuances in experiences of immigration and adjust the gaze of the research to include the immigrant who moves from developed world to developed world, of similar language and seemingly similar culture. There is only one strand of research that seems to do this, exploring the experiences of Irish immigrants in the UK and particularly, the relationship between immigration and depression (Ryan, Leavey, Golden, Blizard & King, 2006).

However, the same critiques that may be levelled at the research explored in the ‘Diagnosing immigrants’ section of this paper may be levelled at this research. Particularly problematic is that it does not screen for other psychological and emotional difficulties in its sample before measuring for depression. This a powerful possible confounding variable for a quantitative study aiming to produce a statistically significant correlation. However, it is the beginnings of turning the gaze onto more similar immigrants and would suggest by its findings, however methodologically problematic, that the Irish sample measured does indeed suffer higher depression rates than the mean. As such, indicating perhaps that cultural similarity cannot be presumed and also may not act as a buffering factor at all. This is but one paper. It would be interesting to explore this further and to how perceived cultural similarity (and by extension dissimilarity) affects attributions of mental illness and how it mediates a therapeutic alliance. The bulk of current research, seems to assume that it would have a positive impact on both. It might also be an interesting exercise to shift the

geography of the research and look at the experiences of those who immigrate from the centre to the margin.

There is also very little research on gendered differences in the emotional and psychosocial experiences of immigration and its impact on mental health and well-being. Some quantitative epidemiological work does offer descriptive statistical comparisons. However, the qualitative work that does address gender in some form tends to focus on the situated experiences of women. It does not offer the masculine experience, or indeed possible comparisons and contrasts between the two. For example Shin & Shin (1999) explore only the experiences of Korean women after immigration to the USA. Exploring the gendered nature of the experiences of immigration seems to be asking for further exploration.

Very little research looks explicitly at the inter-generational experiences of immigration and how this relates to mental health care and practice. What of the children of first generation immigrants, or their grandchildren? The research seems to limit the immigrant-subject to that person who was born in another country and then relocated permanently. Again this seems to relate to the difficulties in defining who is or who is not an immigrant for the purposes of study. However, it seems like an interesting consideration for future research. Following on from this, another notable silence in the research is one of the impact of immigration on family, friends and communities who are left behind. What of the psychological impact of immigration on them? Only one paper begins to explore this population, but does so in the context of how they may offer social support *to* the immigrant (Messent, Saleh & Solomon, 2005).

4. In conclusion

All research reviewed in this paper indicates that immigration and mental health difficulties are linked, and that working with immigrant populations present challenges for psychologists, immigrant-clients and mental health care institutions.

Throughout the review, three key issues seem to predominate: firstly, does immigration act as a precipitating factor for mental illness in the migrant, and as such, should research and treatment focus on the mental illness as opposed to the experience of immigration? Might it be the experience of immigration in and of itself something that warrants more understanding and exploration within the counselling and research contexts? And finally, what is the most ethical, sensitive and parsimonious approach to take in understanding the experience of immigration and any concomitant mental health difficulties suffered by the immigrant?

No single type of research seems to be able to address all of these questions completely. However, it would seem that approaches that draw upon westernised taxonomies and practices *as well as* more situated emic understandings and practices and integrate these into situated application can offer a step towards a work-able solution. Especially, if combined with a critical ‘thinking space’ about power and the fluidity of identities, this way of working can present practitioners with helpful insights for applied work. Counselling psychology is appreciably well-placed to straddle these binaries, given its emphasis on relational collaboration not only with the client but also with institutions and systems of knowledge.

Nonetheless, given the projected increases in global mobility and immigration over the next decade, thinking about immigration and mental health care is a vital enterprise for psychology as a whole. Practitioners will be increasingly required to work *with* immigrants, while simultaneously situated *in* the web of our institutions, regulatory bodies and repertoires of personal identities. Indeed, it seems not only futile but impossible to separate ourselves from the context of immigrant and immigration.

5. Reflections on this piece of work

Three years on, this paper still strikes a personal chord. The idea of the immigrant seems both absurd and also highly relevant. It seems absurd because the complexities of same and different, alien and native, and staying and leaving seem to apply to everyone, in the minutiae of all encounters. Borders, binaries and the confusion in between seem to me to be emergent, and wholly necessary, in almost every intersubjective exchange. The therapeutic space particularly can be described as in continual positional flux, knowing and un-knowing, and bordered and boundaried. The boundary of the relationship is considered sacred, and is discussed in almost every supervision or MDT meeting I have been in. This is a line of critique I might have pursued in this review had I written it now. I might have asked more about boundaries, borders and migrating and whether the enquiry levelled at trans-national immigrants might also be levelled at all people who cross borders into spaces that are other to them.

Re-reading this piece, I found some of the terms used to be jarring. I felt the desire to put almost everything into quotation marks, and to denote that they were problematic constructs. Undoubtedly this is a result of having travelled further and further into social constructionism. Yet, in practice, I have seen many clients who had migrated to the UK and who were struggling with the process: with social isolation and loneliness, with xenophobia and the loss of habitual markers of meaning. However individualising or clumsy this practice might be, many of these clients told me that that they had found some comfort in the space of the therapeutic relationship. The trajectories of these academic and clinical journeys have now positioned me in a space somewhere between the intellectual pursuit of critical deconstruction and a desire to still have a way in which to practice therapeutically. It seems all too easy to deconstruct the system of mental health care without offering an alternative. For all of

its shortcomings and insensitivities, it is still one of few spaces available to people who experience the distress associated with all manner of violations of boundaries, borders and norms.

This paper raises that dilemma for me: how does one problematise the constructs of mental health and the immigrant and yet still hold onto a space of practice that can offer support for difficulties and distress of people who immigrate? The latter demands that one holds onto something as-if real and that one treats the labels of immigrant and mental health with some degree of legitimacy. I have attempted to address this in part in this paper by emphasising the merits of a marriage of critical and integrative work. However, were I to re-write the paper now, I would address my position in this liminal space more conspicuously, clearly stating this as motivation for the review beyond its more obvious academic merits.

6. References

- Ahmad, F., Shik, A., Vanza, R., Cheung, A., George, U., & Stewart, D. (2005). Voices of South Asian Women: Immigration and mental health. *Women and Health, 40*(40), 113-130.
- Ai, A., Peterson, C., & Uebelhor, D. (2002). War related trauma and symptoms of posttraumatic stress disorder among adult Kosovar refugees. *Journal of Traumatic Stress, 15*(2), 157-160
- Berry, J. (1980). Acculturation as varieties of adaptation. In A. Padilla (Ed.), *Acculturation: Theory, models and some new findings* (pp. 9-25). Boulder, CO: Westview.
- Berry, J. (1997). Immigration, acculturation and adaptation. *Applied Psychology: An International Review, 46*(1), 5-34.
- Berry, J. (1998). Acculturative stress. In P. Organista, K. Cren & G. Marin (Eds.), *Readings in ethnic psychology* (pp. 117-122). New York, NY: Routledge.
- Bhatia, S., & Ram, A. (2001). Rethinking 'acculturation' in relation to diasporic cultures and postcolonial identities. *Human Development, 44*(1), 1-18.
- Blinder, S. (2012). UK public attitudes toward immigration: Overall attitudes and level of concern. *Migration Observatory Briefing, University of Oxford*.
- Bonnett, A. (1997). Geography, 'race' and Whiteness: Invisible traditions and current challenges. *Area, 29*(3), 193-199.
- Bowker, P., & Richards, B. (2004). Speaking the same language? A qualitative study of therapists' experiences of working with proficient bilingual clients. *Psychodynamic practice, 10*(4), 459-478.
- Bhugra, D., & Arya, P. (2005). Ethnic density, cultural congruity and mental illness in migrants. *International Review of Psychiatry, 17*(2), 133-137.
- Carey, S., & Geddes, A. (2010). Less is more: Immigration and European integration at the 2010 general election. *Parliamentary Affairs, 63*(4), 849-865.
- Castles, S., & Miller, M. (2003). *The age of migration: International population movement in the modern world*. Basingstoke: Palgrave MacMillan.

- Claassen, D., Ascoli, M., Berhe, T., & Priebe, S. (2005). Research on mental disorders and their care in immigrant populations: A review of publications from Germany, Italy and the UK. *European Psychiatry, 20*(8), 540-549.
- Constantine, M., & Kwan, K. (2003). Cross-cultural considerations of therapist self-disclosure. *Journal of Clinical Psychology, 59*(5), 581-588.
- Conwill, W. (2010). N'Deup and mental health: Implications for treating Senegalese immigrants in the US. *International Journal for the Advancement of Counselling, 32*(3), 202-213.
- Dineen, T. (2004). *Manufacturing victims*. New York, NY: Studio 9 Books.
- Djuretik, T., Crawford, M., & Weaver, T. (2007). Role of qualitative research to inform design of epidemiological studies: A cohort study of mental health of migrants from the former Yugoslavia. *Journal of Mental Health, 16*(6), 743-755.
- Eleftheriadou, Z. (2010). Cross-cultural counselling psychology. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of counselling psychology* (pp. 195-212). London: Sage.
- Fearon, P., Kirkbride, J., Morgan, C., Duzzan, P., Morgan, K., Lloyd, T.,...Murray, R. (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP study. *Psychological Medicine, 36*(11), 1541-1550.
- Flaskerud, J. (2007). Cultural dissonance: therapist and client. *Issues in Mental Health Nursing, 28*(10), 1081-1083.
- Foucault, M. (1965). *Madness and civilisation: A history of insanity in the age of reason*. New York, NY: Random House.
- Furukawa, T., Sarason, I., & Sarason, B. (1998). Social support and adjustment to a novel social environment. *International Journal of Social Psychiatry, 44*(1), pp. 56-70.
- Gilroy, P. (2004). *After empire: Melancholia or convivial culture?* Abingdon: Routledge.
- Gone, J. (2010a). Psychotherapy and traditional healing for American Indians: Exploring the prospects for therapeutic integration. *The Counselling Psychologist, 38*(2), 166-235.
- Gone, J. (2010b). The road to wellness: Cultural reclamation in a Native First Nations community treatment centre. *American Journal of Community Psychology, 47*(1-2), 187-202.

- Griner, D., & Smith, T. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, 43(4), 531-548.
- Haasen, C., & Sardashti, H. (2000). Relationship between depression and psychosocial stress among Iranian emigrants. *Psychiatrische Praxis*, 27(2), 74-76.
- Hani, H., Stile, W., & Biran, M. (2010). Loss and mourning in immigration: Using the assimilation model to assess continuing bonds with native culture. *Counselling Psychology Quarterly*, 18(2), 109-119.
- Hansen, R. (2000). *Citizenship and immigration in post-war Britain*. Oxford: Oxford University Press.
- Hansen, R. (2003). Migration to Europe since 1945: Its history and its lessons. *The Political Quarterly*, 74(1), 25-38.
- Harrison, G., Glazebrook, C., Brewin, J., Canbrell, R., & Dalkin, T. (1997). Increased incidence of psychotic disorders in migrants from the Caribbean to the United Kingdom. *Psychological Medicine*, 27(4), 799-806.
- Hassiotis, A. (1996). Clinical examples of cross-cultural work in a community learning disabilities service. *International Journal of Psychiatry*, 42(4), 318-327.
- Hermans, H. (2001). The dialogical self: Towards a theory of personal and cultural positioning. *Culture & Psychology*, 7(3), 243-281.
- Hermans, H., & Kempen, H. (1993). *The dialogical self: Meaning as movement*. San Diego, CA: Academic Press.
- Hewitt-Taylor, J. (2006). *Clinical guidelines and care protocols*. Chichester: Whurr/John Wiley.
- Hopkins, P., & Noble, G. (2009). Masculinities in place: Situated identities, relations and intersectionality. *Social and Cultural Geography*, 10(8), 811-819.
- Huysmans, J., & Buonofino, A. (2008). Politics of exception and unease: Immigration, asylum and terrorism in parliamentary debates in the UK. *Political Studies*, 56(4), 766-788.
- Jarvis, E. (2001). Schizophrenia in British immigrants: Recent findings, issues and implications. *Transcultural Psychiatry*, 35(1), 39-74.
- Khan, S., & Watson, J. (2005). The Canadian immigration experiences of Pakistani women: Dreams confront reality. *Counselling Psychology Quarterly*, 18(4), 307-317.

- Kirov, G., & Murray, R. (1999). Ethnic differences in the presentation of bi-polar affective disorder. *European Psychiatry, 14*(4), 199-204.
- Kirmayer, L. (2003). Failures of imagination: The refugee's narrative in psychiatry. *Anthropology and Medicine, 10*(2), 167-185.
- Kuhn, T. (1962). *The structure of scientific revolutions*. Chicago, IL: Chicago University Press.
- Laungani, P. (2002). Cross-cultural psychology: A handmaiden to mainstream western psychology. *Counselling Psychology Quarterly, 15*(4), 385-397.
- Leavey, G., Hollins, K., King, M., & Littlewood, R. (1997). Health research on the Irish in Britain: invisible and excluded. *Psychiatric Bulletin, 21*, 739-740.
- Littlewood, R. (1990). From categories to context: A decade of 'The New Cross-Cultural Psychiatry'. *British Journal of Psychiatry, 156*, 308-327.
- Manacorda, M., Manning, A., Wadsworth, J. (2012). The impact of immigration on the structure of wages: Theory and evidence from Britain. *Journal of the European Economic Association, 10*(1), 120-151.
- Mann, C., & Fazil, Q. (2006). Mental illness in asylum seekers and refugees. *Primary Mental Health Care, 4*(1), 57-66.
- Messent, P., Saleh, H., & Solomon, X. (2005). Asian families back home: An unexplored resource. *Contemporary Family Therapy, 27*(3), 329-344.
- Morris, L. (1997). Globalisation, migration and the nation-state: The path to post-national Europe? *The British Journal of Sociology, 48*(2), 181-201.
- Neeleman, J., & Wessely, S. (1997). Suicide by age, ethnic group, coroners' verdicts and country of birth: A three year survey in inner London. *British Journal of Psychiatry, 171*(5), 463-467.
- O'Mahoney, J., & Donnelly, T. (2007). The influence of culture on immigrant women's mental health care experiences from the perspectives of health care providers. *Issues in Mental Health Nursing, 28*(5), 453-471.
- Panayi, P. (2010). *An immigration history of modern Britain: Multicultural racism since 1800*. London: Pearson Longman.
- Patel, V., Mutambirwa, J., Nhwatiwa, S. (1995). Stressed, depressed or bewitched: A perspective on mental health, culture and religion. *Development in Practice, 5*(3), 216-224.
- Patel, V., Simunyu, E., Gwanzura, F., Lewis, G., & Mann, A. (1997). The Shona Symptom Questionnaire: The development of an indigenous measure of

common mental disorders in Harare. *Acta Psychiatrica Scandinavica*, 95(6), 469-475.

- Patel, V., Abas, M., Broadhead, J., Todd, C., & Reeler, A. (2001). Depression in developing countries: Lessons from Zimbabwe. *British Medical Journal*, 322(7284), 482-484.
- Rodriguez, M., Baumann, A., & Swartz, A. (2011). Cultural adaptation of an evidence-based intervention: From theory to practice in a Latino/a community context. *American Journal of Community Psychology*, 47(1-2), 170-186.
- Rose, N. (1985). *Psychological complex: Psychology, politics and society in England 1869-1939*. London: Routledge & Kegan
- Rose, N. (1996). *Inventing our selves: Psychology, power and personhood*. Cambridge: Cambridge University Press.
- Roysircar, G. (2009). Evidence-based practice and its implications for culturally sensitive treatment. *Journal of Multicultural Counselling and Development*, 37(2), 66-82.
- Rozas, L., & Smith, E. (2009). Being on this boat: The provision of culturally competent mental health services to people living with HIV/AIDS. *Journal of HIV/AIDS and Social Services*, 8(2), 166-187.
- Ryan, L., Leavey, G., Golden, A., Blizard, R., & King, R. (2006). Depression in Irish immigrants living in London: a case-control study. *British Journal of Psychiatry*, 180(6), 560-566.
- Samson, J. (1991). *The British Empire*. Oxford: Oxford University Press.
- Silveira, E., & Ebrahim, S. (1998). Social determinants of psychiatric morbidity and well-being in immigrant elders and whites in east London. *International Journal of Geriatric Psychiatry*, 13(11), 801-812.
- Shin, K., & Shin, C. (1999). The lives experience of Korean immigrant women: Acculturating into the Unites States. *Health Care for Women International*, 20(6), 603-617.
- Strawbridge, S., & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of counselling psychology* (pp. 3-22). London: Sage.
- Steyn, M. (2001). *"Whiteness isn't what it used to be": White identity in a changing South Africa*. Albany, NY: SUNY Press.

- Summerfield, D. (1995). Addressing human response to war and atrocity. In R. Kleber, C. Figely & B. Gersons (Eds.), *Beyond trauma*. (pp. 17-29). New York, NY: Plenum.
- Summerfield, D. (2003). Mental health of refugees. *British Journal of Psychiatry*, 183(5), 459-460.
- Terre Blanche, M., & Kelly, K. (1999). Interpretative methods. In M. Terre Blanche & K. Durrheim (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 123-146). Cape Town: University of Cape Town Press.
- Tribe, R. (2002). Mental health of refugees and asylum seekers. *British Journal of Psychiatry*, 8(4), 240-247.
- Wexler, L. (2011). Behavioural health services “don’t work for us”: Cultural incongruities in human service systems for Alaska Native Communities. *American Journal of Community Psychology*, 47(1-2), 157-169.
- Whaley, A. (2008). Cultural sensitivity and cultural competence: Toward clarity of definitions in cross-cultural counselling and psychotherapy. *Counselling Psychology Quarterly*, 21(3), 215-222