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“Us vs Them” inpatients or fellow inmates?

An autoethnographic exploration

By Aika Jane Goodwin

Submitted in fulfilment of the requirements for the degree of:
Doctor of Psychology

Department of Psychology City, University of London

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Declaration

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Abstract

Research shows that mental health professionals hold stigmatizing and negative attitudes towards people with mental health problems. Professionals can engage in “othering” whereby they create distance between themselves and the “different” patient, diminishing discomfort. There are significant mental health difficulties amongst professionals, but there is insufficient research exploring clinicians with lived experience, including how this impacts and/or enhances clinical practice. How professionals manage occupying multiple positions, such as professional and patient, has not been sufficiently explored, perhaps owing to the stigma in the profession.

I employed Autoethnography, a method and methodology (Campbell, 2016), to critique, contribute to and extend existing research and theory. I seek an increase of insight, facilitation of social consciousness, and societal change (Adams, Linn & Ellis, 2015, p. 33). This research is a direct response to the persistent gap in literature when it comes to first-hand accounts of inpatient psychiatric treatment (Short, Turner & Grant, 2013, p. 41) and a call for more writing from professionals working in mental health with lived experience. I used my insider knowledge of a cultural phenomenon (life of a wounded healer in training) and a life-altering experience (being admitted to a psychiatric institution) to critique cultural norms and practices amongst mental health professionals, including myself. The data collection and analysis was iterative and resulted in the production of an evocative narrative. I provide the reader with a theoretical chapter that discusses salient themes that arose during this process and link these themes with parts of the narrative. I demonstrate that autoethnography can be a particularly valuable method for counselling psychologists and conclude with a number of implications and suggestions for practice stemming from my research. By using myself as both the researcher and the researched, while highlighting my hybrid identity of patient and professional, I blur the boundaries that could otherwise perpetuate othering.

Abbreviations and Glossary

BPD Borderline Personality Disorder

CMHT Community Mental Health Team

EMDR Eye Movement Desensitization Reprocessing

EUPD Emotionally Unstable Personality Disorder

MBT Mentalization Based Therapy

PT-G Posttraumatic growth

Abilify- this is an antipsychotic medication used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar I disorder.

Apolaniati- this is a made-up name of a city in South East Asia

Batu- this is the made-up name given to a small part of a country in South East Asia.

Consumers- in this thesis consumers refers to consumer of mental health services.

Diazepam- this is a medication, which produces a calming effect. It is typically used to treat a range of conditions such as anxiety, muscle spasms and seizures.

Disidentification- the act of identifying a personal or group identity and then rejecting it

Foot drop- this is the name given to muscular weakness or paralysis that makes it difficult to lift the front part of your foot and toes. It is a sign of an underlying problem rather than a condition itself. The problem could be muscular, caused by nerve damage in the leg, or the result of a brain or spinal injury.

Otherring- the act of characterizing people in this case with a mental illness, as being easily identifiable, abnormal and different to oneself whilst characterizing the self as normal and not susceptible to mental illness

Psychiatric survivor- this is the term used by activists for those people who have survived the psychiatric system.

Service user- in this thesis I use the term service user and patient interchangeably. Service-user refers to people who use services (in this case mental health services).

PART A

Preface

i. Providing a context

Autoethnography, a method and methodology (Campbell, 2016), provides a unique insider's perspective that no other research method could "easily, if ever, reveal" (Jones, Adams, & Ellis, 2015, p. 32); this is the method I employ. Although an unusual choice for my thesis, this allows me to use myself as both researcher and participant to answer the research question, how do I live with my multiple and seemingly in tension identities as both patient and trainee therapist. I use my lived experience as a psychiatric inpatient following a steroid-induced hypomanic episode while travelling in Asia. I hope my insider perspective and knowledge will challenge the stigmatization of mental illness amongst "us", the professionals.

I am taking the reader with me, through some painful times, vulnerably exposing parts of myself. When a story is memorable, the lessons embedded within it are often more memorable and have an ability to assist the reader to develop insight into a certain phenomenon, or to even change their behaviour. Stories allow the reader to engage with unique experiences from a safe distance. I do not wish my experience on anyone, but I hope to be able to share or part with some of the value it has given me in my way of life, my clinical work and my drive to create change in our professional culture from within.

ii. Being sane in insane places

In a ground-breaking study, "On Being Sane in Insane Places", by Rosenhan (1973) a group of eight pseudopatients – Rosenhan himself (a psychology graduate), three established psychologists, a physician, a psychiatrist, a painter and a stay at home parent– presented themselves to different psychiatric institutions complaining of a pseudo symptom: hearing a voice that says, for example, "empty" and "hollow". Once admitted, the pseudopatients had to convince the Psychiatrists that they were fit for discharge, thus immediately stopped any symptomatic behaviour and became highly cooperative, yet it was hard to get out. Once deemed fit for discharge, they were all discharged with the label "schizophrenia in remission". Amongst other issues, the study demonstrated the powerful role of context in determining how people's behaviour is regarded. The study also raised serious questions about the validity of psychiatric diagnoses, which are still being debated to this day. Importantly, the study also noted

the extreme powerlessness, division between us and them and dehumanization that came with becoming a psychiatric patient. In this thesis reference is made to a number of psychological discourses and social structures. This complex multitude of theories, institutions and diagnostic manuals has become very powerful. There is a potential for us to get captured or positioned within these, defining ourselves and experiencing ourselves in this way. This is something that I do, and consequently make note of in the main Narrative as well as in the Themes chapter. The value of diagnosis is frequently and consistently debated, and a discussion of the subject is beyond the scope of this thesis, I direct interested readers to Rosenberg's "Contested Boundaries: Psychiatry, Disease, and Diagnosis" (2015). However, I feel it is important to describe my position and view on this to the reader, which I shall do now briefly before we move on.

Throughout this thesis, constructs such as "mental illness" and diagnoses such as "depression" or "schizophrenia" will be in quotation marks. This is done to remind the reader that they are indeed constructs and not definitive, real, valid or true depictions. As concepts, they are never fully clear nor fixed. They can be contested and are likely to change. An example that is often given to demonstrate this fluidity is how homosexuality was once classified as a mental disorder. Homosexuality was only removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1987. My general opinion on diagnosis, both personally and professionally, is that it has the potential to cause serious harm when it is used to categorize, oppress, stigmatize and discriminate individuals and groups. I believe the main way that diagnosis can inflict harm is when it is rigidly held onto, both by a clinician or by the individual who may only come to see themselves through the lens of a 'disorder'. I believe it is dangerous to make diagnosis quickly without attempting to take a holistic view with regards to what is going on for the individual. Both the clinician and the patient should be consistently reminded that any diagnosis is tentative, or a working diagnosis, and not something fixed or definite which is how it can sometimes be received. An example of this can be seen in the Rosenhan (1973) study, where it was clear that an invalid diagnosis was given to the participants and they were later defined and seen through this lens throughout their stay in the hospital and upon leaving the hospital carried the 'in remission' label.

However, in saying all of this, I can also see the potential value of diagnosis within society when it comes to finding suitable treatment. It can also have an important role for individuals who, for years, may have struggled with the pain that their mental health problems caused

them yet didn't have a clue about what was going on. Those people can find solace in having a name for their inner turmoil and an explanation or way to communicate it. A diagnosis may also have helpful societal consequences such as the allocation of housing, financial benefits, funding and additional support for those in education. As the reader will become aware, I benefitted from as well as craved a diagnosis yet also experienced being mislabelled and was fearful of being potentially trapped in the discourse or system. This will become more apparent to the reader as they move through each chapter.

Back to the Rosenhan (1973) study and its personal impact, I can remember vividly my feelings of outrage and disbelief when I read this study during my undergraduate training in Psychology in 2009. Unfortunately, or perhaps fortunately, the discomfort produced from reading this study subsided and I slipped back into blissful ignorance of the very real threat that one's narrative power can have over another. I am increasingly aware that some types of narratives are given more respect over others, stories of staff members often trumping and discrediting the stories of individual patients in the "politics of storytelling" (Short, Turner, & Grant, 2013, p. 44). Not dissimilar to how quantitative research, and indeed other more established forms of qualitative research, might trump autoethnography. Holt (2003) points out the irony that the method, which attempts to reclaim marginalized representational spaces, is then marginalized by the academic review process.

Ironically, during my time spent as an inpatient, one of my delusions, in fact my main belief, was that I was performing a "ground-breaking" study to expose maltreatment of the mentally ill. I can remember thinking back to the Rosenhan study (1973) while in my cell. It could be argued that my delusion of replication of this research is one of the factors that enabled me to survive and subsequently thrive from my traumatic experience (see chapter 3). I did not know at the time that the "data" I was collecting and my subsequent story would later be used for the purposes of this autoethnographic thesis.

iii. Discovering autoethnography

I don't think I can do research into mental health stigma amongst professionals. I get frustrated when I read the literature and then empowered, feeling a rush of energy. I have too much to say about the matter I fear I am "contaminating" the research project. How can I possibly sit opposite a participant and ask about their mental health experience in the profession without a whole host of my own emotions bursting to come out.

I remember thinking these things and arguing with my father on my way to a family Christmas in Sussex*.

Father: Why can't you write about your Batu story?

Me: Because it's not research!

Father: But you could be interviewed by Dr Stephane – you have all your photographs and conference notes – it's a unique story and position.

Me: I know. I want to, and I want to tell it. I feel it's important I don't just throw away all that I learnt and I am continuing to learn from it, but that is more like a book, not a thesis

Father: Couldn't you interview yourself?

Me: Don't be absurd.

Later, in a hotel room in the Seychelles at 3am, watching the fan spinning above me horrible memories flooded my mind; it was coming up to my first trauma year anniversary. I felt the need to explore them. How could I have experienced something like that and then find myself there, in a hotel, trying to come up with a topic for my doctoral thesis. I searched for company in the literature, are there others? I stumbled upon a paper – The Dilemma of the Wounded Healer (Zerubavel & Wright, 2012) – and I was so deeply moved that I stayed up all night writing: my thoughts, my own journey. I remember thinking it was such a shame I couldn't use it.

Back at university, I missed the deadline. The perfectionist me was struggling with the uncertainty. I had a quantitative project proposal already written up – But there I was, not doing that anymore, feeling a pull to something more meaningful but feeling completely stuck. I burst into tears with my personal tutor, briefly explaining the Batu story and how I felt I wanted to use it but that it might impact my research.

Me: I have too much to say.

Tutor: Have you heard about autoethnography?

* All identifying locations have been changed throughout the thesis.

That's how it all started. It came to me: I didn't look for it. I had no idea about it, being quite comfortable in my positivist quantitative training. Yet it changed me completely, and my way of working: it still does, and probably will continue to do so. I spoke about it to my existential supervisor who said he had a colleague who wrote about his breakdown in the NHS and was big on autoethnography. I read his paper and thought, "I can do this if he can. I *should* do this if he has. Why should I sit silently with my angry observations and not be brave enough to speak out? I am only perpetuating my situation."

I was at a friend's house for a catch-up dinner. All of us were hovering in the kitchen pretending to be useful when I got an email from university saying Carla Willig was interested in the methodology and would be happy to supervise me – wow. There was a sudden rush of excitement, followed a second later by fear when I realised the undertaking it would be.

iv. Sections of the portfolio

Section A

The study examines two experiential phenomena: my insider knowledge of a cultural phenomenon (the life of a wounded healer in professional training) and a life-altering experience (being admitted to a psychiatric institution). I explore shame and self-stigmatization, as well as the struggle of constructing an identity that incorporates my lived experience into my professional identity. I start with the more traditional approach to qualitative research by providing the reader with an introduction and brief literature review to provide context and justification for this research. The literature discussion is deliberately brief, as I would prefer readers to engage with the story rather than be bombarded with theory. In line with usual procedure for formal academic work, I include an extensive methodology chapter.

The literature both informed my creation of the story and my understanding of my experience and what emerged from writing my story. It was not approached as a literature review task but an emerging engagement with the literature throughout, as well as an iterative process. Indeed, as reader, you may pick up on themes that I was unaware of, or perhaps deliberately avoided. In order to demonstrate how I interacted with the process of my research and my take on the chosen theory, I have chosen to elaborate on those themes I found salient to me during the undertaking of this research and my lived experience as a psychology trainee. I do not want to feed the reader with my understanding, my choice of theory and my own view.

Rather, I am attempting to, as described by Ellis (2004), show rather than tell so that you, the reader, are able and encouraged to make your own conclusions, and then subsequently contrast them with my understandings of the pertinent themes.

Perhaps it is important for me to say here that one theme which emerged from my reading and undertaking of this autoethnography was how theory can be used to move away from the discomfort of the unknown. It was for this reason that I decided to have a separate theme chapter. I had started weaving the theory into my narrative but noticed that it was detracting from the emotional engagement with the story. It is essential to note, however, that it is impossible to separate the two completely, as they both mutually influenced each other in the creation of something new and unknown (see chapter 3).

Autoethnography designates such a wide array of textual practice that Ellis and Bochner (2000) suggest it is both impossible and undesirable to arrive at a single definition. I hope that the reader will gain a better experiential understanding and insight into what an autoethnography can look or be like. I am presenting my way of engaging with it, and I will do my best to describe my process to the reader along the way.

Section B

This comprises two publishable pieces: it is in two parts to meet the criteria for publishing in *The Psychologist* (the magazine of the British Psychological Society). Part 1 discusses the wounded healer and how one way to challenge mental health stigma from within is by embracing and disclosing our hybrid or dual identities: namely, our ability to be both a patient and a clinician. In Part 2, I explore the use of autoethnography as a methodology in Counselling Psychology research. Both of these pieces are presented in a more journalistic form as requested by *The Psychologist*, the aim being to engage a wider audience and to write for impact.

v. Tying the sections together

The aim of writing for impact in order to create changes and shifts within the system alongside bringing the person into psychological research and practice is what ties the three sections together.

The publishable piece, rather than being an academic or theoretical paper, has aligned itself with the re-launch of *The Psychologist*, which has an increased focus on more journalistic, creative writing, a narrative form where references don't interrupt the flow of the piece, so

that a wider audience may become engaged, not just academics and practitioners. The publishable pieces therefore appropriately challenge me again to write in a way that I am not used to.

I struggled throughout the undertaking of this autoethnographic research with how much of the subjective creative story part to include and how much academic and theoretical literature to include. The reader will see in my methodological reflexivity section in the methodology chapter (see section 2.7.1) the evolving way I tied the story and the theoretical parts together as I became more trusting and accepting of the power of story as research. An academic style of writing creates a distance and excludes emotions speaking from outside an experience rather than emotionally from within it. By using autoethnography, I am bringing emotion and the felt bodily experience back into my academic writing. I am writing from within my experience in an attempt to create an evocative narrative, to encourage others to reflect on difficult topics and hopefully learn something as I describe my learning's. Strawbridge and Woolfe (2010) describe how counselling psychology transcends "the gulf that has existed between the prevailing view of science, as objective and value-free, and practice that engages with subjectivity and meaning and is characterized by uncertainty and values conflict (p. x).

Part A, the research, and Part B, the publishable piece, demonstrate my struggle at bridging these two together in a creative synthesis. At the end of writing this thesis I came across a letter written in *The Psychologist* by the President of the British Psychological Society, openly disclosing how he has "Bipolar". Following his letter there is a sequence of responses about the need to join together to speak out and disclose our own struggles as professionals. The research itself is a disclosure, the publishable piece, particularly part 1, is a disclosure itself but also a reflection on the challenges of disclosing.

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Chapter 1: Introduction

This thesis is about mental health stigma, shame and self-stigmatization, which can exist for those who work in the field of Mental Health and have experience of psychological distress. I discuss the prevalence of mental health stigma which adds to and perpetuates an “Us versus Them” culture, and use the paradigm of the wounded healer to explore post-traumatic growth, what it means to be wounded rather than impaired, and hybrid identities.

1.1 Mental health stigma

Stigma comes from the Greek word used to indicate the belongingness of animals by a mark or a scar. Mental health stigma's most cited description is that of being the reduction of “a whole and usual person to a tainted, discounted one” (Goffman, 1963). It has been described by Falk as the “ultimate stigma” and a universal issue (2001: cited in Thornicroft, 2014). Stigma exists at structural, interpersonal and individual levels (Link & Phelan, 2001). A discussion regarding the development, maintenance and perpetuation of mental health stigma is beyond the scope of this thesis; I recommend those interested to read an article by Ahmedani (2011). We know that people who experience mental health problems are often discriminated against and will experience social distancing (Lucksted & Drapalski, 2015). Other negative consequences of stigma are exacerbated psychiatric symptoms and increased cognitive and emotional distress as a consequence of managing hyper-vigilance and helplessness. Deciding whether to disclose or not also has a psychological toll. Research has established that stigma is a stressor in its own right and has the potential to compound mental health problems, reduce the chances of recovery and increase the likelihood of suicide (Rüsch, Zlati, Black, & Thornicroft, 2014). Negative attitudes can influence an individual's treatment seeking, attendance and engagement: at best weakening the efficacy of treatment and at worst causing further damage to the individual. I refer interested readers to a review on the impact of mental health stigma on treatment seeking (Corrigan, Druss & Perlick, 2014). Whilst society undoubtedly plays a large role in this, it is crucial not to overlook self-stigma (Watson, Corrigan, Larson & Sells, 2007). Lucksted and Drapalski (2015) state that “self-stigma is only one, albeit an impactful part, of a complex problem” (p. 101). Self-stigma, according to Hatzenbuehler (2016), occurs when the person suffering from mental health problems accepts and internalizes stereotypes held against them and agrees with prejudiced beliefs, subsequently altering their behaviour. Lucksted and Drapalski (2015) alert us to the fact that perceived stigma can increase an individual's self-stigmatization and result in them

trying to handle things on their own. They suggest that self-reliance as a consequence of self-stigma is one way that seeking help is delayed or avoided altogether. Consequently, this impacts upon the individual's self-esteem and sense of self-efficacy, leading to a vicious cycle whereby it becomes harder to negate or reject negative stereotypes or to make positive changes in one's life to enable or support recovery. This thesis will explore my on-going interaction with and experience of stigma and self-stigmatization as a trainee with lived experience of mental health problems. Rüsç et al. (2014) note that self-stigma leads to a powerful cocktail of shame, social withdrawal and demoralization. For example, an individual who experiences discrimination may internalize this and believe they aren't good enough to apply for a job. Rüsç et al. (2014) also note that self-stigma may lead to a "why try" attitude and a feeling of not being worthy or capable of pursuing life goals.

A number of authors, in the literature write about iatrogenic effects of what is supposed to be treatment for mental health suffering (Bassman, 1997; Deegan, 2000; Schiff, 2004). Wahl (1999) notes that many individuals avoid treatment because they fear negative reactions from the treatment providers. Sadly, those professionals who are "on the frontline", as it were, can be some of the most stigmatizing. The mental health system has the potential to and does cause multiple traumas as the consumer faces a number of challenges, such as negative professional attitudes and professionals that disempower and devalue the individual.

1.1.1 Stigmatizing mental health professionals

A Stigma Shout survey of 4000 people who had used mental health services reported that professionals are a common source of discrimination (Time to Change, 2008). Recent research supports the notion that mental health professionals are indeed a source of stigma (Corker, Hamilton, Robinson, Coney, Pinfold, Rose, & Henderson, 2016; Lasalvia, Zoppei, van Boxtel, Bonetto, Crisofalo & Wahlbeck, 2013). In a comprehensive review of the research assessing stigma amongst mental health professionals, Shulze (2007) notes that the majority of studies report that mental health provider's attitudes don't differ from the general population, and in some instances, are even more negative. The better knowledge mental health professionals have about mental health problems does not always act as a protective factor against stigma, and it is not associated with less stereotyping or a greater willingness to interact with people suffering from mental health problems (Shulze, 2007). An important point to take into consideration when thinking about stigma interventions which focus on

increasing the general public's education about, and contact with, sufferers of mental health problems.

Lauber, Nordt, Braunschweig and Rössler (2006) found that, in Switzerland, psychiatrists held more negative stereotypes than the general public towards individuals suffering with mental health problems, such as believing they are more dangerous, less skilled and more socially disturbing. Shulze (2007) cautions that the poor prognosis that many clinicians hold for their patients can be inadvertently or advertently conveyed to patients. Personally, the most worrying form of stigma that I found in the literature is the pessimistic attitude that many providers hold regarding recovery.

One of the rare studies looking at psychologist's attitudes is that by Servais and Saunders (2007) that assessed the attitudes of 306 Clinical Psychologists towards people with "moderate depression", "borderline" features and "schizophrenia". Their survey found that clinical psychologists viewed individuals with "schizophrenia" as considerably more ineffective and incomprehensible than individuals with other types of illness and viewed patients with "borderline" features as the most dangerous. They viewed "borderline" features as undesirable and "schizophrenia" as most dissimilar to themselves. Servais and Saunders (2007) note concern that a portion of psychologists reported very negative responses and that the study potentially underestimated the extent to which negative attitudes are present. They suggest negative attitudes may not only inhibit the psychologist's ability to display empathy towards their patients but may also discourage the efforts of their patients trying to recover.

In an attempt to explain their findings that psychiatrists can have a tendency to engage in social distancing to the same degree as the general population, Lauber et al. (2006) refer to the "not in my backyard phenomenon". This describes how individuals may be open minded when the stigmatized or discriminated person doesn't affect them personally, yet when it becomes personal, the care-giving individual becomes just as discriminating as everyone else.

Before becoming psychologists, we lived in the realm of the layperson and were subject to similar social contexts as a number of our patients; we grew up with the same stigma and prejudices around mental health. Lucksted and Drapalski aptly suggest "much like breathing in polluted air it is very hard not to take in at least pieces of societal prejudices... (2015, p. 99). As much as we like to think we are not affected, this polluted air we have inhaled does not simply disappear when we start training. Like the rest of the human race we have a

propensity to categorize and then distance ourselves from and discriminate certain groups (Crisp, 2001). More about this will be elaborated on further (see section 1.6.1).

1.2 The myth of the wounded healer

The archetype of the “wounded healer” implies that a clinician’s power to heal comes from their own woundedness (Sedgwick, 1994). “The mythological image of the wounded healer is ubiquitous” (Norcross & Farber, 2005, p. 940) and has been cited frequently over the past 2500 years (Zerubavel & Wright, 2012). The “wounded healer”, like other myths and metaphors, contains multiple meanings for different individuals. Thus, although it is a familiar term, we might not fully understand what it means. Perhaps this is because we each refer to it in the way that we as an individual understand it, without actually pausing to reflect on its real meaning. Whilst it is familiar, please do not confuse this for acknowledged, researched or spoken about. There is a dearth of academic attention and active dialogue surrounding the background and the wounds of clinicians, the recovery process, what it means to be healed and the impact this can have on both enhancing and hindering clinical work. I believe a large part of this silence is to do with the stigma that exists amongst professionals. Indeed, Zerubavel & Wright (2012) note how there seems to be an implicit agreement within psychology that it is risky to disclose one’s woundedness for the fear of judgment, overt hostility from other professionals or risk of stigmatization.

1.3 Mental Health Professionals and wounds

The presence of mental health problems amongst mental health professionals can no longer be ignored or disputed. Green (2016) notes that surveys are consistently reporting that mental health professionals are experiencing difficulties, even more so than the general public. Pope and Tabachnick (1994) completed a survey of 800 psychologists: 61% of the sample disclosed having at least one episode of “clinical depression”, 29% had felt suicidal and approximately 4% reported having made a suicide attempt. A recent survey on psychological staff wellbeing completed by a collaboration of the New Savoy and the British Psychological Society found high levels of staff stress (70%) and found that 46% who completed the survey, reported experiencing “depression”.

Gilroy, Carroll and Murra (2001) note that therapists are a population identified as at risk for “depression”, explaining that one of the reasons is the emotionally demanding nature of the

job. Although unfortunately solely looking at women, Gilroy et al. (2001) completed a much-needed study to update our awareness of the prevalence of “depression” amongst psychotherapists. They report that 15% of participants acknowledged some form of “depression” but did not seek treatment in the form of personal therapy. Sadly, highlighting a central issue of my thesis, those clinicians who did not seek help stated it was because the shame was too great. The study cannot be generalized owing to a number of methodological limitations, yet it still provides very valuable information and food for thought. An important limitation of their study is the sole focus on “depression”, asking participants to indicate if they had or had not experienced any “depressive symptoms” since starting practice and if they had been hospitalized with “depression”. The researchers also do not report, inquiring or controlling for, symptoms or diagnoses present before training.

1.4 Coming into the profession

There has been a surge of interest into the reasons why psychologists come into the profession (Norcross & Farber, 2005; Rizq & Target, 2010). It is often suggested that many mental health professionals come into the profession because of their own experience of mental health difficulties or the experience of helping family or close others who suffer from mental health problems (Charlemagne-Odle, Harmon, & Maltby, 2014; Mackaskill, 1988, 1992). When reviewing the literature, I quickly noted the difference in opinion between the perceived benefits of lived experience and the dangers of this in clinical practice. The reasons for coming into the profession vary from negative connotations, of healing oneself rather than the client or satisfying clinicians needs to be wanted and depended on, to the other end of the pole, wounds being essential and to be celebrated. These differing opinions, some believing it is essential and beneficial (Cain, 2000; Kottsieper, 2009; Mander, 2004) while others portray the experience in a slightly more negative light may arise from a lack of understanding. For example, Cushway and Tyler (1996) identified one of the main factors influencing the decision to become a counsellor to be a desire (intentional or not) to resolve early childhood difficulties and DiCaccavo (2002) suggests that some individuals in their childhood were valued for their caregiver role and thus come into the profession to repeat this gratifying experience. Whilst on the other hand, it is “often therapist’s own existential challenges and the consequential *awareness of their resilience* [emphasis added] that attracts them to the profession of Counselling Psychology” (Milton, Charles, Judd, O’Brien, Tipney & Turner,

2003, p. 20). Along similar lines, Conchar and Repper (2014) highlight that the troublesome backgrounds of some clinicians give them a “prized source of strength and learning” (p. 39). This acknowledgment of clinicians’ pre-existing wounds, their potential benefits for clinical practice and the importance of the professional’s resilience lends itself well to “celebrating the wounded healer” (Farber, 2016; Martin, 2011).

1.4.1 The time point factor: when

Highlighted above as a limitation of Gilroy et al.’s (2001) study, most literature tends to look at those professionals coming into the work force with existing wounds; more awareness of the possibility of becoming wounded later in life is necessary. We should be asking questions such as when did the wound or wounds occur? Did the clinician have the experience of a traumatic childhood or did they experience a trauma later on in adulthood? Further, we should discuss when the wounds become triggered: are they triggered pre-training or during the training process itself. Perhaps the mandatory therapy as part of training opens up wounds that the clinician wasn’t aware of? Or maybe the clinician will experience smooth sailing until a particular patient comes in with something too close to home. There is also the possibility that dormant wounds re-open when a clinician faces a current trauma or illness. Most importantly, we are human and we respond to life in unpredictable ways. Although it is tempting to buy into the notion of professional immunity, life often reminds us this is a fantasy.

1.5 Potential impact

How can the therapist’s suffering enable or benefit his or her own practice? The lack of research and discussion regarding the experience of woundedness and recovery makes it difficult to ascertain the impact that wounds could have on the therapeutic endeavour. Schaverian (1999), like Conchar and Repper (2014), suggests that wounds are only useful if they have been or are explored and properly processed: note that this does not stipulate that the professional has to be fully recovered from their wounds.

The analyst’s own hurt has been described by Laskowski and Pellicore (2002) as “that which gives him the measure of his power to heal” (p. 403). I believe a professional’s acknowledgement and working through of their wounds leads to an experiential understanding of resiliency and the possibility of not only recovery but growth. Indeed,

Zerubavel and Wright (2012) note how the wounded healer “embodies transformative qualities relevant to understanding the recovery process” (p. 482). Discussing trauma and resilience in clinicians, Fussell and Bonney (1990, p. 506) suggest that it is perhaps an ambiguous environment (rather than a severely pathological one) where the child experiences both acceptance and rejection that predisposes the child to a greater ability to tolerate frustration: an important ability for psychologists to have. Some of the detrimental consequences of “depression” on clinical practice, for example, can be lack of energy and motivation and memory problems. Impairment, resulting from distress not being attended to, can result in more serious consequences such as boundary violations (Gilroy, Carroll and Murra, 2002). Ivey and Partington (2014) note that it is important to distinguish between facilitative and obstructive woundedness.

1.5.1 Facilitative woundedness and post traumatic growth

Biering believes that within western psychiatry the “wound” is not expected to promote growth or, even more pertinent, it’s potential for healing is not fostered (1998: cited in Conchar & Repper, 2014). However, alongside the recent shift towards a recovery model, the past decade has seen an increase in research and clinical attention to post-traumatic growth (PT-G; Tedeschi & Calhoun, 1996). Zoellner and Maercker (2006) define PT-G as “the subjective experience of positive psychological change reported by an individual as a result of the struggle with trauma” (p. 628). Jielsing and Xinchun (2017) highlight this move away from an exclusive negative focus on “post-traumatic stress disorders”, and acknowledge that often positive changes such as a changed sense of relationship with self and others and philosophy of life can occur after traumatic events. Resilience is a related concept, which Jielsing and Xinchun define as a “resistance to pathological outcomes” (p. 23) after challenging or traumatizing events. This thesis is an exploration of the phenomenon of my own PT-G, via both the resilience required to survive the trauma and also the positive and creative element that I came to embrace as I learned to integrate the trauma into my identity.

1.5.2 Wounded or impaired?

It is vitally important that we are able to distinguish between those who are wounded healers and those who are impaired professionals (Zerubavel & Wright, 2012).

The Health and Care Professions Council Standards of Proficiency for Practitioner Psychologists clearly outline that to maintain fitness to practice psychologists must “be able to manage the physical, psychological and emotional impact of their practice” (HCPC: Health & Care Professions Council, 2015, p.10). One way to prevent distress turning into impairment is to engage in self-care practices, one of our ethical imperatives (Barnett, Baker, Elman & Shoener, 2007), yet we do not always attend to our own care adequately, one reason being the sense that it is self-indulgent, another being the stigma that is attached to help-seeking, particularly for professionals who are usually providing the help.

1.6 What are we doing as professionals?

1.6.1 Othering

The universality of the desire to “other” in order to enhance our self-esteem has long been understood in social psychology (Turner, Turner, Oakes, Haslam & McGarty, 1994: cited in Servais & Saunders, 2007). There is thus an understanding of the process by which one wishes to separate oneself from another.

In a qualitative study exploring the experience of psychotherapists with a history of psychiatric hospitalization Cain (2000), notes how one participant described othering as a protective function because it is incredibly difficult to be with someone’s pain – something that we do on a daily basis. Servais and Saunders (2007) discuss “disidentification”, originally described by Cumming and Cumming (1957: cited in Servais & Saunders, 2007). They suggest that disidentification, or othering, involves characterizing people with “mental illness” as both easily recognizable and different or abnormal while simultaneously characterizing oneself as normal and not susceptible to “mental illness”. They suggest that categorization tends to lead to an “us versus them” mentality, which can contribute to the othering process. Rather than seeing distress on a continuum diagnostic categorization has the potential to increase othering a personal example can be seen in this thesis (Appendix 6). Sedgwick (1994) notes that therapists who don’t acknowledge their own vulnerabilities and deny their inner conflicts run the risk of projecting onto the patient the persona of their wounded interior: I would extend this to include projection onto the colleague who experiences mental health problems.

Viewing ourselves as similar to our patients suffering from mental health problems can cause us distress, as we are no longer able to deny that we too could or do suffer. Acknowledging our similarities involves acknowledging our vulnerabilities, which is not an easy task. If we do not acknowledge it, I argue by ignoring it we run the risk of taking what Denshire (2014) calls “professional detachment” too far.

Acknowledging our own susceptibility to “mental illness” is equated to losing the safe distinction between “us and them”. One could argue that as professionals one reason why we engage in othering is to avoid suffering the anxiety and fragmentation of identity that will likely occur when we stop clinging onto the “expert” identity, losing the safe distinction between us and them. As therapists, by not encouraging disclosure and open discussion surrounding our own wounds, we could be engaging in the separation of “us versus them” or “locked in a battle of objectify-or-be-objectified” (Cooper, 2003, p. 20). By this, I mean that, out of fear of others objectifying us as something we do not wish to acknowledge in ourselves (perhaps vulnerability or weakness), we objectify the other (either our patients or our colleagues). Perhaps we are creating this distance as a reaction to what has been described as “courtesy stigma”. This is clearly exemplified in the statement “psychologists are flakier than their patients” (Sadow & Ryder, 2008).

1.6.2 Role models

Servais and Saunders (2007) note the important role that Clinical Psychologists, and by extension Counselling Psychologists, play in correcting the public’s misperceptions of mental health problems and in promoting attitudes of acceptance and understanding. Lauber et al. (2004) also note that mental health professionals are considered to be opinion leaders regarding mental health issues and that their opinions may have a multiplying effect in the general population, but also amongst other health professional groups. Schulze (2007), Servais and Saunders (2007) and Lauber, Anthony, Ajdacic-Gross and Rossler (2004) are just a few of those who note we must be mindful of and caution against the detrimental consequences of our own negative attitudes, beliefs and behaviours. Psychologists with the “Dr” title have a responsibility to behave ethically; Burke (1995: cited in O’Brien, 2011) writes how harm can be done if others perceive a therapist’s public behaviour as negative, and that this can discourage people from seeking out and pursuing treatment in the future.

I believe the promotion of a deeper understanding of the lived experience of mental health problems and particularly a demonstration of our belief in recovery and growth is our ethical

imperative: it is at least mine. At the end of their research article, Servais and Saunders (2007) call for tackling negative attitudes on *both* an individual and profession-wide basis, in line with my personal belief and indeed the aim of my research. But why are we, as mental health professionals, engaging in, allowing and participating in the stigmatization of mental illness when we are supposed to be the ones promoting a patient's recovery? Not only is it shocking, it's unacceptable that we do this. I wonder if it could be because *we* are trying to rid ourselves of our own shame on a mass level. Not only do we, as mental health professionals, stigmatize patients we can also discriminate those colleagues who have or have had mental health problems.

1.6.3 Stigmatizing colleagues

Acknowledging our vulnerabilities or potential vulnerability is especially difficult if there is a perceived "stability" of the identity we inhabit. Martin (2011) aptly asks why anyone would want to step out and explore the bits of themselves they have conveniently allocated to others? Callahan and Ditloff (2007) noted that others might expect psychologists to be immune from pain. It is rather ironic that we have a higher prevalence of "mental illness" than the general population yet we cling onto the view that we are somehow "healthier" (Sherman & Thelen, 1998). I argue that it is this perceived pressure to be immune to emotional pain that can lead us to reject our vulnerability. Shepard, Boardman and Burns (2009, 2010: cited in Richards, Holtum & Springham, 2016) note that those unwilling to move away from their perceived role as experts may hold negative views not only towards service users but also towards professionals who have or have had experience of mental health problems. An example of this can be seen in a study by Gilroy et al. (2001) who quote a participant (a therapist with "depression") regarding their experience of interactions with colleagues: "almost as though I represented something they didn't want to face in themselves" (p. 27). The fact that we often want to relegate vulnerability to other colleagues is supported by O'Connor (2001), who reports (from a survey of psychologists in California) that identically defined personal problems were judged as more impairing when they were attributed to colleagues as opposed to the self.

Adame (2014), in a journal article that describes the stories of a number of "survivor therapists" notes how many of them not only had their human rights abused when they were patients but also experienced further distress by being devalued as a therapist because of their past or present patient status. Whilst, I agree that engaging in othering to protect our self-esteem is a universal and natural phenomenon, I concur with Servais and Saunders (2007)

that “our need to create better coping mechanisms is well overdue”. This thesis is an attempt to think about ways in which we can change this.

1.6.4 What can we do about it?

I am saddened when I think about the amount of time, energy and cost that has been spent trying to tackle mental health stigma. If we as professionals with extensive knowledge, training and contact with patients with mental health problems are unable to tackle it from within, how can we realistically expect the layperson to change their attitudes and behaviours? A discussion regarding the results and long-term effectiveness of anti-stigma campaigns is beyond the scope of this thesis. I refer those interested to a recent review of the data (Thornicroft et al., 2016). Of note, in their review of the evidence, Thornicroft et al. (2016) suggest the strongest and longest lasting benefits were found in those interventions that involved someone with lived experience of mental illness. Along similar lines, Hankir, Zaman, and Evans-Lacko (2014) note that studies looking at the efficacy of interventions targeting mental health stigma amongst the medical professions, report the most lasting changes are a result of those interventions that are delivered by a member of the same professional group who also have lived experience. One way to tackle othering, I believe, is to embrace our “hybrid identities”. By fully engaging in my story and lived experience, I hope to increase the reader’s awareness of the similarity rather than distance between us and our patients, subsequently reducing the potential to other.

1.7 Hybrid identities

I start this section quoting Denshire who suggests “the notion of the coherent, individual self [has] been called into question” (2014, p. 835). In a recent relational autoethnography on hybridity in the mental health nursing profession, Grant describes hybridity as being borrowed from post-colonial studies (Barlow & Grant, 2016). Within mental health, this can be seen as the blending of the colonized (service user) and the colonizer (mental health professional). Hybridity can also refer not only to the effect of the mixing of cultural identities but also to the effect of changes to power relations where the traditional hierarchies are compromised or undermined. Grant goes on to note how it is usual practice that service users are written about more often than not by mental health professionals – be it in clinical records or in research – and he states that research and writing (such as his and others who embrace the hybrid identity) is likely to create anxiety, especially for the “colonizers”. It is likely to be uncomfortable for some readers who have not yet decided to look at themselves

in this way. Indeed, Berry (2006) writes about autoethnography as having the potential to be an unwanted gift. I am aware that my desire may be, in truth, to cause some discomfort, as I believe it is only through recognizing and owning our discomfort that we can attempt change. I am not excused from this myself; the struggle with my own discomfort will hopefully be apparent to the reader as they continue reading and engaging with this research.

Barlow and Grant (2016) use dialogue to “expose and interrogate stigmatizing mental health cultures” (p. 33). This is achieved by offering the reader email exchanges between Barlow, a mental health nursing student and Grant, a reader in mental health nursing – both also psychiatric survivors. In the emails, Barlow describes some of her darkest moments, which Grant responds to, noticing the impact this has on him and the memories that are being conjured up. He writes how he would like many more students and academics who have had the experience of extreme psychological distress to acknowledge “the hybrid nature of their identities” (p. 33). He states, and I agree, that it would be “really good emancipatory, anti-stigmatising practice” (p. 33) for those mental health professionals and the people they help. He notes how it is essential that these types of exchanges take place given their potential to impact mental health practice and scholarship by collapsing the boundaries between professional and user narratives. It is this essence of the hybrid identity that I wish to demonstrate using autoethnography, presenting myself as both the researcher and the researched.

1.8 Celebrating the wounded healer

Alongside service user narratives, a number of mental health professionals and academics have been writing and publishing accounts of their own experiences of suffering from both mental health disorders and the mental health system. Interested readers are referred to a number of engaging and moving texts that have also encouraged me along this journey of writing about my experience (see Chadwick, 1993, 1997, 2001; Grant, Leigh-Phippard, & Short, 2015; Jamison, 1996).

An American psychiatrist, Fisher (1994), identifies himself as a survivor of the mental health system. Through his writing he seeks to dispel the myth that those who have psychiatric disabilities should refrain from working in the mental health system. Like many others (Breeding, 2008; Harper & Speed, 2012), Fisher believes that a shift in the thinking within the psychiatric system from one of an illness paradigm to a healing vision will facilitate the

transition of those who are “consumer survivors” (i.e., users of mental health services) into the role of “mental health providers”.

Chadwick (2001) suggests that by valuing lived experience we can gain a better understanding of mental health problems, and this can also lead to the development and subsequent evaluation of forms of treatment. More attention is being given to ensuring service users have a greater voice than previously. This is in line with the shift to a recovery model “based on a system of health promotion and where individuals actively define their needs and collaborate with others in their healing process” (Schiff, 2004, p. 214). The value of personal experience of mental health problems is now being recognized in policy and research. There has been a concurrent increase in involvement and participation in planning, service delivery and research by service users (Ochocka, Janzen, & Nelson, 2002); some say that the idea of service users being involved in this way is now commonplace (Ion, Cowan & Lindsay, 2010). However, although it may be commonplace, I have not experienced this and I feel we could do a lot more to celebrate the value that wounded healers can bring.

1.9 Relevance to Counselling Psychology

Autoethnography as a method requires the researcher to embrace their own “vulnerability as a way to understand emotions and improve social life” (Adams, Linn & Ellis, 2015, p. 33). This is similar to the endeavour of counselling psychologists and their patients. How can we ask our client to embrace and explore their vulnerability if we are not yet able to fully go there ourselves? Autoethnography and therapy are both relational pursuits (Turner, 2013), and Ellis (1999) has suggested that ethnographic training might be just as important for a therapist as their therapeutic training. Adams et al.’s (2015) statement that they commit themselves to “improving the lives of others and our own” highlights the particular relevance of this research method to my self-development as a practitioner and the profession of Counselling Psychology. Denzin (2014, p. 70: cited in Denshire, 2014, p. 12) has described the goal of an autoethnography to be to “write texts [that] move others into ethical action”. I have noted earlier that we need to re-address our attitudes towards mental health problems and be active in targeting stigma, improving the lives of others and our own. Lincoln and Denzin (2005: cited in Morrow, 2007) predicted major themes that will be addressed in coming generations of qualitative research: one of these being the reconnection of social science to social purpose. This implies that social scientists must move beyond mere academic inquiry to renew, reclaim or discover their social justice roots.

In the context of clinical practice, autoethnographic accounts may necessitate a significant questioning and reworking of received clinical binaries such as patient–therapist (Denshire, 2014), or what Sparkes (2017) refers to as resisting the “warping tyranny of dualisms” (p. 1). My desire to tackle othering means that I must “strip away the veneer of self-protection that comes with the professional title and position” (Denzin, 2003, p. 137: cited in Denshire, 2014), making myself more accountable and vulnerable to the reader. Denshire and Lee (2013) eloquently describe how putting the self of the clinician into the picture is challenging, but that a self at risk opens up places of vulnerability. They suggest, however, that these places of vulnerability are also places for the reworking of thoughts and actions.

Doty (2010) notes that autoethnography has the potential to create spaces where we can challenge the status quo, offering an opportunity to engage readers in a way that makes them moved to care, and that we (autoethnographers) are changed by the process. I have indeed changed my practice and my development of a professional identity profoundly from engaging with autoethnography as a method. Both having to write through my struggles and, perhaps more importantly, having to read others’ works have inspired and encouraged me to be brave enough to stand up for something I believe in. This has been incredibly hard to do while training, and it is indeed an ongoing process; however, the struggle has made me a better clinician.

Regarding research in Counselling Psychology, Gergen (2001) has critiqued the profession, describing it as frozen in time and slow to embrace the blurring of boundaries between the social sciences and humanities. Along similar lines, Morrow (2007) alerts us to the fact that Counselling Psychology has “yet to embrace all of the possibilities that qualitative research offers to accomplish its inquiry goals” (p. 225). Strawbridge and Woolfe (2010) suggest that as a discipline, Counselling Psychology has a critical edge and proposes alternative approaches; I suggest autoethnography is one of these. This thesis is a response to the call for expanding methodological diversity (Morrow, 2007) and is in direct opposition to the idea that psychological theory denies “the therapist as a person” (Milton et al., 2003). I aim to demonstrate the value of autoethnography as a qualitative method that is particularly suited to Counselling Psychology because of the growing interest in conducting research that is congruent with paradigms and methods that are more closely related to practice.

Much like Wall (2006), my learning has been and continues to be the reading of others’ autoethnographies. I hope that this thesis can serve as an example of one of the many ways that counselling psychologists could embrace this methodology and also bring recognition to

it's potential, from the reading of other people's works, to enhance our practice. An excellent example of this is an article by Jones (2012), which describes how autoethnography can help the professional to develop their therapeutic use of self while working with the borderline personality disorder population. In my review of the literature it was abundantly clear that the field of mental health nursing was significantly further ahead with the recognition of the value that this method can bring to their profession. Whilst different arms of the mental health profession, I believe developing a therapeutic relationship and empathy is at the heart of both.

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Chapter 2: Methodology

2.1 Introduction

This chapter aims to provide a description and explanation of the way I have attempted to answer the research question, which has come out of the literature review and the focus on stigma and shame: How do I live with a dual identity and make sense of mental health stigma and shame that exists within the profession? I describe my epistemological and ontological assumptions and provide a detailed account of both the general and specific approach taken and why this was chosen for this thesis. I provide the reader with a rationale for the choice of autoethnography, and within the various subheadings I attempt to clearly describe the shape and form this took. Autoethnography should be creative and the detailed methodological description below comes into tension with this. I am mindful of the purpose of this autoethnographic piece of work being for the submission of a doctoral thesis, and thus have tried to keep a balance between the academic and the creative.

In this chapter I also demonstrate the way in which I engaged with the ethical difficulties one encounters when doing autoethnography. I also note the process of ensuring that I produce not only an ethical piece of research but also one that is reliable and valid. Willig (2013) recommends the researcher describe what they want to find out and what type of knowledge the project aims to generate in order for the research to be evaluated in a meaningful way. Indeed, there has been considerable debate about the proposed criteria for judging the quality of autoethnographic writing (Holt, 2003). Being an underused approach in the field of Counselling Psychology (Wright, 2009), I describe suggested criterion to evaluate the research and, more importantly, the ways in which I attempted to follow these.

2.2 Ontology and epistemology

It is essential to consider, before embarking on any research endeavor, what we are trying to understand or gain further information about and how we think we might do this. These assumptions and beliefs then inform the chosen methodology and methods employed within the research. Willig (2013) describes how ontology concerns itself with the form and nature of reality and what we can know about that reality. Related to this is one's epistemological position which concerns itself with what and how we know, which is also concerned with the relationship between the researcher/s and participant/s. This research is complex as it defies binaries and seeks knowledge about the personal, cultural and political.

So, to what extent do I believe there is a reality that can be known and understood? My ontological position can be best described as critical realist. Therefore, I accept that there are true realities but believe they can only be measured imperfectly given I don't believe that I can have direct access to reality. This being also because of my belief in shifting and fluid 'realities' that are context dependent. I therefore comfortably reject the belief that there is one true reality that can be identified and measured (naïve realism). I also take a relativist position given, as I mentioned earlier, I believe reality to be subjective and influenced by the context. However, I cannot align myself fully with a relativist position as I feel by doing so I am not fully acknowledging that 'real' events occur such as oppression. A relativist position proposes that what is experienced as 'real' depends on the mindset of the person experiencing it and therefore there is no 'reality' beyond such subjective realities. It is this latter point that I struggle with as I believe in accepting this we can easily deny 'real' social processes and power dynamics explaining them away as subjective constructions.

The ontological positions I have described are seen on a spectrum with a realist conception of knowledge on one end and a relativist position on the other. At the offset the notion of a spectrum whilst, should be seen as fluid, does give rise to an either-or quality, making one question am I a realist or a relativist? I believe this edges us towards an unhelpful categorization or binary, something which I am attempting to destabilize throughout my thesis. Burr (2015) also highlights how the perceived dualism can be unhelpful. In a thought provoking an aptly titled paper "Constructivism and 'the real world': can they co-exist?" Willig (2016) describes the positions well and highlights how most (if not all) qualitative research is actually based upon a position of ontological realism together with epistemological relativism. A further debate regarding this is beyond the scope of this thesis. I recommend interested readers to the paper and text I have cited.

Therefore, in summary my ontological position I feel is neither realist nor relativist but a combination of the two. I believe that 'real' events occur, for example discrimination, which needs to be exposed and acknowledged. However, I don't believe in a singular reality and I do believe that realities are constructed by people in interaction with others and the world. So something 'real' happened in that I was physically locked in a cell. I maintain that regardless of how I construct it, it doesn't change the fact that I was locked in the cell or the duration of my time in the cell. However, how I constructed and made sense of it at the time and then

later, including whilst writing this thesis shifted. These understandings of the experience therefore are true and real to me in different times and contexts.

Now I have discussed my ontological position, concerned with the form and nature of reality, I describe to the reader my epistemological position which Willig (2013) reminds us is concerned with how I can know, what I can know and the various ways I can ‘access’ knowledge. Epistemology is also concerned with the relationship between the researcher and participant. Most papers discussing or describing what epistemology means and the various positions one can take focus on this relationship. They discuss differing opinions on how the researcher can access knowledge from the participant. They suggest it can never be, for example, purely descriptive phenomenological knowledge as it is always interpreted by the researcher. Things, however, get complicated naturally when I am both the researcher and participant.

Given my position as both researcher and participant and my beliefs and assumptions outlined above, which will be further outlined below, this research is one of methodological pluralism (Willig, 2013). I take the view that three types of knowledge (realist, phenomenological and social constructionist) can be produced which are not mutually exclusive. I view them as complementary, each providing access to different aspects of ‘reality’. My choice of a pluralistic approach, as Willig (2013) states is “based on the assumption that human experience is complex, multi-layered and multi-faceted” (p.20) and thus an equally complex methodology is suitable. The result of acknowledging and validating the different types of knowledge can be seen in the production of a coherent yet fragmented narrative chapter and a theme chapter. A pluralistic approach is also suited to this research given autoethnography has the ability to encompass tensions such as the “personal and academic, scientific and spiritual” (Anderson & Glass-Coffin, 2013, p. 58). I shall now provide the reader with a summary of the ways in which I have positioned myself in various stages of the research process.

A phenomenological epistemological position aims to produce knowledge about a subjective experience, remaining as close as possible to the data. This applies to my research, mostly in the narrative chapter where I am offering my subjective experience of my ‘accident’ and then my further experience of training as a counseling psychologist and wounded healer. I could take a descriptive phenomenological position where I am capturing the experience as it

presents itself or an interpretive phenomenological position which aims to go further and understand the meaning of my unique experience and position in relation to the wider social context (social, cultural, theoretical). I am able to remain close to my data given I am the participant and I am offering my subjective experience. Therefore in the narrative chapter I am taking the more descriptive phenomenological position offering readers an evocative, emotional glimpse of my experience, encouraging empathy and understanding. Should I have wished to maintain this position, the choice of emotive narrative fits with the descriptive phenomenological position. However, I then went further and engaged in analysis. I used my reflexive self and transparent dialogue/narrative to explore my expectations and assumptions both at the time of the experience and retrospectively. I am therefore at this point taking an interpretive phenomenological stance as I am actively understanding the meaning of my account of my experience and reflecting on it in relation to the wider social, cultural and theoretical context. This position is most clear in the theme chapter and leads well to the social constructionist position that I also took up.

The social constructionist position focuses on the way I talk about my world. One's position as a social constructionist also exists on a spectrum from a radical social constructionist to a moderate social constructionist. I take a moderate social constructionist position. Why do I take this position? A social constructionist position places a significant amount of attention on the language that is used to construct versions of reality, also paying attention to how some discourses construct knowledge and position people with the consequences of this. It is therefore suitable for my research aims since I aim to explore how dominant discourses surrounding inpatient treatment and professionals with mental health issues, past or present, are positioned and what some of the consequences of this discourse are (Grant, 2010). In the theme chapter, I focus on how socially available ways of talking about being a wounded healer in training are deployed and the consequences. For example, the consequence of some discourses may lead to self-stigmatization or the objectification of other colleagues. Important to the social constructionist position is the belief that language is a form of social action where we construct versions of reality for particular purposes. This position also has an affinity with the critical realist ontological position that I take, with the ways in which available discourses can constrain and limit what can be said or done within particular contexts.

The social constructionist position is suited to autoethnographic research as it shares a belief in a resistance to finality and closure. Anderson and Glass-Coffin describe the resistance as “reflecting a conception of the self and society as relational and processual, mutually written in a moment that opens onto a panoramic albeit not unlimited future of possibilities (2003, p. 79). This position is also well suited because autoethnography lies at the intersection of discourses and experiences of “self and other, insider and outsider, native and colonialist” (Anderson & Glass-Coffin, 2013, p.73).

In summary, I was interested in both the experiential world of myself as a participant (phenomenological) and the social structures that give rise to my understanding of this experience. Beyond the experience described, I was interested in the social processes that drive individuals (including myself) to perpetuate stereotyping, stigma and shame. Through unpacking my own constructions and discourses, I hope to demonstrate how my experience shapes the meaning I give to it in various contexts. I am providing the reader with phenomenological knowledge of the quality and texture of the experience in my narrative chapter by taking the reader with me on a journey. There is also an element of interpretation as I am writing both retrospectively and currently how I am feeling whilst writing the material (including felt body sensations). Whilst I am writing I am also aware and reflecting on what I have read and my general experiences of stigma and shame that exist and continue to exist in my environment. I am then, taking a wider lens when I am producing the themes chapter, linking my experience of culture and theory that exists, producing moderate social constructionist knowledge.

2.3 Choice of qualitative methodology and autoethnography

Ponterotto (2005) notes that, within counselling psychology research, there has been a recent paradigm shift, from a reliance on quantitative methods towards a more balanced use of qualitative methodology as well. He highlights how counselling psychologists in particular have been calling for more postmodern perspectives and qualitative methods for decades. Qualitative methods focus on the description and interpretation of experiences and phenomena which incorporate the use of the participant’s own words and everyday language. It is an idiographic research approach interested in understanding the meaning that is given to or made about phenomenon, with a focus on understanding individuals as complex and unique characters. The notion that qualitative research treats humans as “patterned but not

fully predictable human beings” (Peters, 1999: cited in Linn, Adams, & Ellis, 2013, p. 24) fits my own views and resonates with my clinical work.

Literature regarding mental health stigma consistently notes how certain elements of stigma are best explored with qualitative research, yet there is a noted “underutilization of qualitative methodologies” (Link, Yang, Phelan, & Collins, 2004). This will be a qualitative study, developed from a predominantly social constructionist perspective, providing insight into an experience that cannot be observed directly. Storytelling has been described as one of qualitative research’s distinguishing attributes (Wolcott, 1994: cited in Muncey, 2010): thus, autoethnography seemed like a natural fit.

2.3.1 What is Autoethnography?

Autoethnography was formed out of a recognition of the limits of scientific knowledge and a growing appreciation for qualitative research (Linn et al., 2013). It blossomed as an alternative to the “excesses and limitations of theory-driven, empiricist social science” (Bochner, 2013, p. 53). Muncey (2010) describes it as a method that challenges traditional research boundaries between art and science and abandons the search for truths and facts. It has also been described as a method that embraces the unique experience of individuals and the contingencies of knowledge, often disregarded in larger scale social scientific research (Jones et al., 2013). It is the answer to the problem of lacking personal voice in social science research and it thus challenges other methods of inquiry that intentionally separate the researcher from the researched. It also challenges Hammersley’s “suggestion that social research cannot, and should not, advocate on behalf of social change” (Jones et al., 2013 p. 36).

Autoethnographic texts can pose challenges to “entrenched beliefs, practices and ways of understanding experience” (Douglas & Carless, 2013, p. 88). Anderson (2006) also notes how an evocative text can create further dialogue and increase the sympathetic understanding of a particular subculture while also developing and redefining generalized theoretical understandings, informing change and social knowledge. Indeed, it was not until I experienced my own inpatient stay that I really engaged with the literature, theory and political debates regarding this, that had been available to me as a practitioner. Reflecting on my experience and my ongoing interaction with empirical knowledge has enabled a deeper understanding of these issues that I hope to share.

Jones et al. (2013, p.22) propose four distinguishing features of autoethnography:

1. purposefully commenting on or critiquing culture and cultural practices
2. making contributions to existing research
3. embracing vulnerability with a purpose
4. creating a reciprocal relationship with audiences in order to compel a response.

Thus, in contrast to the more positivist idea that the subjectivity of the researcher contaminates scientific objective research, I have chosen a method that embraces the researcher's subjectivity.

2.3.2 Rationale for an autoethnographic approach

Holt (2003) tells an incredibly helpful story depicting a review process for publishing autoethnographic research. Given that one of the suggestions he highlighted was to elaborate on why autoethnography was chosen and how it is useful, I provide here my rationale.

Autoethnography was deemed an appropriate method as it frequently “explores emotive topics and those which are conventionally kept private” (Chang, 2008, p. 50) and breaks silences around sensitive topics (Philaretou & Allen, 2006). As my research looks at what has been termed the “dilemma of the wounded healer” (Zerubavel & Wright, 2012) and at “shame” amongst mental health professionals, the method suited the aims of the research: the focus being the inpatient and wounded healer “status” as silenced areas in the profession, and the purpose being to evoke emotional responses and create dialogue that may begin to reduce stigma and shame.

I felt autoethnography could offer vivid descriptions and insights that a detached observer could not about taboo topics and traumatic experiences. It has been described as a method that addresses “questions that would be hard to obtain through conventional research methods” (Linn et al., 2013, p. 34). It can be a particularly useful tool for researchers who deal with human relations in multicultural settings (Chang, 2008, p. 51), thus it sits well within the context of Counselling Psychology. It was also deemed appropriate as an approach because, as Linn et al. (2013) highlight, autoethnography can, and has been used to, intervene in systems and practices, creating change within selves, communities and cultures. As with Anderson and Glass-Coffin, I was “drawn to this genre where self and others interact, relate and dance together in ways that challenge the received wisdom of more traditional social science” (2013, p. 57).

One of the strengths of autoethnography as an approach is the ability to look at both the auto and the ethno: self and culture. This autoethnography will expose and explore my own sense of shame and how this has been progressively chipped away during my training years in order to arrive at this point where I am now able to use my disclosure for academic and activist endeavours. I undoubtedly experienced varying levels of shame during the research process itself, and the tracking of this in research journals was an important part of the work. Reactions from others when I disclose the nature of my doctoral thesis, my reaction to them, my fears surrounding publication and the judgement of readers and my own self-judgment will provide an example of the development and maintenance of stigma within the subculture of mental health professions. Adams et al. (2014, p. 96) note the importance of an avoidance of blaming and shaming when writing an autoethnographic account. My own experience of shame exposed during this research will hopefully illuminate some of the maintaining factors in our oppressive system and my own involvement in supporting and maintaining that system (Jackson & Mazzei, 2009). A relational perspective is thus taken whereby I attempt to figure out how my self, my interaction with others and society creates and maintains stigma, acknowledging that all people involved in a relationship “perpetually and mutually influence each other in innumerable and uncertain ways” (Adams et al., 2014, p. 38).

Alec Grant has posited that universities and mental health services engage in “an avoidance of asking awkward questions or challenging the organizing principles” (Short, Turner & Grant, 2013, p. 35). There is thus a need to explore this further and to ask questions such as how are we socialized in our various organizations, does it depend on the particular school of therapy we are trained in, and how much of this is influenced by the mind of the clinician who is potentially hesitant to step outside of the perceived boundaries, especially within the current context of manualized treatments, evidence-based practice and a culture of continual evaluation. As mental health professionals, are we not speaking up or researching issues such as these because we fear shame and rejection from the mainstream, or assumed mainstream, views?

Another important rationale for choosing this method is the criticism that other research methods have not engaged sufficiently with the challenges, both methodological and ethical, of transferring the value of social science research meaningfully in areas where it could make a productive difference (Muncey, 2010). This leads me to a discussion of the purposes of my research.

2.3.3 Responding to the purposes of autoethnography

Jones et al. (2013) suggest some of the purposes of an autoethnographic approach (pp. 32–36):

- disrupting norms of research practice and representation
- working from insider knowledge
- manoeuvring through pain, confusion, anger and uncertainty and making life better
- breaking silence/reclaiming voice and writing to right (Bolen, 2012)
- making work accessible.

I hope that this project addresses all of the aforementioned features of an autoethnographic study, with particular reference to my own aims of the research endeavour. I hope that, by referencing existing theory surrounding the concept of the wounded healer and the experiences of inpatient treatment alongside my own written response, this will not only expand knowledge of this under-researched area but will stimulate an on-going interest and much needed discussion. I hope to ignite in others a passion for future research in this area. In disrupting the norms of research practice in my field, I hope to demonstrate the specific value of this approach to Counselling Psychology.

2.3.4 Researcher's claims

I do not claim to be producing general knowledge, and I certainly do not pertain to give voice to those who cannot speak up: this would go against my argument of the dominant discourse squashing psychiatric patients' stories. Indeed, Jones et al. (2013) note that we should no longer think of ourselves as the ones who give others a voice or who articulate for them the knowledge of their lives and cultures. I am instead offering a unique insight into my own understanding of knowledge, at this present moment, questioning social and cultural discourses. As Anderson and Glass-Coffin (2013) have described, I am representing understandings and insights that were captured, at one point or more, in temporal and sociocultural contexts, with the belief that social identities and relationships are fluid. I am attempting to use my personal experience to facilitate an understanding of this particular societal experience, via nuanced and thick descriptions. I am attempting to respond to Walker's call for research that makes "life experience come alive" (2009, p. 26: cited in Linn et al., 2013, p. 33) and to use my own subjectivity and reflexivity as a researcher with a commitment to social change.

I also have what Wall (2008) has described as a relentless feeling of the importance of sharing my insights. One of the goals of this research was to evoke an empathic response from readers and raise a desire for their own self-exploration. Autoethnography has been described as an inquiry whereby the open and transparent exploration of “character weaknesses, struggles and ambiguities of the researcher can touch readers deeply and evoke an open heart and mind to self-scrutiny as well” (Douglas & Carless, 2013, p. 75).

My claims above stem from my understanding of knowledge and of the social world. It is therefore important that I now describe my epistemological position.

2.4 Research design

Autoethnography has been described as not so much a methodology but “as a way of life that acknowledges contingency, finitude, embeddedness in storied being, encounters with otherness, an appraisal of ethical and moral commitments and a desire to keep conversation going” (Bochner, 2013, p. 53). It is also likened to taking an adventure with a map and compass but not being hidebound by expectations and predictability (Muncey, 2010). In light of the purpose of this research, I attempt to give an extensive overview of what I did and how/why I did it.

2.4.1 Researcher as participant

In autoethnography, the self of the researcher and others can be positioned in different ways. While I acknowledge that there is no “me” without others, any exploration of others in detail is beyond the scope of this research and would have challenging ethical considerations (see section 2.8). The choice of only one participant is in line with the methodology of autoethnography: it “celebrates rather than demonizes the individual story” (Muncey, 2010). For the purposes of this work, therefore, the researcher is the primary focus, while others are only explored in auxiliary relationships with myself (Chang, 2008, p. 64). This methodological decision allows an in-depth account of a particular experience (Grant, 2009), offering “nuanced complex and specific knowledge” (Adams et al., 2014, p. 22) about my experiences and interactions with myself, others and culture.

2.4.2 Researcher membership

Anderson (2006a) writes about the difference between a researcher that goes into a culture with the aim to understand and transfer this knowledge through text and the researcher who is “thrown into a group by chance circumstances”. Although I could argue that I pertain to both,

for all intensive purposes, with hindsight, I believe the latter applies to me and subsequently to this research exploration.

In the case of this research, I take the storied position of both patient and mental health professional (my hybrid identity); by fluctuating between the two positions I hope to demonstrate that we can all occupy the space of one or the other, often inhabiting both (Short et al., 2013). Further, my position now in space and time is very different to when the experience occurred. This will be explored and discussed throughout the research process.

2.4.3 Choosing the type of autoethnographic approach

Similar to the multiple possibilities for positioning the author, there are different types of narratives that can be employed in autoethnographic work. Autoethnographies have been broadly divided into two poles, evocative and analytic. Analytic autoethnography proposed and defined by Anderson (2006) as “ethnographic work in which the researcher is (1) a full member in the research group or setting, (2) visible as such a member in the researcher’s published texts, and (3) committed to an analytic research agenda focused on improving theoretical understandings of broader social phenomena” (p. 375). On the other end of the spectrum is evocative autoethnography (Ellis & Bochner, 2006) which “uses stories to do the work of analysis and theorizing” (p. 436), the main goal being to evoke a desire for the reader to engage with the text, by feeling and empathizing. A lengthy discussion surrounding the similarities and differences between the two is beyond the scope of this thesis, but I recommend those interested to read “Analyzing Analytic Autoethnography: An Autopsy” (Ellis & Bochner, 2006) which helpfully describes these tensions and moments of similarity in an easy to engage with story.

One type of narrative that was considered was a progressive narrative. However, because in this narrative the character is seen to resolve a transformation coherently, it did not fully fit my research purpose or epistemological stance. While a large part of what I discuss and my reaction to the trauma has now been integrated into my own narrative, as does the passing of time and the mundane experiences of life, the training context provided new challenges and created a constant state of flux for me; my experience was constantly evolving within my shifting contexts.

Thus, given my belief that transformation is never complete, a narrative that could depict this was sought. My perspective resonated with Alec Grant’s statement, “I want to tell a story with no real beginning or end as I’m kind of always in the middle of it” (Short et al., 2013, p.

33). One narrative that seemed appropriate, therefore, was confessional–emotive, given that it is a method which can expose confusion and problems, usually hidden for fear of self-exposure. Given the importance that I place on linking my experience to theory and indeed the context of the research being for a doctoral thesis, this confessional narrative in isolation did not fully meet my research aim. What has been named the analytical–interpretative (Anderson, 2006) writing style, committed to analytical research that provides theoretical understandings, was therefore deemed equally appropriate to meet the goals of this project. Ellis and Bochner (2006) suggested that autoethnographic research must be intimate and vulnerable, whereas a criticism of Anderson’s (2006) approach was that it is producing a distancing by theorizing. While one can see them in tension, I have chosen to combine them. This way I could analyse my confessions and “case” as it were, linking this to the broader cultural and societal issues of stigma, shame and of the experience of inpatient treatment. Thus, for the purposes of this study, a mix of emotive and analytical–interpretative writing was employed. The more emotive narrative is where I feel most comfortable in therapeutic writing, but and the analytical writing is closest to what I have been accustomed to academically.

2.5 Data

2.5.1 Types of data

Bochner (2013) notes how facts are important in autoethnography and how they are able to be, and should be, verified. I included and actively sought data from alternative sources, such as medical records, offering a different lens to look through or for me to interact with and also perhaps more importantly to explore my immediate reactions to each piece.

However, Bochner (2013) also reminds us to acknowledge that the truth is never stable in autoethnographies “because memory is active, dynamic and ever changing” (p. 54). Indeed, I believe it is not an accurate portrayal or validation of truth that is important but the ability of the story to evoke something for the readers, stimulating their creation of their own truths. I am more concerned with the generation of an in-depth evocative account demonstrating to readers my own meaning-making process.

2.5.1.1 Self-observation/reflection

Two types of data frequently used in autoethnographic work are that of self-observation and self-reflection. In terms of self-observation, my feelings at the time of doing the project and

when interacting with others were noted. I also wrote down more self-reflective thoughts and feelings, which were later added as data. Here, I was more actively analysing and evaluating my past experience. While the two types of self-observational data could be seen to be separate entities, a complete division of the two data forms was impossible. Every effort was made to note down the introspective observation as close to the occurrence as possible. This was maintained by keeping an introspective journal with me throughout the duration of the research project.

2.5.1.2 Narrative

As well as the above data collection, I also provided brief snapshots of important events: the description being part of the data collected. A large majority of textual data was generated by myself in the form of a narrative surrounding my experience of the event and its subsequent ramifications; Reed-Danahay (1997) notes that self-narrative is both a method and a text.

2.5.1.3 Other texts

Diary extracts, letters and communication exchanges were also included in the data collection. Official documents were also collected and formed a significant part of the data, both as standalone data and as evocative material for further exploration and narration.

2.5.1.4 Visual imagery

Photographs provide rich material for both autoethnographic introspection and evocative presentation. Photographs that “sometimes supersede the benefits of textual data” (Chang, 2008, p. 109) were included in the data collection: the images both as standalone data and also in conjunction with a rationalization, such as the emotions and memories that they evoke and why they were chosen. “Visual Autoethnography” (Smith Shank & Keifer-Boyd, 2007) has emerged as a specific genre, reflecting the increasing popularity of photographs. In the analysis, the images were presented in tandem with my interpretation and understanding of the picture and the surrounding narrative, and the links with theory, if present, were also incorporated.

2.5.2 Data collection

A large majority of the data was collected unintentionally whilst the experience that I am studying actually took place. This is where the benefits of autoethnography can be seen, as often naturally occurring data is difficult to obtain, if not ethically wrong, yet “in situ” data has been noted as ideal for qualitative data (Willig, 2012).

Anderson and Glass-Coffin (2013) note that, when writing as data and inquiry, in order to build the richest data set possible its important to include “everything and everyone” (p. 76). Although I am collecting “everything”, I am then engaged in a form of analysis, ranking the data in importance and value to this particular research question. The value of any document or artefact for an autoethnographic project is its evocative potential. I asked myself questions throughout such as does it open me up to deeper reflection on the relevant experiences and relationships that I am attempting to describe and explore? With regards to ethics (see section 2.8.5), it was necessary to selectively remove certain data entries and note the reason for this. Ranking and analysing such as this has been described by Chang as the process of “deficiency, redundancy and irrelevancy” (2008, p. 115).

2.5.2.1 Data storage

As noted above, the data was simultaneously collected and organized. Initially the various types of data described above were labelled and then added to an excel inventory (see Appendix 1) to ease subsequent retrieval. All of my data were then ranked and colour-coded by their power of evoking emotions within me. For example, item number 10, notes to myself, was highlighted in light red. In the description I write, they were made when I reached full delusion state, thinking I was a spiritual healer. In the comments alongside I had written: “feeling now about it shame but also confusion as to how it spiralled out of control so quickly”. Item 14, medical report from 16/01/2013 is coloured dark red. It was my report from the mental asylum in Batu. In the description I type, “diagnosis: affective bipolar disorder current manic episode with psychotic symptoms. still get sick and worried reading this. Angry as some of the things said in the report don’t seem true to what I was trying to explain” (see Appendix 8). Those artefacts that were not images or in the form of written text were stored separately. However, a picture of them was taken and added to the excel inventory should I want to have incorporated it into the analysis.

As I developed as an autoethnographer and began to embrace the more creative element I detached from the Excel spread sheet. The data became the narrative that can be seen in the Narrative chapter, which stemmed from my initial engagement with the Excel spread sheet. This process will be described in the methodological reflexivity section.

2.5.3 Procedure on-going

I was “privileged with a holistic and intimate perspective” (Chang, 2008, p. 52) of the data collected and analysed, given I was the sole participant in the autoethnographic approach.

While the data collection and analysis have been separated out for ease of reading and in accordance with traditional academic standards, I ask the reader to bear in mind that data management, collection and analysis are seen as dynamically interconnected to inform and modify each other (Chang, 2008, p. 113).

2.6 Analysis

2.6.1 Analytic Process

As noted and alluded to in the previous section (2.5.4), analysis and interpretation were occurring at all stages of the project. Bochner (2013) states that the author's burden is the process of making meaning out of all the collected data. Analysis and interpretation have been described as a balancing act between science and art, much like the therapeutic endeavour (Roth & Fonagy, 1996). A noted pitfall or critique of autoethnographic work has been the potential for the power of the story to result in the researcher neglecting interpretation and analysis, the analysis and interpretation being what makes the project an autoethnography and not simply an autobiography (Holt, 2003).

Chang (2008) notes that a custom-tailored approach to analysis and interpretation in autoethnography is absolutely necessary. There are multiple methods that the researcher can employ with regards to data analysis. I am aware that equal importance should be placed on the intellectual knowledge and aesthetics/artistic craft (Adams et al., 2014, p. 25). This was a challenge for myself, being heavily versed in academic writing. Every effort was therefore made to embrace the more aesthetic and poetic element inherent to this research methodology. I reminded myself it was important to make the story come alive to my readers and that I was like Ellis (2004) suggests: trying to show my experience to the reader rather than simply tell a story.

A crucial element of "analysis" was my interaction with empirical research and theoretical literature. As the thesis developed so did my custom-tailored approach and I decided to add a theme chapter rather than weave the theory into the evocative narrative. The decision and process of this will be described below as it linked to the supervision process.

2.6.2 Role of supervision

Throughout the process of data collection, I consulted my supervisor regularly. During these meetings, we discussed what the data brought up for me and why I was choosing to include it. I described my data at length and the rationale or emotional reason behind some of the data

collected being coded dark red for highly evocative. These discussions greatly enriched the analysis of the data, as it helped me to think about things that, alone, I would not have considered.

It is also important to note that it was an interactive experience, and the emotions that it brought up for both me and my supervisor meant something new emerged in the collaborative exploration. By talking through some of the more significant data, I was already creating a narrative in a context that was different to any other.

The supervision sessions, just as Holt (2003) notices, became quite therapeutic and cathartic, and they helped my own process regarding disclosure of certain events and experiences in an academic setting. In a sense, through discussions with my supervisor, I gained increasing confidence to write about some painful and shaming moments. Those times when I felt more ashamed or embarrassed by certain pieces of data or photographs enabled me to reflect afterwards on why I had that reaction. This collaborative inter-subjective meaning-making was invaluable for the project.

The analysis was occurring as I observed themes in my data, and the interpretation occurred when I looked beyond my data to examine the available literature. I then sought to understand how the literature surrounding my topic interacted with the themes in my text. While I included some excerpts or segments of raw data, the aim was to create a story as a whole, using data to support the arguments that I made and the questions that I was asking. I used different formats within the text to indicate different positions in time as I moved from the past experience to present reflections. Interpretation was tightly bound to my creative expression.

2.7 Reflexivity

Given that the use of personal experience to examine and critique cultural experience is the binding characteristic of all autoethnographies, reflexivity takes on a new role in this project. Throughout this project, I endeavoured to identify what Pathak (2010) has described as those systems that shape, constrict, disrupt and inform my narrative and myself as narrator.

Anderson and Glass-Coffin (2013) note that, while the presence of the researcher in autoethnographic inquiry tends to be maximized, there is still considerable variability in where and how the self is inserted into the data and analysis. In this study, I attempted to demonstrate my use of self throughout, in particular through my analysis of data. I was less

reflexive when collecting data from my everyday experience than when I later returned to it and explored why I was including it and how it linked to my other reflections.

2.7.1 Methodological reflexivity

Contextual constructionist research requires scrutiny of the study's use of reflexivity. Finlay and Gough (2003) proposed that different versions of reflexivity reflect different epistemological orientations. I have endeavoured to demonstrate this throughout the project by having a pluralist epistemological position, and I hope to have demonstrated the use of reflexivity and that it is compatible with such a unique approach (Willig, 2012).

I also attempted to embrace the full creative component of the project and handle the uncertainty of a new method alongside the constant changes to data presentation and analysis. Given Holt's (2003) observation that one specific way to demonstrate a study's validity is to describe the researcher's responsiveness throughout the project, I tracked the changes to the method throughout the project and reflected on the course I ended up taking at each stage as recommended (Chang, 2016).

One paradigm shift that occurred for me during my engagement with the autoethnographic process was my increasing desire and belief in the more artistic and emotive part of the work. This shift can be seen in my approach to the "data collection and analysis". I stepped away from my positivist research roots, stopped clinging onto my Excel spreadsheet and started to write a story. This happened as I engaged over the past year with other autoethnographic texts and read more about the approach, placing a greater value on story as academic research (Sparkes, 2000). Every time I read someone else's work, particularly the work of activists, or read horror stories about people's maltreatment within the mental health system, I was moved to write, and further scenes and patterns began to emerge for me. Without planning it, I began to write my story in free form, each paragraph triggering another scene in my mind that I allowed myself to follow. This then resulted in the creation of my Narrative, which I began to trust as a suitable response to what has been described by Morrow (2007) as a key goal of qualitative research: to "gather data that are rich and descriptive and illustrate the phenomenon of interest intensely" (p. 216). I also incorporated pictures, but it was hard deciding which ones to include and which ones weren't necessary. I had clung on to a lot of the data collected and the pictures taken during that time, and part of me felt I wanted to show it all, but I was aware I needed to be succinct and selective. In terms of shifts in the way I went about the research, initially I envisaged including the pictures numbered in a raw data

section and then referring to them. In the end, I included them in the story itself and wrote about them and what they meant for me.

Similarly, I began writing this thesis without a clear idea of how I would link academic and empirical research with my narrative. While I wrote the narrative, I made comments on the side where I linked particular theoretical constructs, references or themes as they became apparent to me. I was determined not to simply provide a story, and I had been wary since reading the critiques of autoethnographies that lacked an analytical lens (Anderson, 2006) or were self-indulgent (Delamont, 2009). However, as I shifted away from my positivist roots and became more exploratory within the methodology, as discussed earlier, I noted a desire to protect the narrative. Indeed, once the narrative had taken form, and I was much more accepting and validating of the notion of “story as research”, I didn’t want to take away from the power of the evocative story, having also noticed the theme of theory being a block to “being with” difficult emotions (see section 4.1.1, Theory and getting technical, p. 111). With much debate, I therefore decided to leave the story as a stand-alone chapter and offer the reader a chapter where I could describe the salient themes that I had recorded throughout the process (chapter 4, Themes, p. 109). To show my process I have included examples of the development in the appendices. In Appendix 2 the reader will find notes that I typed up directly copied from the original source with my comments alongside it. Appendix 3 provides the reader with an example of an initial draft of the Narrative, where you can see how I have highlighted the arising themes to remind me where to weave in the theory. This helped later when I was referring back to sections of the Narrative to support some of my findings in the Themes chapter.

2.7.2 Engaging with a new approach

Sparkes (2000) highlights how it can be difficult to grasp new methods that are vastly different from the traditions that we have been professionally and academically accustomed to. Owing to the novelty of the approach for myself, I aimed to follow recommendations from others on the writing process (Ellis, 2004). I chose not to review the creative narrative as I went along and to fully engage in the creative process of the unknown, which was a significant challenge. Muncey’s (2010) descriptions of edgelands, a transitional area between established and new methods, resonated with me as being similar to managing the unknown in the therapeutic process. This creative process was described beautifully by Woolf (1996) regarding the writing process: “it is meaning in moments of astonishing excitement and stress we perceive in our minds without words” (p. 71: cited in Muncey, 2010, p. 7).

2.8 Ethics

2.8.1 Ethical considerations

I shall describe below the considerations I made regarding the ethical principles and guidelines for conducting research with human subjects. I also add additional ethical issues that arise with this particular approach. Given the novelty of the approach, and acknowledged lack of guidance, Wall (2008) suggests that we observe and enquire how other autoethnographer's have managed ethical issues. However, in a critique of autoethnographic work, Tolich (2010) highlighted particular ethical failures made by exemplary autoethnographers. For a detailed account, readers are referred to his paper, which provides foundational guidelines for completing ethical research. I will discuss those particularly salient below.

2.8.2 Researcher as participant

Autoethnography has been described as a viable research option, particularly within areas where patient privacy might limit access (Chang, 2008, p. 51). Given that the researcher is the only participant, the access to data may initially seem to be a smooth process, but there are many inherent ethical considerations that are unique to this approach. I applied the same ethical considerations to myself as I would to any other participant, thus I had a right to withdraw at any point in the project. In order to not feel constricted by the need to produce a doctoral thesis, a "plan b" project proposal was devised which would have looked at similar issues whilst removing myself as the main participant.

2.8.3 Self-care

I particularly liked Tolich's (2010) suggestion of likening an autoethnographic work to an inked tattoo: there being both current and future implications for the author. This highlights the double bind of this project; it is stigma that leads me to be vulnerable as the author, yet it is precisely this stigma that I aim to tackle with this project.

Undertaking an autoethnographic piece of work is an "emotionally laden" (Douglas & Carless, 2013, p. 99) journey that places demands and challenges of vulnerable inquiry on the researcher. Anderson and Glass-Coffin (2013) note how it is only recently that the issue of self-protection in autoethnographic research has been critically considered; it is now known to be crucial to take into account the impact of the approach on the self of the researcher. By offering such an intimate and detailed account of my own life and how I make sense of it, I am opening myself up to criticism from the readers.

Indeed, Muncey (2010) highlights that, because the author has been brave enough to publish their personal life stories, the audience or readers often assume the writer is robust. In addition to criticism from others, it was certain that I would be revisiting difficult memories, given I was writing about a traumatic event. Other autoethnographers have noted that this can be unsettling and potentially distressing, and so this was monitored closely throughout the process of the autoethnographic study. In line with recommendations from other autoethnographers who have written about difficult subject material, I had a system of care and support set up. Throughout the research process I attended weekly individual therapy, and the feelings that were brought up by this project were taken there. My clinical supervisors were aware of my traumatic experience and also my decision to write about it for my thesis, thus, if anything had come up during the time of the study that could have potentially impacted upon my clinical work, I knew that I could seek advice and solace. It was incredibly important for me to liaise with my research supervisor and personal tutor at University, knowing that any concerns would be flagged up by either party.

Following the suggestion to enquire as to how others managed the ethics of self-care, I referred to the example of Chatham-Carpenters (2010). She managed the unsettling feelings and struggles while writing about her traumatic experience by reminding herself of the belief that her account would be beneficial to others. Thus, it was important throughout this study to be constantly measuring the benefits of the research to both myself and others, and checking if it outweighed the struggles. This is in line with the ethical principle of maximizing the possible benefits of the research participants whilst doing no harm. Autoethnography and writing about traumatic experiences has been noted as therapeutic and beneficial to the writer (Wright & Cunningham, 2013), in line with Chatham-Carpenters' (2010) strategy for self-protection, I "surrounded myself with supportive individuals who knew background and pain" (p.10). A significant aid and inspiration to me was meeting with Alec Grant and reading his work. He provided me with the strength and courage to complete this work and not to shy away from my own voice. At times when I felt discouraged I would pick up his paper "*Living in the borderlands; writing in the margins: an autoethnographic tale*" (Short, Grant, & Clark, 2007), which would remind me that I too had important things to say. If he could be, why shouldn't I be brave enough?

2.8.4 Publication considerations

In addition to self-care during the process of the study, it was also important to have considered the issues surrounding the completion and subsequent publication of my work.

Anderson and Glass-Coffin note that it is “wise to be judicious and self-protective to some degree in published work” (2013, p. 76) and how more professional judgement and personal discretion is needed. This was considered in light of the call to not keep the work “hidden behind academic doors” (Adams et al., 2014, p. 42): thus the impact of publication was continually discussed and considered. I continually reflected on the potential impact that publishing such a personal text may have on my patients, both current and future.

Similarly, the portrayal of myself in the research would be bound in published text, yet how I have changed since then will not have been accounted for. I was aware that I could become identified with this aspect of my life, which could create a sense of perpetual self-disclosure (Boylorn & Orbe, 2014). After a lot of deliberation, discussion with colleagues and consultation with other professionals open about their lived experience, it was decided I would publish in my name.

2.8.5 Relational ethics

Being the only participant in the research project did not mean that others were not implicated in my project; stories are never “made in a vacuum and others are always visible or invisible participants” (Chang, 2008, p. 69). I endeavoured to attend to relational ethics throughout all stages of the project. The inevitable implication of others in our story has been described by Douglas and Carless (2013) as a prickly ethical issue. Every effort was therefore made to protect the privacy of others and the institutions by not disclosing any specific identifying details. However, in some cases the anonymization was not plausible. For example, I wrote this for my doctoral thesis at City, University of London, so all references and discussions about my experience were known to be discussing that particular university. Similarly, close friends were able to identify certain people in the text no matter how much I changed their details. For this reason, I included the bare minimum I felt necessary to convey the meaning I wanted to get across, largely writing others out of the text.

As per Ellis’s (2004) recommendation that I let others read the work, throughout the writing of my autoethnographic study I was mindful about who was being implicated by my writing. I offered those who I thought to be implicated by my work a chance to read and feedback on how they felt about the material and how they were represented. I also endeavoured to include only brief segments of communicative exchange and remove any identifying names or places.

2.8.6 Readers

An important ethical consideration not to be overlooked is the impact on the reader. Berry (2006) notes how the reader of the narrative might not experience it in a positive light; they might not know how to respond to an evocative text, and they might not be willing to “subject themselves to inadvertent conversion” (Chang, 2008, p. 53). While I cannot predict nor apologise for the responses of readers to my autoethnography, I did keep this in mind throughout the process. Certain parts of my story, in particular certain images, which could have been disturbing or too evocative, were discussed with my supervisor. A lot of thought went into the need to produce something that is evocative, emotional and close to reality while being mindful of the audience. In particular, certain traumatic moments in the narrative could have triggered unpleasant emotions for those who were alongside me during this journey, and who we must not forget have their own story.

2.8.7 Ethical approval

Ethical approval for this study was granted by City, University of London (see Appendix 4).

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Chapter 3: The Narrative

Before the “accident”

I call it my “accident”; the choice of words is interesting. I deliberately do not refer to it as a breakdown, and I still do not view it as such. I react strongly when others call it that. An accident is dramatic, and that resonates with how I experienced it. It wasn’t a car crash with a physical injury; it was a physical injury that resulted in an emotional crash. An event that triggered a multitude of events: the main event being the topic of this thesis. However, the trauma also led to post-traumatic growth and further events that have enhanced my life.

So, I need to start somewhere... There is so much information that I personally feel is necessary to explain the lead up to the accident, but the word limit constrains this – once I engage with it in this manner it is hard to know when to stop. Every experience, small and big, led up to the culmination of this accident, and narratives involving those around me and myself help to form an understanding of it. I have, therefore, carefully chosen some key experiences I believe to be helpful for the reader.

Six years ago, before the accident, I had a surgical scare: I lost complete sensation in my right leg and had foot drop. A surgeon told me that I might lose the sensation in my leg completely if I didn’t have corrective surgery immediately. The MRI had shown that I had a disc protrusion that was squashing my nerve. I panicked. In shock, I started thinking about such things as wills: major neurosurgery, a metal spine. The night before the surgery was scheduled, I went for a second opinion. The neurosurgeon asked if nerve conduction studies had been done. They hadn’t, so he ordered them immediately. The results showed a lesion in my knee: nothing to do with what was on the MRI. *One can often see what one wants to see* or what one thinks they are looking for (a salient theme that I will return to in the thesis at multiple points). I didn’t go for the surgery. Instead, I lived a bizarre existence for a few months before slipping back into the daily routine of life, where I was able to ignore existential crisis again.

Three years later, the same symptoms returned. I was due to travel to Thailand on 2 January, so I was rushed for another MRI on 30 December. As I waited for the results, I feared that perhaps the first diagnosis and need for surgery was correct. Reality and the faith I place in medicine became confused. *Uncertainty was the only clarity I had*. I was given the results and told that I would be fine, but that I should have steroids injected into my lower spine so that I could travel.

On 31 December 2012, I took a diazepam pill on my way to the clinic; I have a phobia of needles. I went in and lay down on the table, and my father watched the procedure through a window. I knew I needed to keep very still, but it hurt, so I wriggled away, making it take longer. Once the procedure was over, I got dressed and asked the doctor if I could drink that night: it was New Year's Eve and I was going to a dinner party. I was told it should be fine. I was dazed and confused, but I put it down to the fear of needles and perhaps the diazepam I had taken. So, I went to the dinner party.

Later I was told my friends thought I was stoned (even though they all know I don't do drugs).

The “accident”

2 January 2013

I fly to Bangkok. To this day, I don't remember the flight, save a few memories. Perhaps I did remember but then the memories were overpowered by the trauma? Or maybe this was part of the early symptoms? I don't know. What I do know is this:

- I experienced a steroid-induced hypomanic episode.
- I didn't know I was experiencing a hypomanic episode.
- I thought I was happy and that I was not sleeping because of jetlag.

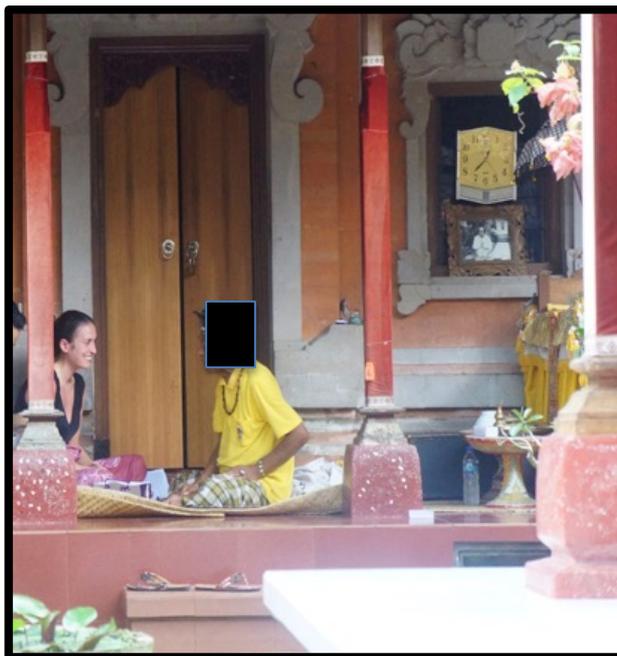


Figure 1: Second visit to the healer

Out of context one could see this as a nice tourist picture. What one can't see is that I have got carried away with what the spiritual healer is telling me: that he had Goosebumps seeing me the second time and "you are my daughter". I took this and ran with it in my manic state.

9 January 2013

Owing to extreme pain during one of my nights in Batu, the hotel doctor referred me to a neurosurgeon, whom I see two days later and whom requests I return for a repeat MRI. Post MRI (in a clean general hospital) the surgeon comes to dinner with me. We are celebrating the good results of the MRI and we are drinking vintage champagne: manic spending, another symptom. Below is our conversation, I am not eating as I am excited and I have pressured speech.

Me: It seems like such a happy spiritually connected place. Do people go to psychologists or doctors or to a healer?

Dr: It depends...

Me: So, you do get mentally ill people here?

Dr: Yes, but we hide them...

Me: ...Why?!

Dr: Because they are dangerous.



Figure 2: Dinner in the hotel with the neurosurgeon

This was the dinner that the neurosurgeon should not have attended, breaking patient–doctor boundaries – which at the time I had been excited about. I was unaware that he had noticed some bizarre symptoms and this was a set-up. I wasn’t really going to meet the patients or to get permission to visit, I was going to be forced into not only visiting but also staying amongst the “dangerous”. Some of them, I might add now, actually were highly dangerous.

Why in my mania did I choose this as an area I wanted to research? My ego was increased by my importance? My ability to work with those who have wrongly been deemed “dangerous”? I knew better? I was more caring and compassionate?

I feel uncomfortable and ashamed confronting this part of myself. Negative associations such as research into the therapists own narcissistic needs being met, etc. (A).

Being sane in insane places

11 January 2013, Batu's General Hospital: interaction with the psychiatrist

I go to the "consultation". I am told that I am going to meet him because of my research interest in psychology and to gain permission and access to meet some of the hidden people. I'm looking forward to meeting him. I dislike him when I meet him. I feel he is rushing me. I don't understand why he is asking me questions about myself and I start to sense a pressure from him. This is the first time in my episode (indeed my first contact with "services") where I become angry and paranoid. Although, now reflecting back on it, I don't think it was actually paranoia, as even my paranoid mind couldn't have predicted what was to occur.

Dr: I think you are too clever and you're thinking too fast. I want you to take a pill.

I sense something is up. I feel pushed and not listened to. I try to ask him what the pill is. I ask him for a pamphlet. I'm in a foreign country. I don't trust this. I am also taking a cocktail of other medication he hasn't asked me about. I'm being cocky. I want to show him that I understand medicine. He thinks I don't want to take the pill. I try to explain to him I'm happy to take the pill, I just want to know what it is before I take it (a legitimate request one might say?).

He leaves the room to go and get water. I lock myself in his room. Rage takes over. I take a pen, which looks erasable, and write on the wall.

I hope now that had it not have looked erasable I wouldn't have done it, but that, like many other things, I will never know.

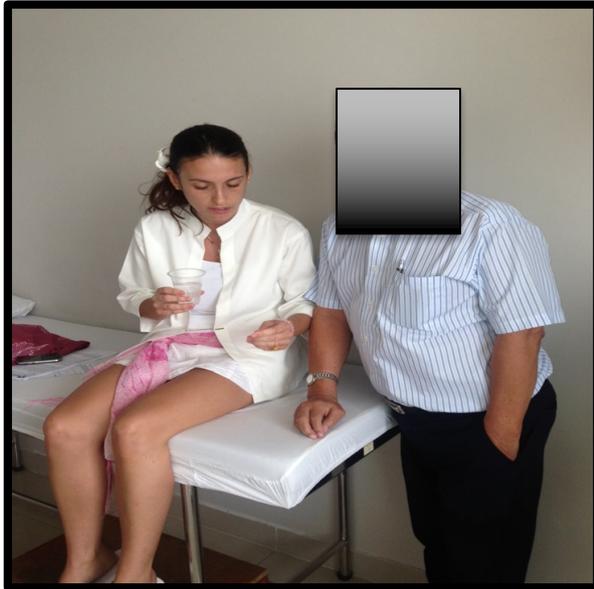


Figure 3: Me taking abilify (an atypical antipsychotic) in the initial general hospital

I am angry that he has manipulated me into a psychiatric assessment and that he hasn't asked for my opinion, my psychiatric history or my medical history. Grandiosity is coming in here again. How I hate that word. I write all the diagnoses that I can think of in the short space of time before the doctor returns. I write down all the medicine I was taking and all the illegal drugs I could have taken (Figure 3).



Figure 4: Writing on the wall

I don't really know why I added those. I think it was to prove a point. Interestingly, I later find out friends had thought I was experimenting with illicit substances after receiving some unusual texts and reading odd Facebook posts.

The psychiatrist enters with the water and pills. I'm getting increasingly angry but, like other moments in this journey, I become calmed by the delusion that this is all happening for a purpose and that I need to follow the path. Everything will make sense eventually. This is my research. I now believe I will expose them for maltreatment.

That becomes my delusional mission. It is the reason why I now have all the data collected that I have used in this thesis.

Psychiatrist: Come on, we will do it together: I will take one and you take one.

Ha ha ha. Bullshit. He is infantilizing me. I respond to this by being cocky again, and I tell him I will take two or three if he wants me to. I don't care. I am compliant.

Me: If you think I'm crazy take me to where you keep the other crazy people. I would rather be with them!

We leave the hospital and get back into my private taxi that takes me to the asylum. By the time I am in the taxi I forget about the bad experience I have just had. I read the print out information of the pill I have taken. I laugh out loud and tell James it is an anti-psychotic. I read the symptoms and counter-indications: shouldn't take it if you're pregnant. (I'm not, but a number of times I think I am).

I ask the driver to play a new CD I purchased downtown three days earlier on my manic shopping spree. I fall asleep for the first time in weeks.

I continued to listen to this CD religiously once I was back in the UK. Surprisingly, I do not associate it to the trauma that followed. I played it for three months, until one day I stopped playing it and it was forgotten about – until writing this.

Arriving at “prison”

The taxi pulls up. I look at James and tell him this isn't going to be nice. He should let me go first; he shouldn't see the psychiatric asylum. I will just go and get some pictures, talk to the staff and come back. I am back to my research delusion. I am grateful now that I had that delusion.

I step out of the car and I notice that there are offerings (Canang Sari) on the floor. I remember the neurosurgeon explaining a few nights ago how women couldn't go to holy

places when they have their menstrual cycle. I am on the second day of mine. I try to tell the doctor that I can't go in; what irony that I thought it was a holy place.

They kick the blessing away and I'm appalled. I go in and get shown around. It's dirty; the hallway has mattresses on the floor with pee stains. The staff all have face masks. There is a horrible smell. The first person to attract my attention is Jaddi; he looks at me with his big eyes behind bars. He has a shirt with two thumbs: one pointing up and one down. I ask the nurse why he is locked away and she tells me he has a low IQ. I tell her with a grandiose authority that he shouldn't be in there. I tell myself to make a note of this and expose them for locking him up unnecessarily. I go and take a picture of the hierarchy of the hospital staff with the view to later complain to those in charge.

I'm not with the nurse now. I am in the hallway and there is a stray dog jumping on me. In my delusion, it is because I have reached an altered level of consciousness and all animals are responding to this natural energy and warmth. My logical mind is, however, still there, as I think he might have rabies and I might get bitten. I start to panic and the security guard comes and kicks the dog away. I'm pained to see them treat the animal this way and, again, start telling them off.

The doctor comes over and brings me to a cell. I think he is just demonstrating to me the "facilities". He invites me to sit on the urine stained bed. I look at it and my OCD brain says it's dirty. I reassure myself in my head that I can sit on it and when I'm back in the hotel have the clothes washed and give myself a long hot shower. This enables me to sit down relatively calmly. I'm quite impressed with myself now. I think, "Ha, I've conquered my cleanliness stuff!"

The doctor starts asking me lots of questions. He wants to know how I know about certain things to do with their culture and spiritual beliefs. I start explaining and he is asking me another question all over again (something that happened a lot throughout the whole ordeal). I tell him it doesn't really make sense now but it will make sense when I'm at the hotel and can calmly show him why I am thinking the way I am. I can show him photographs of me with the healer (Figure 4), and I can show him my research proposal. He gets increasingly impatient and my paranoia begins to return. I start to get a feeling I'm not being listened to. He doesn't believe me. He is turning. I go to see where James is and can't find him. I start walking towards the driver briskly – "I think its time to go home now".

As I am writing this, my heart is beating quicker and a panicky feeling is rising in my chest and throat. A lump is forming. I ground myself. This is nothing like the reaction I used to have. I'm doing well. This is part of the process of this thesis. I feel like I'm on a roll and need to work through it. Perhaps once I've written this body of the story things will make sense and fall into place. I'm thinking of my father while I write this. I'm thinking of the dinner I had last night and the way I told the story to him. I'm simultaneously thinking of my supervisor and Alec Grant reading this, and I am wondering if they will like it. Will they think it makes sense? Is it too much to put into the thesis? I am a bit worried that I haven't added a lot of "analysis" yet, or literature.

11 January 2013: “Admission” to Batu’s mental asylum



Figure 5: The outside of my cell, padlocked

Eye Movement Desensitization and Reprocessing (EMDR) therapy

A year after the accident, 3 months before I start the Doctorate training, in a private consulting room in central London. This is a fictional account and not actual transcript. It is the material that came to mind throughout a number of sessions. It is the part of this narrative that I define as: my “accident” my “trauma”.

EMDR therapist: I would like you to tell me about the trauma. Go into as much detail as possible. Try to tell me what you are feeling, seeing, holding these in your hand [*he places two small stone-like objects in my hands*]. I will talk and guide you through it and they will pulsate alternately.

Me: OK. Should I open or close my eyes?

Therapist: As you prefer. Are you ready to begin?

Me: Yes [*although I am still thinking “not really!”*].

Going with the process, where do I begin? At what point did this nightmare become a nightmare? I’m trying to figure out when it did, talking to myself, saying “relax, go with it. Just say whatever comes...”.

Me: I am being grabbed. Four men. I am screaming, “get the F**k away from me”. They are carrying me down what seems like a long corridor. I am screaming and wriggling but there is no way to escape. I don’t have time to think about what is happening. [*Now I don’t know what I was thinking.*] I turned and saw Jaddi [Figure 6]; he was the only reassuring face amongst the terror. He gave me a thumbs up. I looked at him and caught his eyes. I am becoming like him now. It will be me behind the bars with others taking pity and saying, “Oh, but she doesn’t belong here. Let her free”.



Figure 6: My Jaddi (note the use of my: I wrote this naturally as I felt a warmth and connection to him).

The stones are vibrating each hand. I am trying my best to stay with the feelings and not distance myself from it by overanalysing it.

Henceforth the doctor speaking is the doctor treating me in Batu.

We are back in the room I had sat in before. Only, this time, I don’t have free will to move as I please. I’m still tickly in their grip. Somehow, instinctively, I know they will restrain and inject me.

How did I know this? I haven’t seen it in clinical practice. Is it because of the films I have seen?

I am still screaming. They are each armed with a tape: it was once white, now it is stained and yellow. Each man has a part of my body. I am becoming more and more panicked. Where is James? Does he know what's happening to me?

Me: Please stop. Stop. Leave me. Please, no needles.

Dr: But you need it. See? You are distressed.

Me: I'm distressed because I'm being grabbed by you all. Please, I promise you, give me 5 minutes. I will do some breathing exercises, then I will show you I don't need the needle.

But it is too late. I feel a sharp scratch and a pain.

I later find out it is haloperidol, and also that my muscle has been ruptured from the hip down due to the needle being inserted whilst I was wriggling ferociously.

I panic. What if the needle's dirty? Luckily, I pass out.

I wake up still stuck, arms and legs spread out tied to the corners of the bed. It must be night-time now. There's no daylight in the corridor, and no people walking back and forth. Why am I still restrained? Surely this is a joke. I jump up with all my force and miraculously, after many attempts, move the bed closer to the cell bars, shrieking out loud "James! James! Are you there?" I can hear his voice muffled in the distance. All I can make out is, "This is ridiculous". Even though I can't see him, just hearing his voice and knowing he is there slightly reassures me. I pass out again.

I wake up again. Still restrained. I scream for James once more but nobody comes. I need to pee. I am yelling. Still, nobody comes. Where is the toilet anyway? Like an angry 2-year-old, I pee myself. If they are going to restrain me for this long and not come let me use human facilities, I suppose that's what I'm reduced to. I fall asleep in my own urine, one part of me content with the angry act, the other disgusted.

I wake up again. This time I'm more awake than before. I slowly manage to get one hand out of the restraints from wriggling. I get a flashback of being 3 or 4 years old in a cot with a broken arm and a cast on. I don't remember if it's my memory or the story my mother tells

everyone about how I managed to shove my arm through the bars of the cot and wriggle my way out of the cast. This memory is reassuring. I tell myself, "Just be calm. Don't force it. Continue to wriggle and it will become free. If you panic, you will get more stuck". I fall asleep again.

I wake up and continue to wriggle. I get one hand free and I am so pleased with myself. But I don't know what I will do with myself once I'm out of restraints. I hear footsteps and I immediately hide my free arm.

Why do I do this? Instinct? Films again? Power dynamic.

They leave and I manage to untie the right leg restraint with the free hand. The more I am becoming free the more reassured I am. I feel proud. I keep thinking of the memory of me in a cot, and this alongside how I will tell this part of the story to my mother when I am out gives me hope. Once I'm fully free I wander around the cell. I see Jaddi peeing in his cell; I now discover that the toilets are in fact the hole in the ground surrounding the walls of the cell. How was I supposed to pee in front of him?! I'm glad I peed in the bed: best of the two options.

The security guard comes past and opens the padlock. I walk out of the cell for the first time. Yay! Where's James? I'm being freed! We need a picture of this!

They come and there are two of them now. They say, "Yes, yes. Lie on the bed and we will take a picture". They begin to restrain me again. "No, no. I'm fine, really. We don't need it to be that realistic for the picture." Then I realize this isn't for a picture: I am not free. I am being tied up again. This time I protest less. I have learnt that protesting makes things worse.

I don't remember much. There is a large blur. I remember bits in no order. Seeing James for the first time. Trying to talk to him but being so numbed and drowsy by the medication.

Now I have submitted myself to them I am calmer. Perhaps the mania is still there and I am forgetting yet again the horror of where I am. I go to sleep thinking it will be all right: my father will come and get me out. I recount the words of the spiritual healer, "I am your father

in spirit, you are my daughter, and I shall be forever with you". It becomes part of my story now. I relax thinking at least one of them will help me out of this.

Dr: Take this.

Me: I don't want to.

Dr: Take it. You have to.

Me: Ok. But it makes me sleepy. Can I see James first?

Dr: No. Take this, then you can see him. If you don't take, you can't.

I never saw him. If I did, I must have been too drugged up, as I don't remember it.

I try to start to negotiate with them but they are not fans of communication.

Dr: TAKE IT or I will get a needle.

I give in. I'm saddened that they won't talk with me. I am a compliant patient. I know fundamentally what they are trying to do is "for my own good". I will go along with what they want, but why do they have to be so dismissive of my feelings?

They come back on what must be ward rounds with more medication. They look at me whilst I take it.

Nurse: Did you take it all?

I open my mouth, stick my tongue out and make a noise. They are not dignified with my communication. If they treat me like an animal, I shall behave like one. Why not?

Reflections on going back into practice

Should I go back to the doctorate? Months of depression after the hypomanic episode. Comedown is awful.

Discussion with James

Me: I'm too *embarrassed*. All those emails I sent...

See the dreaded emails, p. 100 below.

James: If any profession or group of people should be understanding and compassionate it's yours, no?

Me: Yes, I know. But it's not like that...

So, *is it* in my head or is there a culture of shame and stigma?

Psychopathology lecture

I'm in my second year of my Psychology degree, in a lecture room at university. I am the student, I am the professional and I am the patient...

I'm boiling up inside. I can't tell if I'm having a panic attack or if I'm angry. Am I ashamed? No. I feel like I'm holding something back. As the lecturer goes through the mental health act I want to scream out, "I've been restrained! I wasn't sectioned though".

Four weeks later I am in a supervision group listening to a peer present a case. It's about a schizophrenic patient with auditory hallucinations. She is presenting him in a cold and detached way.

Am I overly warm and too attached?

Again, I'm boiling up. I can feel it in my chest. I'm worried I'm going to cry. I'm debating getting up and walking out. I realize the tears are from anger. I ask her questions instead. I want to attack and criticize her clinical work, but instead I ask questions with the hope she will become more familiar with the person.

Me: What did the patient do before they had these auditory hallucinations, what do they hear?

She doesn't answer. She looks down at her notes. I am stunned.

I feel anxious writing this. I am criticizing a peer. Perhaps she was having a bad day, maybe she just didn't prepare. Or, am I just shying away from my own voice?

The afternoon lecture is, again, on the mental health act. I tell my friends I think I'm going to go home. I'm feeling too triggered today. I don't think I can sit through it again.

I was having my flat re-decorated and living with it and the builders and this had been pushing me to breaking point. I was in touch with my rage.

Friend 1: Aren't you engaging in avoidance strategies if you go home?

Me: Yes, I probably am. But I don't care. I am just going to sit this one out.

I text my psychiatrist's secretary and ask her to find out if I can add an anti-anxiety medication to my prescription.

We had been talking about it for a while, as the new anti-depressants had been making me more anxious. I had to change them because the other ones that did work for anxiety and depression were causing me to gain weight.

In writing this I wonder, if I had "come out", would I have needed those tablets? I'm still taking them now, and I debate if I should stop. I think this period in life, although I had increased anxiety, was situational. I was going through a house refurbishment and so my safe base was gone, and, importantly, my safe base of identity was being challenged. I was more acutely in touch than ever before with my struggle with my identity of patient or therapist. (B).

First research presentation

29 May 2015

This was the first time I was going to speak to a group of my peers and a number of professionals about my research. Up until then it was happening quietly in the safety of my

research supervisor's office. Now was the time that I needed to start to get comfortable at disclosing and exposing myself. I had to present my research proposal and describe what stage I was currently at with a power point presentation. I remember the night before it messaging a colleague and trying to figure out with her how best to disclose my experience. Similar to earlier on where I write about how I talk about my accident this was a new context. I only had 15 minutes and I was aware that I didn't want to take away from the time discussing my research with the evocative story. Having been reading a lot about autoethnography and a critique that sometimes the story overpowers the research, I was acutely aware of the potential for it to occur in my presentation.

I felt relatively comfortable speaking openly about my experience as an in-patient. I remember not wanting to shock the audience as well. I really struggled with how to disclose. Again, it wasn't the disclosure, it was the how and when to do it. I decided to go with the flow and my disclosure was impromptu.

This comfort is likely to be related to the fact that, at this point in time, I was still clinging very tightly onto the fact that it wasn't me, it was the steroids.

My turn to present was approaching, of course my USB stick decided to not work as they so frequently do right at the moment they are needed. So, I'm anxious about when to disclose and now I'm anxious about having to present without the PowerPoint. Someone else goes in my place as I continue to try and figure it out. Luckily a colleague has a laptop and manages to get my presentation onto her computer and then on her USB stick – which works. Phew. I now have to wait my turn again, extra anxiety time.

I stand up and on the first page of my PowerPoint is the image of the padlock (see Figure 5, above). Without thinking, I start the presentation saying, "I've chosen this image here because it is the padlock that was used to lock me up when I had a steroid-induced hypomanic episode in South East Asia last year". I continue with the presentation – my academic voice largely being used – and finish with a question and answer session. I receive positive feedback and encouragement afterwards, particularly from staff.

At the end of it, I sat down and felt such a great release, as if I had "come out" of my metaphorical closet, no longer having to sit in lectures and squash my patient voice and

identity. It was good to feel encouraged and not to have my voice shut down, and to feel part of a university that is forward thinking and open to creativity.

I am still caught up in the adrenaline and the release from my presentation that I am not fully listening to my colleagues' presentations afterwards. I feel like a switch has been flicked on in my mind and I can't turn it off. I feel like there is something missing in each presentation. Why are people doing the topics they are? Surely, we are all drawn to a particular research question because of our past and what makes us who we are today... I start playing the guessing game. She's researching x because... I wonder why reflexivity isn't being fully embraced – not just in my peers' presentations but also at universities in general. We don't really get taught that much about it except that there is a section in the dissertation where we have to explain how we could have impacted on the research.

30 May 2015: email to Alec Grant the day after my presentation

I presented to my university cohort and a panel of other supervisors yesterday. I admit I was slightly nervous initially as I didn't quite know how to “drop the bomb” of my inpatient experience however once on stage I felt comfortable and it went smoothly. The project was extremely well received by the audience. Some of the professors suggested I start looking into advocacy work and they were impressed with the creative use of methods we haven't seen before on the doctorate. I am glad about this. Perhaps there will be a lot more autoethnographers soon!” (C)

Conference – Crossing Boundaries

November 2013

I have been invited to speak at a three-day conference on inpatient treatment, and I am in the audience as a professional the first two days. I am amongst colleagues, mostly much more senior colleagues, leading psychiatrists. I am merely in my first year (second attempt) of a doctorate in Psychology. I feel at one with my professional identity. I feel proud to be amongst these clinicians experiencing an opportunity for reflective practice and growth.

Right before another lecturer comes on, I read the programme. I start to feel the panic. The last day there will be a service user presentation; I am no longer a professional, I am a service user. But I'm sitting here in a classroom engaging with other professionals. I feel I am deceiving them. I burn up a bit. Should I tell them? How do I tell them? Do I just go along with the professional identity until I have to go up on stage? (D).

I am sitting in the auditorium on the last day watching the clock tick: my time is coming. During the break I find Dr Stephane. He asks how I'm doing and I say, "I have a diazepam. I think I might have to take it". I do take it, although I sort of regret this now. It feels a bit of a cop-out. I wish I had been brave enough to just embrace both identities.

Once I have "come out" by literally coming out of the audience and walking onto the stage – identifying myself as the service user – I am more relaxed. Dr Stephane is interviewing me. I am quite sarcastic – playful – as I describe some of the horrors of my experience.

Dr Stephane: And so, they kept you, tied you to a bed, for how long?

Me: Eight hours maybe? I don't know... maybe more. They released me but then did it to me again.

Dr Stephane: And you weren't violent?

Me: No. I don't know why they restrained me for so long. I tell them about the "let me do some breathing techniques" and the caring response in return... a sharp stabbing needle in my thigh.

This experience was so liberating. There was applause, and afterwards I had psychiatrists coming to me telling me about their struggles with depression. In the tearoom after, a number of psychiatrists came along and asked me questions and applauded me. Something that struck me was their statement that it couldn't have been only that January, that it was a quick recovery. They thought it had happened a lot longer ago, before the conference.

I had never really thought about my recovery speed. But I was pleased to hear this... they thought I was recovered. Inside me there were seeds of doubt. There still are on bad days.

I have evidence: we need to inform the police

January 2013: Between Apolaniati and London on the flight

My father and I get upgraded to First class. He is a Concorde cardholder because of the number of miles he has travelling around the world for business. They give him special attention and I enjoy flying with him. I'm excited (normal excitement level) to be in first class and I am in the free pyjama's surveying the goods inside the travel kit. It is a pink bag and done by one of my favourite handbag designers, Anya Hindmarch. I already have asked dad

to keep his for me. He is fast asleep in the flat bed next to mine. We are separated by a small passageway the cabin crew use to serve us.

I now don't remember how I felt to be coming home. I think I was sad to have been leaving Asia. I had made dad promise me I could come back. I had an anxious excitement to see all of it; I wanted to explore, and I was scared that it wouldn't happen, that I would never get to go back.

I am writing on my Batu laptop. I am trying to use one of the templates available as I have decided to write a book about my experience. I have started writing about my personal life and wondering if I should or even could write about it and publish it as it involved other people, i.e. my ex-partner. I'm struggling to get the picture in the right place for the cover page of the book when I hear a loud noise. I can't really describe it but it was a loud panicked breathing gulping in of air. The noise has come from my father – he must be quite traumatized I think. He has been through a lot to try and get me home.

The air stewardess comes over and tells me not to make noises because it will wake up other passengers. I am outraged. I tell her it wasn't me and she says she heard it. I ask her, "Do you know why I am here and what I am doing!"

I wanted to show her about my book and how I was doing something valuable to stop prejudice about mental health: something that she was doing.

Stewardess: Yes, you've had a breakdown.

Me: No, I haven't, who told you that?

This is the first time I am told this or have heard the word "breakdown" being used to describe what happened to me. It doesn't resonate with my narrative. I always thought breakdowns were something from the movies, when people have too much stress and they can't cope, they need help. This was not my case. I didn't have any

stress. I was happy. I was actually probably at my happiest.

She walks away as she notices I am getting angrier. I wake my dad up and I tell him hurriedly what happened, exaggerating.

Me: She thought I made the noise and accused me of it, and then told me I had a breakdown! Even if I had had a breakdown, what does it have to do with the bloody noise? And doesn't she know that by her doing this she has now created more noise in the first-class area? And she has disrupted my writing. Talk about waking up other passengers. What about my writing! Get rid of her! We should make a formal complaint; she is horrible. How dare she accuse me of something just because she thinks I've had a mental breakdown?

My father goes and speaks to the cabin crew. The manager comes over and talks to me and is very kind natured. He asks me about the book I'm writing. I talk to him for over an hour. I see links in everything he says and tell him about my predictions. They are all good, of course, because he is on my good side. He is kind. He should be a therapist, not a flight attendant. I tell him this.

I am embarrassed now writing this. Did I make his job seem less significant, inferior, by saying this? I was attempting a compliment, but could it have been taken the wrong way? I hope it wasn't.

I'm in the kitchen area of first class and he has to go to business class to attend to another passenger (perhaps he just needed a break). I am chatting away to another stewardess and explaining to her the story of my journey. She shows me a newspaper article about a grandmother who has been caught drug smuggling in Batu. I read how she is taken to a place far away where they line her up and can kill people. I imagine the asylum. I have a vivid picture of the garden surrounding the asylum and I imagine that actually what happened to me was that I was being used as a drug mule because of all the drugs I have and I took pictures of the "asylum" which I now think is some sort of drug lords place of business. I tell her we need to inform the police that I have evidence and we could potentially all be in danger.

I don't really fully recall this delusion, so this part of my memory and narrative lapses. The key important aspect I want to note is that she went along with my delusion.

Ever since I regained my sanity and worked through the shame of being psychotic and paranoid, I have questioned what might have happened if she had told me that what I believed wasn't true. This question has plagued me ever since my accident. So many times people went along with my delusion, each time the delusion being enhanced, elaborated and increasingly psychotic. Like a ball of hay rolling and becoming bigger as it goes along. If people had told me that the things I believed weren't true, would I have reached the heights of psychosis that I did? Would I have thought I was doing research? Would I ever have gone to the asylum? Why didn't someone just tell me, talk to me or attempt to explain what was happening?

I worked through the anger of this: it took a while. I learnt to give up on the notion that I could have predicted what would have happened or, more specifically, that it wouldn't have happened if people had talked to me. I asked a question in year one at a lecture on client-centred therapy: what does the therapist do when the patient is delusional? By getting alongside the client and not pointing out they are delusional, does one collude? At this time only a small handful of classmates knew about my experience and I imagined them guessing the place that the question was coming from.

Back to the story:

She tells me she has told the police and that they will meet us off the plane and take me to a secure place to give them the evidence. I tell dad. When we land a steward meets us with a wheelchair. I tell him I don't need it, I can walk. I'm so sick of being pushed around in a wheelchair. I ask him where the police are and he responds with, "what police?" I try to explain to him. Dad starts telling me that it is ok. We must go, and not to worry about the police.

Dad: Your godfather is waiting for you outside, please, darling, let's go. You are safe, and don't worry. Let's just please go. And you're going to see Dr X. Don't you want that?

I am angry. He is dismissing me. Everyone is dismissing me.

Perhaps this is what happens when people don't go along with the delusion. The psychotic person gets angry. Very angry.

I run around asking security staff to speak to police. I try to call the police. I don't remember how, but somehow my father gets us to go outside where we meet my cousin/godfather. I don't want to get into the taxi; I think the police are coming and I want to wait for them. Dad tells me we can speak to them once we are home safely. I think this must have worked. I don't remember now how I ended up in the taxi. I'm sat in-between my dad and my godfather who has a multi-coloured blanket that he gives me from his kids. It's comforting. I only have summer clothes: flip flops, tiny shorts and the airlines pyjamas.

I remember thinking I didn't like the colours and it didn't match my white flat, but it meant a lot as it was my goddaughter's baby blanket, and I had missed her a lot.

Summer 2016: Drive from Gatwick

I get a flashback of the taxi journey. The winding roads covered in trees. It's funny it was the darkness and trees that triggered a memory, as if I was there again and I could remember the conversation.

Me: Where are we going?

Dad: We're going to go to hospital to wait for Dr X who wants to see you.

Me: But it's early. I want to go home – I have all my bags!

I had, through my manic shopping experience and general normal amount of over-packing that I do, accrued three large suitcases and numerous duty-free bags. I felt anxious as people had

packed and unpacked my things. This happened a lot, and is something I still get anxious about.

Dad: I know, darling. Don't worry, I can take your bags home – I won't touch them. Dr Stephane wants to see you, and I think it is safest we wait at the hospital.

Me: Where is it?

Dad: "x".

Me: Why there?

Dad: Because that's where he works.

Me: But why can't he meet us at home?

Dad: We have to meet him in the hospital... it's the safest, darling.

Me: But can't we go to "y" hospital? It's closer. I want to go home and drop my stuff off. Your friend works there, we could go and see him.

Again, I don't remember how we ended up finishing the conversation. Rewriting this now I feel sadness and an extreme amount of gratitude for the patience my father had. I know now it was not easy for him: he was scared and he needed me to be safe. He had tried to get me back to London ever since he found me in the cell. I had done nothing but fight against his wishes to protect me. I'm moved to tears thinking about all that he did and went through. For confidentiality reasons, I won't mention the others implicated in the story, but they know who they are and my gratitude is beyond words.

The hotel – I mean hospital

End of January 2013: “x” Hospital

We get taken to a room and I am told a psychiatrist will see me shortly. I ask why I’m not seeing Dr Stephane. They explain that he doesn’t come to do rounds until the evening and in order to admit me I need to see a psychiatrist. I become anxious. Why admit me? Nobody told me I would be admitted! I thought I was waiting for Dr Stephane so that I could tell him about what had happened. Show him my research, my pictures, and get him to tell the authorities about the maltreatment and stop it from happening.

Me: I do NOT want to sleep here; there is NO WAY I will sleep here. I have all my things to unpack and sort through. I have been through hell. I WANT TO GO HOME!

A nurse comes to the room and tells me I need to go through my personal items that I want to keep with me. I laugh and I tell her I have three bags full of a million and one little things: gifts for my godchildren and friends, speakers, computers, cameras, ornaments. She tells me I don’t need all of that. I tell her I know, but that I wasn’t told that I was coming here and that I’ve just stepped off the plane. I didn’t deliberately bring all of it here! I am anxious again about losing things. I want to sort my stuff in the calm and privacy of my own home.

When I came back from Spain (last summer) a security guard peered over me, trying to take all of my big liquids. I reacted very strongly and became infuriated. I only link these two reactions now, while writing this.

I don’t open the suitcases. I tell her my dad will take them home; I don’t want to root through them. I only keep one, and we go through it and list all the items I have. She is checking for anything sharp in case I will hurt myself.

Me: I’m not going to kill myself. I don’t want to. I never wanted to. You don’t need to worry. All I want to do is go home. I’m fine, honestly.

She leaves and another male nurse comes in to take my blood. I’m lying in bed in what looks like a slightly nicer version of a Travelodge and he is taking my blood. I think this is weird, but it is much better than being stabbed and jabbed with potentially dirty South East Asian needles.

I speak to my godmother on the phone. I start to cry. In-between the sobs all I say is, “I don’t want to sleep here. I think they are going to make me stay. I just want to go home. I don’t really belong here”. She tells me about her son and how he said the same thing – I am polite, so I don’t tell her what I’m thinking – he had schizophrenia, I am not mentally unwell. I am not a patient. I am just happy and have found spirituality, and other people don’t understand. Dad is just overly protective.

I debate taking this out. I am ashamed that I am rejecting the patient identity as if it is something dirty, something very separate from me.

Dad has gone home to rest. I’m lying on the bed with my cousin. A huge box of duty-free Ferrero Rochers divides us. We consume them one by one. It’s soothing unwrapping and then folding the wrapper up. I don’t care about my weight (normally I would). I am happy. It is nice to have this time with my cousin. He doesn’t normally care for me in this way, and I’m grateful he is here.

You’re just not listening to me

Admission consultation with psychiatrist, Dr. Black

I am sat in a form of armchair (I think it is blue) in a small room facing out onto the main road. The Doctor has glasses and a beard and is relatively young looking (early thirties). He asks me a number of questions, which I try to answer but it seems before I get to the end of my answer he asks another question. I’m getting frustrated. I am also annoyed that I have to speak to him and not Dr Stephane. I had been looking forward to talking to him.

I realise now, with hindsight and insight (still slightly lacking during the above consultation), that I was probably speaking at lightning speed and could have been jumping all over the place.

I tell him I don’t want to talk to him about the trauma and that he shouldn’t be asking me too close to the traumatic incident: this was anti-therapeutic. (E)

I remember at the time I wanted the doctor to know that I knew “stuff” and that I was, in many ways, a colleague of his. I wonder now if I was merely antagonizing him or trying to irritate him because I was annoyed I had to talk to him, or if I genuinely was concerned I might be re-traumatized. I do know that I just wanted to be left alone by professionals and to go home. I felt he didn’t listen. I wondered at the time why he went into the profession. I was relieved later on when talking to another patient that they had experienced something not too dissimilar to me.

I had read a fascinating book *The body keeps the score* (Van Der Kolk, 2014) for an essay on trauma during my master’s degree. I recall telling my therapist about how that book was helping me to go through the process post trauma. I can’t say it saved me, as I believe I would have survived it regardless, but at the time I felt it was saving me. Perhaps it was saving me because by clinging onto theory I was avoiding some of my shame?

Nevertheless, I understood certain phases I was going through and my desire to feel alive again. I was bored. Having felt something so alive and been so engaged and excited, how could I possibly lead a boring life? Again, I slipped back into that “normal” life, although this thought did come about from time to time – in fact, it still does, just to a lesser degree. I wondered at the time just how scary it must be for someone who is not privy to this knowledge. A lot of the time throughout this journey I was thankful for my education. I could understand why I was being treated a certain way. I remember thinking – while holding onto my prison cell bars, looking into the cell opposite mine to the patient whose family members had him locked up because they didn’t know what to do with him – thank God my father is a therapist, thank God I know about this stuff.

Writing this, my brain trails off to thinking back to the prison cell. I remember lying down so as to give my opposing inmate privacy when he urinated in the hole in the floor (the toilet). I remember a rather funny instance, that made me

laugh and that I told once released, many a time, perhaps to laugh off the severity of the situation. The patient opposite had a packet of cigarettes under his clothes and he lit one up in his cell. He then spoke in Batunese to his father who took a cigarette from him through the bars and walked over, giving it to me. I looked at him, then the cigarette and then the father. I had quit smoking. I wasn't a smoker. He had been kind to give me one of his cigarettes. Then I looked around and said to myself, "Look where you are. You're in a fu**ing prison cell, it's OK to smoke". It was a menthol cigarette and after that one cigarette I was obsessed with menthol cigarettes: I had to have those specific ones. My one request to my friend: chocolate and menthol cigarettes.

Cell life Back in Batu

I had a plant. A rose bush, I believe, that I had ordered in the hotel for my friend's arrival. I don't know how or why it ended up coming to the cell with me. I know he went back to get hotel bed sheets to make the prison cell bed slightly more pleasant, so I assume he brought the plant too.

Thinking about the plant now I have a warm longing feeling to go back there, to be back in that beautiful room, feeling so happy. Everything was just beautiful, and the people were lovely. I am almost moved to tears by my strong desire to go back. I am not allowed – not just yet. I fantasize that when this thesis is finished I will go back. Will I be as happy? Was it real happiness? Did I really have a "spiritual awakening", and can I experience that sense of connection again?

Warmth and desire to return has now turned to a thump-like feeling in my throat. Perhaps it is my blocking of tears, or a slight dormant panic response. Is this a desire to return to the trauma scene, or a fear I might freak out when I'm back there? This is a good example of how the mind can switch so quickly. Just evocatively recalling memories.

I am told that I had a plan with the plant: to use it as a method to send a message to my fellow inmate opposite. I laugh now when hearing that. I don't have a clue what I wanted to tell him. Perhaps it was his cell phone I wanted, but I don't have any clue as to whom I wanted to call. Mine was taken away. At least I think it was. I'm relieved now that it was taken away – it probably should have been taken away sooner to prevent my manic emails (more of those to come).

In my first year of university, during a summer holiday, I noticed that an old school friend started posting a lot on Facebook. The sentences didn't make sense, and some were rude. I contacted a friend we have in common to ask what was going on. I am told that it was the second time she had become psychotic and that she was in hospital. After talking to our friend for a while I suggested that her Facebook gets blocked so only she could see her posts for now – then she could decide later if she wanted them to be made public. He responded saying that he thought the posting was good for her: it was her outlet. I realised I was projecting my experience onto hers, I was pre-empting a shame that she might never feel. This was an important lesson for me to learn.

I'm allowed out of my cell on day two. I am given some paper, and I go and sit in the corner at the end of the corridor – the only place with windows. I am chatting to the nurses. They are interested in my life. The nurses are generally a lot nicer than the Doctors. At night, when the doctors go home, the nurses let me walk about.

Thinking about it now, perhaps I had been granted “leave” from my cell by the doctor. At the time though, I was against the doctors: they were bad, the nurses good. Thank God for the good nurses.

I'm sat on the bed in my cell and I am given some food on a tray. It has flies on it. I don't want to eat it. I'm not even hungry. I haven't eaten in days except for the chocolate James got. Maybe that's why I started being obsessed with Ferrero Rochers. Don't get me wrong, I've always liked chocolate, but never have I had such bouts of chocolate cravings as I did post-accident.

Writing about that I'm reminded of my food cravings. On the antipsychotics, I had many symptoms of pregnancy. I had cravings for foods that I didn't usually: ginger was one of them. I also ate Thai food mainly. Perhaps this was my emotional tie back to Asia, which I considered to be home. I became nauseated by certain smells.

Doe, a deer, a female deer

January 2013: X Hospital

I am required to have multiple blood tests. (I think at the time I had been told I might have had hepatitis C.)

I can probably find out from my medical records. I might do and come back to this here. But part of me is hesitant to read all the medical notes. I am semi-content with my version of what

happened, and I am scared that if I read my psychiatric notes something will stir in me and make me angry. I constantly think about this when I write my own patient records on the NHS system. What if they ask to see the records? How would they feel reading this? Is it fair to write this about them?

This means having an injection. (As I have mentioned elsewhere, I am needle phobic.) Even if I have hepatitis, or something worse, I do not want the injection. A fellow patient (note the change from inmate to patient) comes along to the injection with me to distract me. Just before the nurse comes over with the butterfly needle, the patient belts out the song, “doe a deer a female deer, ray a...”. I laugh out loud and join her in singing. I am proud to be a patient with her in this moment. I am proud to be singing a song as loud as I possibly can, and I am laughing.

This is one of the moments when I didn't want to be on the other side. I didn't want to be the nurse. And, no, not because of the horrifically out-of-tune noises we were making, but because I felt alive: I felt real. I had a rush of adrenaline I was doing something I shouldn't really do, what the “normal person in society wouldn't do without their sanity being checked”. But I also wasn't breaking any rules.

CPA (Care Programme Approach) in the kitchen

Summer 2016: a mental health hospital – I am “the professional”

My line manager invites me to attend the CPA review, where we assess, plan and co-ordinate services for a patient in the adolescent unit. They have been an inpatient for some time and will be transitioning to adult services. I have been facilitating the young adults group in our team and she, my line manager, thinks it will be good for me to come and speak about what we do, and, more importantly, that I could give him, the young adolescent, hope.

It pops into my head, my own experience, and how the main thing I think it has given me professionally is the ability to hold onto hope. I wonder, then, if she means I can give her hope in this way: my line manager knows about my experience.

I'm really excited to gain new experience. And I'm pleased my line manager has asked me. A band 7 post is coming up soon in the team, and I have a feeling she is providing me with extra experience to talk about in the interview. I also have a moment of panic. What if the inpatient unit freaks me out? What if it brings something up for me? I take a deep breath in and ground myself. And I remind myself this isn't the first time I've been to an inpatient unit since my accident.

Walking over to the other site, I am joking and laughing about how, when I took my patient to the inpatient admissions, the nurse kept saying to me, "your bed is ready", not realising I was the care co-ordinator and not the patient.

For some reason, I wasn't wearing my badge. I still don't know why I did that; I love any opportunity to wear my badge.

Actually, writing this I think I remember putting it away in my handbag in the taxi journey to the hospital. I had to take the patient in a taxi to hospital and I didn't want the patient to feel like they were different from me. I wanted us to be equals to the outer world. Also protecting her confidentiality.

We get to the unit and are shown to the kitchen.

Receptionist: Unfortunately, we don't have a big enough room to hold the CPA.

There are a lot of staff attending today.

I go in and sit down; there is a strong smell of fish and chips. It is 2 pm, just after lunchtime. I am shot back to my own CPA meeting, which happened in a kitchen. It is as if I am there:

the smells, the feeling that this was odd to be happening in a kitchen. It doesn't disturb me. It weirdly brings me a smile. I look at the patient and I am determined that I will try to do my best to provide them with hope. I will not patronize them. I am pleased that, even in the NHS, numerous professionals are being brought together to try and care for this young adult.

I'm probably also pleased because it lessens my guilt; every time I see someone going through the NHS mental health system, I am reminded of how fortunate I was to go privately. Sometimes I am scared when I think what would/could have happened to me if I couldn't afford private healthcare. A theme I will return to.

I don't think I can/I can't do this anymore

December 2014

I am in the car on the phone to my father having just admitted my first patient. I'm crying. Sobbing. He is trying to decipher the reason why. I blurt out "I bought the patient a sandwich". I feel so guilty. I broke boundaries by buying her the sandwich. She hadn't eaten in days and I wanted to look after her (I had to monitor her, until there was a bed available). I justify more to myself. I stepped out of role. Did I do it because I identified with her, or just because I am a nice person, a human? I don't think I can do this anymore. I just want to help people; I don't want to have all these boundaries between them and me. I was one of them.

I still wonder if this was a break in the boundaries. I wonder if perhaps I have a stricter notion of the boundaries in my head than actually exist.

The patient is getting worse with therapy

February 2014

I am in a consulting room in an outpatient clinic of a mental hospital – I am the professional. A father and daughter are sat in the office. We are having a review to explain how we think the long-term psychodynamic therapy is making things worse and is not appropriate during

an acute episode of psychosis. I am no longer able to provide therapy to the daughter because she is acutely psychotic and the therapy is making things worse.

During an acute episode of mania exploratory psychotherapy can worsen symptoms and a more structured psycho-educational approach is needed. Exploratory therapy, particularly psychodynamic therapy, can bring to the surface or flood the person with overwhelming emotions that they are unlikely to manage during this time.

We believe it is in her best interests that she is closely monitored by a community mental health team and engages in more structured psycho-educational treatment. The father begs, saying that he can't handle her on his own and that he doesn't know what to do. The patient may kill herself if we don't allow her to have therapy.

I struggle to stick to the decision. I am, again, feeling guilty. I call my father later that night and, again, I am crying and telling him I don't think I can do it. Who am I to make these decisions? Who am I to take something away from someone? I realise that I have overlooked the powerful father–daughter duo. It has brought up my own treatment. (G)

X Hospital: January 2013

Day 2 of hospital stay

I am arguing with a nurse in my bedroom. My cousin is present.

Nurse: Do you want to get better? You have to interact with the other patients and stop over-relying on your friend.

I'm infuriated yet again. My doctor deliberately told me not to go and do the group therapy activities they have because it will be too exciting. I can't do anything excitable. I am also hurt by his comment that I am over-reliant on my friend. Of course I am. I'm traumatized. I've been through hell. I can't sleep. I am so overly independent that for me the fact I am reaching out for help and relying on others is a huge step therapeutically. I tell the nurse this. I think I yell it at her, and then call my father crying.

Re-reading this draft version. I call my father, crying – a LOT

I don't feel safe, why can't I lock my door?

I am really anxious. I can't sleep at night. I hate to admit this, but I was scared of the other patients. They could just walk into my room at any point, and they were male. I kept telling the nurses this was ridiculous, especially after my saga in a cell where I was locked up. I need to rest somewhere I feel safe.

Nurse: We need you to leave the door unlocked so we can check on you.

Me: I'm seriously not going to kill myself [*I repeat for the millionth time*].

I'm angry that "they" are trying to do something to ensure my safety but then that very thing is making me feel incredibly unsafe. I start to think it's not really for my safety but rather to manage their anxiety that I might harm myself.

This issue is present in my work: when risk impedes on my clinical work. Something I am continually working on in supervision, how to manage the fine line between staying with a patient's extreme distress and also monitoring and assessing risk. Whilst I have managed this a lot better over the years of clinical experience with suicidal patients, it is still an anxiety-provoking situation – and should be. The day it isn't is the day I should start to worry. I can't help but think, however, is our fear of risk and the consequences of this on us or our professional identity the one thing that blocks us from truly getting alongside patients during their journey and fundamentally helping?

The nurse doesn't believe my story about being locked up in a cell and tied to a bed for hours on end. I try to tell her so she can understand why I am so scared. She thinks I am psychotic. I again call my father (repeat pattern, spoilt only child, patient father). He comes to visit in the afternoon and explains to my charge nurse that what I am telling her actually did happen, that he did come and rescue me from a cell. For the next few nights the nurse stays with me

throughout the whole night. I know they do this for the highly suicidal patients where they are on constant “obs”. In my case, it was to make me feel safe at night. I finally manage to sleep, feeling taken care of and reassured that no other patient will come into my room and harm me. (H)

Although I am relieved to finally go to sleep, the nightmares are horrific. I am processing the trauma; I’m dreaming I am choking. I wake up with a dry mouth, petrified I won’t get to the water and I will die.

Eating disorder unit

I can’t get in and out of the bath because of intense pain in my left leg. I can still feel it when I write this and think about it. The exact spot. Every time I have a massage and they go over that spot, I move. That’s where they jabbed me with the big needle. That’s when I was petrified. That is how they ruptured my muscle from my hip to my knee. The nurses have to get me in and out of the shower.

Thank God I had got rid of all ounce of prudery.
I embraced nakedness when I was manic.
Luckily, I didn’t ever strip or get naked in front of doctors (I checked this when I came around, like after a drunken night when you wake up and call your friend with the “did I do anything really stupid?” – just a million times worse).

The general psychiatric floor is getting fuller and fuller by the hour with incoming admissions. I ask for a room with a walk-in shower so I can wash myself. The only rooms with walk in showers are on the eating disorder unit. I move there. Increased appetite and no sense of boundaries don’t bode well here.

You’re brave

Many people, professionals and academics tell me I am brave when I describe the nature of my thesis. I didn’t really have much choice about “coming out” or exposing my vulnerability through my writing. As seen above, a large part of my shame stemmed from my manic emails that I sent to a number of highly esteemed professionals.

Even writing this now I get a bubble of heat rising in my chest: shame. It used to feel like a fever, a horrible fever nightmare where you knew it was a nightmare but you still couldn't escape it. I knew it was shame created by me in my own mind, but I couldn't escape it. My therapist's words spring to mind: "it takes time". It has been three years. The feeling is almost gone now. It is more like a fleeting shame. Surely it will be more prominent when I have to actually re-read and analyse the manic emails. For now, I'm avoiding it.

The dreaded emails

I am almost finished completing this thesis. I still haven't included the emails. I wake up today panicked that I'm never ever going to finish this thesis and it's going to hang over me forever. The horrible study guilt when you're out wanting to have fun with friends. The pressure I put on people – "it better be worth my time, I have to write my thesis I can't really take breaks". The countless times I have had to decline invitations. I want it to be over but there is a bit of me holding back. It probably wasn't the best time to start to open the manic email this morning in my already panicked and frustrated state. I scroll through them thinking are they that bad? My chest tightens. I feel a wave of heat throughout my body. Shame. Here it is again. Will it ever go away?

I am going to be brave. I will include it now (see Appendix 5). Perhaps readers won't see anything too bad about the emails, but to me it's perhaps one of the worst things I could ever have done. That in itself is interesting. I have provided the two parts of the email (below) that, without fail, increase my sense of shame every time I read it. It is probably apparent to you, the reader, that I haven't used regular paragraphs and it is more a stream of conscious thinking. My grammar tends to be poor on good days, but in this email extract the reader can see I rarely use full stops and commas – or paragraphs – and my spelling is rather amusing.

January 2013: Pre-hospitalization

This is an email to an ex-course director, which I forwarded to every professional I could.

...I believe that it will either be a minor keyhole spinal surgery or a full blown spinal fusion with metal scaffolding throughout the spine.

...lacked the spiritual more heavily psychoanalytical group level of theory and practice which was missing.

...sadly I taught myself during the year that i was not accepted onto the course therefore it was slightly repetitive yet still good to refresh the material).

Im happy to write the neuro part my self but i think it is better if it is done by someone with a high reputation in the field especially because if what i am certain is true is true then the potential for healing and changing the evidence based practice regulations in the NHS will be excellent.

Because it was medically induced...

It should be easier given it was the steroids, "given it was medically induced".

This is another difficult section to write. I feel the most exposed sharing this. Here I am including a part of my diary extract from an exchange with my psychiatrist that happened in 2015 (Appendix 6). Re-reading it now I'm embarrassed at parts where I'm over dramatic – as though my life shattered. It's really interesting: I get quite upset and hesitant including it, but this is the first time I read it and realize I have written it like a story. I don't know how other people write diaries. I think I'm just noticing it now because of creating this narrative chapter and being concerned that I wasn't a good storyteller.

Year 2: diagnosis and doctors

The fact that I prefer a medical explanation of it fuels my theory of our own role in the development and maintenance of stigma. The steroid diagnosis makes it seem more controllable and more comforting thinking it won't happen again as long as I avoid steroids. I

have to explain this every time I see a new Doctor. I wonder when it can be removed from my records to save me from the pure nuisance of having to repeat the story.

I have a fantasy I can carry my (hopefully one day) finished thesis and tell the doctors – just read that.

How's your sleep?

GP: We want to be careful with your moods. Another two years and I can accept the steroid diagnosis.

Me: But you said that two years ago. I haven't had another episode.

GP: And fingers crossed you won't have another one. It's better to be cautious.

It definitely is not better to be cautious. I had only recently become acclimatized to my general wellbeing and happiness. Not worrying whenever I was too happy that something might go wrong.

I have gained a better understanding now for the complaints my patients make about their experiences in physical healthcare situations. Each time a client is raging in session about a certain experience, I am careful not to let my own rage get the better of me. (I)

Power and the loss of it

June 2016: Hospital in the UK

I am the carer of a patient, a close family member. I am in the hospital, but helpless to do anything. I am angry at the situations and conversations, the feeling of not being heard or understood, and the fact that no matter what I try, I can't get anyone to understand or give credit to what I am saying.

Is this how a small child feels before they have words to communicate and verbalize whatever is happening to them: "You don't get me. You're not hearing me. That's not what I'm saying. I'm scared".

It feels awful to see that pre-verbal state, a flapping of the arms. The more she tries (and fails) to explain or complain, the more frustrated she feels making the situation worse. I see her becoming “that angry patient” or “the one that always complains”. (J).

Are they violent?

I hate it when people ask me about mentally ill patients: “Are they violent? Surely there must be something wrong with you to enable you to kill someone? ...” Although I am tired each time of responding, I do continue to stand up for patients: “it’s really overplayed in the media”. Often the violence is from the professionals owing to a fear of violence from the patient. When I tell people I am a trainee psychologist they often ask these questions, then they go on to disclose their own struggles after my lengthy argument. Sometimes, if I’m feeling particularly annoyed, I say, “I was an inpatient. None of my fellow inmates were violent. Sometimes I really miss being with them”. (K)

“I want to speak to somebody normal”

January 2013: X hospital

I have a distinct visual memory of that phrase. There was one patient that I really admired. I don’t know exactly why, but there was something about her. I felt as if I was back at school and she was the cool girl I wanted to like me. Anyway, I had just come back from a consultation and a very distressing event occurred. (I am unable to write about it here because of relational ethics). I was running around the hospital, very upset. I tried to talk to staff members, but they weren’t very understanding (or perhaps they were, and I was stuck in the “us versus them” narrative). I was walking in the basement towards the elevator after not being able to find any patient in the smoking area where people usually were. I was frantically pushing the “up” button when this patient I so admired came round the corner. I yelled out, “I just want to speak to somebody normal”, and she looked at me and said something along the lines of, “You’re in here too”. I was mortified. By saying “normal”, I had meant I wanted to speak to a patient – the staff had taken the position of abnormal in my mind. I tried to explain this, but she sauntered off. I forgot about it, as I did many things with the fast pace of mania.

I do miss the type of culture there was in the X hospital. Not with the staff, but with the patients. In the smoking area, often the socializing area, I

didn't go to smoke but to discuss. I had some of the most interesting conversations I have ever had. There was genuineness about people, a warmth and a curiosity. There were no nice formalities, no pretences. Often, I wonder what the world would be like if we could all embrace speaking that way. (L)

It's a bit grandiose

This bit was left blank in the first draft, with the following comment:

“Should I include this? Include some of the email excerpt?

Relational ethics: it is a current uni teacher.

Can't hide who she is, she will know it's her.

Discomfort.”

I discuss it with my supervisor and we agree I should include it. It's so important, and it won't be read by anyone other than the markers for now. And, even so, professionals should be able to read and learn from it.

I go into a teacher's office (I will call her Sally) to get a form signed. I am trying to register my private practice work as a placement so that I can include the hours. I have done this openly.

I had been personally struggling with the idea of private practice. I had been asked to join a wonderful team who saw my talents – more than I did. With encouragement, I decided to do it. In my head, I have a fantasy that having the title of “Dr” before my name will get rid of the fraudulent feelings I have. In reality, I know it will help but they will always be there, in the background.

Sally: I'm glad you're here; I have wanted to have a discussion with you about your private practice. I came across your blurb and, well, it's a bit concerning.

I start to get anxious. My blurb has only been up for a week and I struggled immensely to market myself.

Me: Oh, really?

Sally: Yes, I mean, there are a number of issues. I printed it off and have shown it to a number of professionals on the board and, well, quite frankly, we are concerned.

I am boiling up. I'm panicked. I feel a rush of shame through my body. Who has she shown it to? Why didn't she talk to me first?

Me: Oh. Can I ask who you showed it to? And what the concerns are?

Sally: Well, it's a bit grandiose, isn't it? (M)

That's it. That's my trigger word. I can feel shame even more now in the body. I am in a flight or fight mode too. I'm fearful. Part of me wants to delete the blurb and disappear, drop out of the course and remain in a band 6 position as a therapist. I don't need the title of "Dr" anyway. I don't want it from an institution that treats me like this. Both my self-belief and fury are suppressed.

I recognize what I'm experiencing as a parallel process. All of my feelings and unresolved shame regarding my manic emails have surfaced. They were grandiose. I wanted to erase them, and I wished they had never happened. I felt like everyone would be watching and judging me from those emails, and now this. Knowing that it had been printed off and shown to other professionals, I felt observed and lacking control.

I acknowledge that this is merely an excerpt of the experience. The conversation didn't go exactly that way and there is more to it than that, but that is all I remember. The word held so much power; I didn't really take anything else in.

I go to my personal tutor and explain myself, being very apologetic. She tells me not to worry, that she's not concerned because she knows I have handled the situation with grace. However, this doesn't really alleviate my feelings. I have to go and deliver a presentation to a supervision group. I panic that I will not be able to fight back the tears: hot tears, boiling up inside. I surprise myself. I am able to switch off my feelings and deliver my presentation, receiving excellent feedback on my presentation skills and my clinical knowledge. The class ends and I burst into tears. Two of my closest colleagues understand just how painful the

word is. They sit with me and reassure me. But the only thing that really helps with such powerful feelings of shame is the passage of time.

Fear and self-doubt

I email my external supervisor in a panic, worried that I have done something very wrong. They had also called me up on my use of the term “psychotherapist”. Sally had hinted at me potentially speaking to the head of ethics. I send my supervisor the link to the blurb and we have a discussion on the phone. I feel relieved after our talk, but still not fully confident.

This is an extract from my diary two days after the event with Sally.

Really glad I spoke with [supervisor] on the phone. Cried at first.

So glad I can reach out for help now and not be ashamed.

Was worried my email explanation was rambled and manic had to send it to dad for reassurance. Lost faith in self and own judgment

A few days later I have a check-in with my psychiatrist and I explain the situation and how I’m not feeling great. He says, “I wish you wouldn’t get knocked by these things. You’re good. You’re experienced, intelligent”. I feel more reassured. Four or five people have said similar things. And I am not going to lie; getting it from the almighty, powerful psychiatrist confirms it.

Still, to this day, I struggle with my fraudulent feelings and marketing myself.

The “messy, emotionally raw thesis bit”

I have sent my supervisor what I have been referring to as the “messy, emotionally raw thesis bit”. I’m eager to hear her thoughts, more so than with any other piece of work I’ve submitted so far. On the drive there I run through what I have written and what bits I want her reassurance on. Interestingly, the bits that need more context and explanation are the parts of my story that I struggled with the most. For example, the manic emails I sent to professionals. I am aware of a want to erase this from part of the story, but I can’t: it really is one of the main reasons I am writing this. I just wonder if maybe many professionals hadn’t looked at the email. By publishing it, am I just doing it all over again? I think about how much of my email to include in the Appendix and reconcile with myself that I can make the decision at the end, once I’m less anxious about the thesis never being completed.

This is a diary extract from Tuesday the 22nd November 2016.

Whilst waiting for dinner cooking in the oven I'm trying to transfer files from one laptop to the next. It is proving more difficult than I thought. I come across all my conversations that I have in a folder as "data" collected. I am not feeling strong enough to read my manic email tonight and include it. I think to myself when a good time might be. Perhaps I will try to write the whole thesis and then include it last minute in case I wobble and not want to publish my thesis. Definitely do it in the daytime. Not before bed. Perhaps next week, before therapy. A lot of pre-empting I'm sure I will be fine. Perhaps it is the pre-empting making it worse.

The other area of interest is the language or constructions used around my "accident". She is interested in why I had clung on to the steroid explanation. What is wrong with it simply being an experience? This leaves me reflecting. I happen to go to a training event the next day that is about teaching professionals how to work with clinical groups that are particularly stigmatized. It is co-run by a service user and a professional. I like it, but I get frustrated during it with the comments of some of my peers about "those" patients. We are asked to write three things that the media and general public say about people with this diagnosis.

The service user then very powerfully stands in the middle of the room and asks us all to stick the labels with the sayings on him: the positive ones on the back, negative ones on the front and ambiguous ones on the arms.

There is not a single positive one.

I can see the audience being moved. How difficult it is to acknowledge such negative stereotypes when the person is right there visibly covered in "labels". (N)

Chapter 4: Themes

In this chapter, I will relate the themes that emerged during the research process, to the relevant theory, which as noted in the methodology chapter (see section 2.5.3 procedure ongoing, p.50) was an iterative process, impacting then on my writing of the narrative. I endeavour to describe each theme and how it links to broader theory and research and my narrative, to provide an understanding of some of the implications that I have drawn from the research, which form my recommendations in the discussion chapter that follows (p. 137-156).

4.1 Othering

In a review of the literature on psychologist impairment, Smith and Moss (2009) discuss how psychologists can experience feeling inadequate when they can't cope with emotional stress, given that friends and family members expect them to be a "perfect model of mental health" (Sherman, 1996, p. 307: cited in Smith & Moss, 2009, p. 9). As noted in the introduction (see section 1.6.1 othering, p. 18) there tends to be a perception or societal expectation that as psychologists we are immune to emotional suffering. We risk feeling ashamed and a pressure to hide aspects of ourselves if we believe and accept this societal expectation, which is rarely challenged, increasing self-stigmatization. How many times have I heard "but you're a therapist, so surely you know how to handle it". Each time I hear it, no matter how high my self-esteem is that day, I feel a small puncture in my chest. It is hard not to withdraw, and it is even harder to try to explain to others that, just because I'm a therapist, it doesn't mean I don't experience emotional pain. Don't you just love the phrase "easier said than done". Sometimes, I come away feeling like a massive hypocrite when patients bring some of my own issues into the room. I can help explore them, unpack their pain and even help them move beyond it, but I am painfully reminded of my own stuckness.

In the introduction, I noted that as professionals we don't develop in a non-judgemental bubble. Rather, we were influenced by the same sociocultural and psychological factors as the general public and our patients, which can give rise to negative perceptions and stereotypes of mental health problems. Not wanting to be associated with these we can, and at times do, engage in 'othering'. I also noted that, not only do we stigmatize patients, we can also discriminate wounded healers. Supporting this notion, Adame (2011) in a qualitative study looking at how survivor therapists experienced their dual identities, notes that most of the literature exploring this to date has focused on their experiences of stigma and

discrimination. O'Connor (2001) reported findings from a survey of psychologists in California that identically defined personal problems were judged as more impairing when they were attributed to colleagues as opposed to the self. It is suggested that this enables professionals to distance themselves from their troubled colleagues, thinking of them as a separate group entirely (Gabbard, 1994: cited in O'Connor, 2001, p. 347). This is further supported by Smith and Moss (2009) who note one reason professionals don't intervene or report a colleague they believe to be impaired is that they are afraid of being confronted with their own flaws. Relegating impairment to those "bad apples" fosters self-denial in those most at risk, who are unable or unwilling to reflect on their own limitations and blind spots. In an interesting study looking at applications for graduate clinical psychology programmes, Ivey and Partington (2014) found that all most all their participants (selectors for the graduate program) were positively biased towards those applicant narratives that included woundedness. Importantly the selectors were sceptical of those students' narratives which did not make any reference to woundedness.

I have engaged in this type of othering behaviour myself. For example, noting that certain trainees haven't done enough *personal* therapy, which worked to make me feel good about all the therapy I had done. This counteracted those times when I felt ashamed about having wounds (pre-accident). Thus, while I hold a personal belief that therapy is essential, putting others down in order to justify my personal belief is unacceptable. Similarly, some professionals feel they need to justify their lived experience because of the stigma in the culture of their workplace and, as a consequence, look down upon those professionals who do not have it. In the implications section, of their discourse analysis study exploring how mental health professionals with service user experience construct their identities, Richards, Holttum & Springham (2016) note an important benefit of normalizing mental distress. Namely, it can prevent the risk of the development of a new and separate group of professionals, which they aptly describe as "professionals-with-added-vitamins" (p. 11). Similar to my example above, this demonstrates a form of othering whereby wounded healers can become superior to both consumers and non-service user professionals. Whilst a commendable study, I felt there were a number of limitations. Although it was interesting to include different types of mental health professionals, such as nurses and psychiatrists, it would have been more beneficial to explore one of the professions in depth. Whilst, I do not agree with segregating us off into professional tribes, I do feel that some professions and their associated discourse may be more accepting of the "wounded healer", such as

psychotherapists, than others socialised in a medical language, such as psychiatrists. I feel a missed opportunity, rather than a limitation per se, was that one of the researchers identified as a consumer provider and noted that they drew on this experience during the research. How they did this, however, was not explored transparently.

Something I hadn't considered, which I was alerted to while reading the literature, is the othering that can occur amongst survivors and survivors who are also mental health professionals. Adame (2011) notes the reported difficulty of not belonging to either group. A participant in Richards et al.'s (2016) study described a "super-user", which they explain to be a derogatory term given by service users to those "other" service users who have a paid job in Mental Health. Othering or the "us versus them" dynamic clearly occurs beyond patient and therapist, and it can often lead to those professionals, who may internally feel their identities complement one another, feeling they are neither fully accepted nor validated in either the professional or survivor movement contexts. This "lose-lose" situation is a great shame when we think about how much knowledge and experience we can gain if we are able to communicate with both "camps": another opportunity missed. Importantly, Fisher (1994a) alerts us to the struggle that some consumers have when trying to accept the professional or provider identity, as it means giving up a lot of the support they received from fellow consumers. This can be seen in the Narrative chapter when I yell out that I want to speak to someone normal (p.103). Still, to this day, I truly miss being in an environment with patients in which I myself am a patient too (see L, p. 104). Sometimes I think, if only I could go back every now and then. There was honesty, beauty and transparency in some of those emotionally charged conversations "on the inside", which are hard to find elsewhere.

4.1.1 Theory and getting technical

I noted throughout the process of this thesis that theory can often be used to block difficult emotions, and I believe over-use of theory is one way of othering or distancing oneself from discomfort. Bassman (2001) notes how it is much easier to be open to the experience of an other when the listener is told about the pain instead of being with them while they are experiencing psychic turbulence. An example of this can be seen in my reaction to Rambo Ronai's (1995) account of being sexually abused by her father. I felt it was wrong of me to stop reading and block out the discomfort it was causing me, so I continued to read her paper; however, I was admittedly incredibly relieved when she interjected sections on theoretical understandings of abuse. Amundson and Ross (2016) remind us that we are invited to be flexible, fluid and tolerant of the distress of not knowing. As trainees this can be daunting,

and there is the temptation to cling rigidly to specific techniques. Wosket (1999) describes getting technical nicely: when she was a trainee she initially spent more time and energy on trying to be the good therapist with good interventions and techniques, instead of “being with” the patient (Heidegger, 1978: cited in Wosket, 1999).

There are more subtle ways of othering, which I became acutely aware of during this research process. For example, a researcher writing about a participant can be seen as othering:

“Autoethnography can be seen then as a form of resistance to the researcher becoming the ‘other’” (Foster, McAllister & O’Brien, 2006, p. 49). As with othering in the professional context, Gough (2011) notes how higher educational institutions don’t exist in a vacuum and are also susceptible to othering. While it is promising that higher education institutes are involving service users in the teaching and training of future mental health professionals, with the best of intentions they can be inadvertently engaging in othering (Gough, 2011). When tutors are not encouraged to disclose their experiences and service users are hired from “outside” the institution, the us versus them dilemma is fostered.

4.1.2 Vicarious traumatization and burnout

I argue that one example of using theory to defend from discomfort is the increased theoretical and empirical discussion of “vicarious traumatization” and burnout. “Vicarious traumatization” (VT) has been noted as resulting from treating traumatized individuals or consistent exposure to clients’ emotionally arousing subjective reports (Canfield, 2005, cited in: Smith & Moss, 2009). Chronic stress from the demands of being a psychologist can lead to distress and burn out (Rupert, Miller & Dorociak, 2015): burn out being defined as a syndrome with three dimensions – exhaustion, cynicism and sense of inefficacy (Maslach, 2003). Sperry (1987, p. 534) suggests that burnout is a result of the clinician not recognizing or acknowledging their own vulnerabilities and wounds, elevating and distancing themselves from the patient and exhibiting “an air of technical superiority”. Maslach (2003) notes it is a prolonged response to stressors in the work place, particularly the chronic strain that “results from an incongruence... between the worker and the job” (p. 189). I suggest that this incongruence is also present for wounded healers trying to manage their dual identities.

There has been an acknowledged surge of interest in writing about and researching the effect that our clinical work has on us (Smith & Moss, 2009), some effects being emotional exhaustion and disillusionment. I suggest that, rather than openly acknowledging our wounds or vulnerabilities as being part of humanness, we locate our distress as a reaction to an

external event (our clinical work). I argue it is easier to engage in self-care practices when we locate our distress as stemming from our challenging clinical work rather than acknowledging that we are human and not immune to life's struggles. I have no doubt that "vicarious traumatization" occurs: I have experienced it myself. Listening to horror stories on a daily basis is likely to knock you; if it doesn't, I would worry that you are not attuned to the patient. However, I suggest that in some cases this can be used as a form of othering: my argument stemming from the lack of research and discussion of our woundedness and need to self-care, being in stark contrast to the volume of research looking into VT and burnout. An incredibly moving and unforgettable journal article ("The Impact that Changed my Life", 2007) lays out a psychologist's experience of being the perpetrator of a fatal car accident and what it was like to manage this trauma and return to work. She notes how, when she was invited to speak at a conference on Trauma and the Therapist, she chose to do the presentation on her personal tragedy instead of VT. I encourage other therapists and trainers in the field to follow her lead.

Perhaps a need for self-care sounds like there is something self-indulgent to it: one of Delamont's (2009) criticisms of autoethnography as a method in social science research. Perhaps it is more "scientific" to say that *x* caused *y* and because of that I can acknowledge my emotional responses. I am not solely criticizing others for doing this, I engage in it myself. I readily admit (see p. 101) that I found it easier to write about my post-traumatic stress disorder, caused by my experience of hospitalization, than to discuss my earlier susceptibility to bouts of anxiety and depression. I found it easier to say that an external event (steroids) caused me to "go mad", or that an external event (being restrained and maltreated) caused me to suffer. In both these examples the external event meant I could say that *I* was not the reason.

4.1.3 How do we tackle othering?

Schiff (2004) describes how, when working in a humanized way, the professional comes to realize that at another time their role could be reversed. Amongst some of the many lessons that "The Impact that Changed my Life" offered, the sentence "I know that one's world can change in a split second" really resonated with me (2007, p. 568). My experience described in the Narrative and subsequently my being the participant of my own research has highlighted powerfully to me this notion of role reversal. Indeed, evidence suggests that any one of us can be the distressed or impaired psychologist, at any time (O'Connor, 2001). Raising awareness to and developing an understanding of everyone's vulnerability to life's

stressors is an appropriate and advantageous approach to tackle othering: the focus being on education and prevention for all psychologists, not just treatment of those identified as needing extra support. Richards et al. (2016) note that more service user professionals becoming vocal about their lived experience might help to erode the barriers between mental health professionals and service users by increasing communication. This diffusion of othering can be tackled by the acceptance and, I believe, celebration and encouragement of embracing a hybrid identity.

4.2 Hybrid identities

Ivey (2014), in an article discussing the ethics of mandatory personal therapy, notes the complexity of the multiple roles trainees have as clients, therapists and students. Indeed, one of the difficulties that mandatory personal therapy evokes is the role confusion experienced whilst shifting between these positions (Bellows, 2007). Bassman (2001) states that, once you are diagnosed and treated for a “major mental illness”, your life’s course is deeply affected by how you integrate that experience into your identity (p. 18). Although the difficulty of these differing roles shouldn’t be undermined, I believe there is an even greater difficulty of integrating lived experience of mental health problems with one’s professional identity.

4.2.1 From healer to patient, and vice versa

Moving from the role of healer to that of patient can seriously challenge and undermine our professional identity (Wallace, 2012: cited in Conchar & Repper, 2014). For an example of my struggle see (B, p. 71). Richards et al.’s (2016) study pointed out the dilemma that exists when the understandings of patient and therapist are different and the struggle for wounded healers to integrate often-contradictory discourses. For example, a participant in Richards et al.’s (2016) study described how they were unable to use anti-professional discourse whilst identifying as a professional. Richards et al. (2016) also reported that participants switched between different identity constructions, mainly demonstrating an un-integrated identity; however, they also demonstrated an integrated one at times. This was apparent when the participants used a “shared language discourse”, discussing lived experience yet using and not clarifying professional terminology, knowing the interviewer is also a professional. When discussing a clinician with a past history of trauma, Cohen (2009) notes that it is the clinician’s “ability to hold on to multiple identities and still have a sense of coherence, empathy and social engagement” (p. 219) that is of great benefit.

4.3 Challenges of the dual identity in clinical practice

I find my increasing ability to straddle both camps, that of the patient and that of the professional, enables me to meet my clients' needs more fully; however, I need to be careful not to over-identify with either identity, as demonstrated in the Narrative (see I, p. 102). This is one of the many challenges that consumer providers face (Lindow & Rooke-Mathews, 1998). Openly living with a dual identity in the profession has been described as an incredibly challenging and emotionally draining experience by many writers (Adame, 2011).

4.3.1 Boundaries and power differentials

Fisher (1994b) writes about therapeutic distance as one of the struggles that many consumer providers may have in their clinical work. A number of consumer providers describe how they have felt the most helped by those professionals who have allowed their humanness to be seen (Bassman, 2001; Fisher, 1994a). Erskine (2001) writes how, while he needed to rely on his therapist, sometimes he also needed to know that his therapist had suffered like he had in order to gain a sense of the human connection. There are examples in the narrative of times I have projected my own experience onto someone (see F, P.92) or when I have struggled with clinical decisions because of my own lived experience of something similar (see G, P. 97).

Another very important aspect to the clinical work is the acknowledgment of the gap in power. Fisher (1994b) writes how, even if the provider had once been a consumer, in the context of provider they have a power that is greater than that of the consumer, which must not be ignored. I remind myself of this constantly and make sure that I use this additional power for the good of my patients. One example really stood out for me when I was doing a handover meeting. The new care coordinator of my patient was being extremely condescending and downright rude to my patient. I felt a burning anger in my chest and a need to stop it. I intervened and abruptly cut into the patronizing "talking at" my patient and highlighted an alternative narrative – how far they had come, how much they wanted to learn and do things differently. At the end of the meeting the head of department looked at me and I worried that I was going to be seen as over-identifying or causing a fuss. Instead, she said, "Well done, you handled that really well". This is one example of self-scrutiny of my clinical work.

4.3.2 Over-scrutiny

Self-stigma and self-scrutiny can be a powerful and detrimental cocktail for the wounded healer. However, another difficulty that practitioners with lived experience encounter are feelings that their work is over-scrutinized and that supervisors worry to an unhelpful extent about their psychological well-being (Adame, 2011). This fact alongside the fact that most supervisors don't know how to intervene when they need to, highlights the importance of future research and the development of guidance in this area. Unlike physical illness, knowing where to draw the line between distress and impairment is very difficult for the clinician, for their peers or colleagues and for their supervisors. It's a difficult balancing act between intervening and over-scrutinizing; the over-worrying of the supervisor could be stemming from their own anxiety about what to do with the wounded healer (Wheeler, 2007). A recent study highlighted that trainee psychologists often do not report their colleagues, believing it is the role of the university (Rosenberg, Getzeman, Arcinue & Oren, 2005). This diffusion of responsibility is a concern which must be urgently addressed, given that the HCPC (2007) guidelines clearly stipulate we have a duty of care to report problematic peers or colleagues if we are concerned about their ability to work with clients.

4.3.3 To disclose or not to disclose

With all of the challenges that come with being open about one's dual status, it's not surprising that many clinicians decide not to disclose. Deciding to disclose or not was referred to as a challenge by all of the consumer provider participants in Adame's study (2011). Farber (2016) describes, in her book on celebrating the wounded healer, disclosing one's woundedness as being "part of the frightening and strange new territory. Gays are not the only ones to come out of the closet" (p. 10). The reader can see I also referred to disclosing my hybrid identity as "coming out" (see C, p. 81), and I highlight that there isn't just one big coming out and then it's done and dusted (see, D, p. 81). Clinicians with a "mental health problem" or past experience have to choose between secrecy and disclosure in various settings (Hankir, Zaman & Evans-Lacko, 2015); it's something one needs to constantly evaluate depending on one's mental state at the time, the context and who they are coming out to. Farber (1993) describes how one clinician was told not to disclose to her patients that she was once a patient because they would not respect her and would look down on her. Many professionals, such as Linehan (see Carey, 2011), wait until much later in their careers (i.e., once they have established credibility) to disclose their past or current experience of mental health problems. Zerubavel and Wright (2012) also write about the

particular struggle that wounded healer trainees have where they do not yet belong to a professional body: this is, indeed, my case.

4.3.4 What is it like for the patient to have a disclosing therapist?

When trying to figure out what the impact of publishing this thesis, thus disclosing my wounded healer status, might be on my patients I referred to the literature. Not surprisingly, there is a dearth of literature regarding the self-disclosure of therapists' personal experiences of mental health problems and the impact this may have. Egan (2002: cited in Ashmore & Banks, 2003a) discusses under self-disclosure and over self-disclosure and highlights that there are dangers inherent to both of these extreme positions. The challenge is how to find the balance, and I believe it is, unfortunately, not something that training programmes spend enough time on. The few studies available that discuss therapist disclosure predominantly focus on the clinician's opinion. Whilst methodologically challenging, research that explores clients' experiences of professionals disclosing is also necessary. There is an increasing amount being written about the experiences of professionals who have a dual identity – as a mental health professional and of someone who has been on the receiving end of psychiatric services – for example Jamison (1995) and Grant (2016). More writing about how those therapists who openly identify as having lived experience manage disclosure is also needed in order to guide others.

In “The Impact That Changed My Life” (2007), the psychologist describes how, having been the driver in a fatal car accident, she was referred patients who were also drivers in fatal crashes. She describes how she shared with those patients in particular some of her experiences. As I read her story and her process of coming to terms with such an unthinkable moment in life, I must say I fully believed that, should it have happened to me, I would have desperately wanted a clinician who had “been there”, simply because, for me, the incident is so unimaginable. She writes how she came to appreciate the benefits of “thoughtfully considered and ethically informed disclosure” (p. 567). A therapist in Adame's (2011) study describes feeling outraged when one client, after realising she had past psychiatric history, asked if she was fit to practice. We need to consider the potential that these questions may arise; before submitting this thesis, I sought guidance from others in my workplace who openly identified as professionals with lived experience.

It was reassuring reading the suggestion that a clinician having survived mental health problems, or one that is continuing to survive them, is a potential positive factor in patients'

choice of therapist (Conchar & Repper, 2014). Another positive outcome of disclosure that I hadn't considered before reading the literature was that professionals who disclose are modelling an appropriate way of disclosing effectively (Ashmore & Banks, 2003a, 2003b).

4.4 Do no harm

Participants in research who draw on anti-professional discourse, such as those in Richards et al.'s (2016) study, have spoken about "surviving" the mental health system. Anthony (2000) states that iatrogenic effects can be more difficult to recover from than the original "illness", and this was certainly true in my case. Throughout the narrative I have noted when my rights were violated, predominantly in Batu. The impact that "treatment" in South East Asia had on me was indeed the most difficult thing to overcome, an example being my EMDR (eye movement desensitization and reprocessing; Shapiro, 1989) treatment, where I focused on the scene of my being "hospitalized" (see p.73). I never once spoke about the "symptoms" of the "manic episode" itself. Apart from my experience of maltreatment, the only thing I discussed as distressing was my shame at having sent manic emails.

Bassman (2001) writes about his experience in a psychiatric hospital and how his anger, resistance and non-compliance were concerning to staff members. He writes about how "foolishly, I continued to demand rights I believed I had, only to discover that I would pay dearly for my ignorance at playing the hospital game" (p.13). In my narrative, there are parts of my hospital life in which I feel I played the hospital game well; however, I was still not treated according to my human rights or with respect, for example my failed attempt to avoid a needle (see p.75). Unlike Bassman, I submitted and didn't stand up for myself fully. In this case, I believe it was helpful: I dread to think what would have happened had I acted out or demonstrated my anger. Like most things in life, one needs to find the balance.

4.5 Transcending one's wounds: post-traumatic growth in therapists

The post-traumatic growth (PT-G) theme was particularly important for me as I engaged with this research. Amundson, Stewart and Valentine (1993) beautifully explain, in a journal looking at power and certainty in therapy, that the clinician is invited to embrace the wound of uncertainty in lieu of succumbing to the temptation of certainty. I believe the capability to embrace uncertainty more frequently stems from experiencing and surviving periods of instability and confusion. By and large, my reading of the research and my own experience and beliefs point to the fact that we come to the therapy profession because of our propensity

for post-traumatic growth. Indeed, research and current literature are attributing one's development of resilience and ability to tolerate ambiguity to the survival of early childhood trauma. Not too different from the task of living with a hybrid identity, which pulls on often contradictory discourses, it is through their earlier struggle that the therapist develops a capacity to hold multiple viewpoints, "integrate them and move flexibly between seemingly contradictory personal positions" (Cohen, 2009, p. 217).

Adame and Knudson (2007, 2008), in two very important papers looking at the meaning of recovery for psychiatric survivors, describe an important part of recovery from trauma as the construction and use of anger in a new way, shifting from self-criticism and thoughts of being broken to becoming a vehicle of social protest. They note how recovery doesn't mean a happy ending, it means a change in how the person experiences and makes meaning from their continued experiences of worry, pain and unexpected tragedy. This fits with Ivey and Partington (2014) description of the wounded healer, not as fully recovered but as experiencing the on-going or residual psychological impact of adverse experiences and psychic conflicts. Thus, distinguishing the wounded healer from the impaired professional.

4.6 Hope

Following on from the theme of post-traumatic growth is the theme of hope. Before writing this thesis, after disclosing my experience, I would often be asked how I thought it impacted upon my clinical work. The first thing that always popped into my mind was my greater sense of, and ability to hold onto, hope in the face of despair. I've felt horrific shame, devastating loss, chemical lows and moments where I questioned if it would ever shift. Having come out the other side, I feel I can be with clients in a more profound way during their pain, seeing the light at the end of the tunnel without wanting to escape or fix it immediately. I was therefore not surprised when the literature pointed to hope as one of the benefits of those therapists who had "been there themselves". Conchar and Repper (2014) note that wounded healers use their hope and self-belief to initiate and maintain movement for their patients along the difficult therapeutic journey.

Discussing therapists' previous psychiatric hospitalization in a study by Cain (2000), participants also reported their belief in recovery as being the most important benefit of their lived experience to their clinical work. Another benefit described by a participant (psychotherapist with lived experience) in a qualitative study by Martin (2011), is how after

her own traumatic experience, she believed “that the worst is endurable” (p. 15). Similarly, I feel, after my traumatic time tied to a dirty metal bed in a country with poor basic human rights, that the worst for me is endurable. This is something I highlight to patients when they describe how they feel they have survived a difficult moment in therapy. I make sure to validate this experience and remind them, while they are feeling good and stable, to hold onto the feeling in the knowledge that it will serve them well in life’s constant shifting.

I end this section with a quote from Bassman (2001):

for the mental health professionals who genuinely struggle with their own and others’ frightening existential plight, and for all those activists who demand the absolute entitlement of dignity and respect for everyone, I offer my voice to join them in their continuing fight . . . and to inspire HOPE. (p. 34)

4.7 Why do we struggle to celebrate our woundedness?

A number of therapists describe being inspired, by their service use experience, to create change. Adame (2014) notes how many of her participants, in a study looking at the transition from service user identity to one of therapist, explained that the lack of human contact during their hospitalization left them wanting to create a better experience for others. They desired change because of their horrific experiences within the system: “I was so outraged at the things that had been done against my will in hospital as well as the things I saw happen to other people that I decided I wanted to get a powerful degree and have enough credentials to run a healing place myself” (Deegan, 1995, p. 12). It was through my own experience of maltreatment and continued discomfort during training that I noticed the othering and decided I needed to do something about it. I almost shied away from it, but the experience was so powerful I felt I could no longer ignore it. Immediately after my experience in South East Asia, I remember saying to my therapist, “I don’t want to be a therapist anymore, I want to be a psychiatrist. They have the most power, and I can really change things”. I criticized myself for being so “power hungry”, so I am relieved that other clinicians like Deegan write this. I don’t criticize *them* for these statements; however, this discomfort in wanting to do something big, gain accreditation and power, and make a difference in the world is embedded within a pathologizing narrative and the word “grandiose”. This narrative of “grandiosity” comes up in my story (see M, p. 105). I still feel the tension between my passion to fight and change the system and my fear of being perceived as “grandiose”. Sadly, we live in a society that is not positive and encouraging but

rather shaming and restrictive, fuelling the struggle of how to celebrate whilst not showing off success. In the literature, one example of a restrictive culture can be seen in Bassman's article (1997), in which he writes about a patient (a research sociologist) who had to convince his treatment team that he had realistic goals in order to be released from the hospital. When he told them that he wanted to do research on "schizophrenia" the team told him this was a "delusion of grandeur". When he then said he wanted to start a self-help and advocacy group, he was again told that this was another "delusion of grandeur" and that he must accept where he is in life now – a mental hospital. This is also an example of how one person's narrative can be squashed by that of a powerful other.

Towards the end of completing this thesis, a much needed and very moving book, *Celebrating the Wounded Healer Psychotherapist: Pain, Post-Traumatic Growth and Self-Disclosure* (Farber, 2016), was published – quickly becoming another piece of work that encouraged and inspired me to complete and publish my thesis. Instead of coming into the profession to meet our own narcissistic needs (see A, P. 68), Farber highlights an alternative narrative – we come into the profession with a wish to help others the way we have been helped. Indeed, a lot of my reasons for wanting to come into the profession the first time were then re-reinforced after my accident: not to give to others what I didn't have but to try and offer them what I did have. Farber states that becoming or being a wounded healer is "indeed something to celebrate" (p. 3). This makes me smile: it is so simple and bold, and it stands in sharp contrast to the other damaged and shameful positions. If only it was that easy. It is something I would like to work towards, and the process of engaging in this research has been a large part of enabling me to accept and celebrate my woundedness.

4.8 Using the wounded healer's wounds

As noted in the Introduction, some theorists and clinicians believe that we are all wounded healers and must be aware of *how* we use our wounds, not *if* we use them (e.g., Conchar & Repper, 2014). Hocoy (2005) writes that being aware of and working through one's wounds is essential for the development of the "self-knowledge and psychological maturity required of a responsible psychologist" (p. 106). Jung (1961) suggests that the wounded healer never fully overcomes the major problems of his life, but by struggling with and subduing them he can continue developing his sensitivity toward and empathy for others (cited in Farber, 2016, p. 25).

Kirmayer (2003) identified five stages in the development of the wounded healer, the final stage being when “he knows his strengths and limitations to be one and the same. Remaining in touch with his wounds protect[s] him from the threat of pride and arrogance” (cited in Farber, 2016, p. 47). Of note, in several of the papers that are brave enough to discuss the experience of being a wounded healer, there is a consistent message that we must use our wounds wisely and in the client’s best interests. But I am yet to find any paper that adequately explores what using one’s wounds looks like and how one can determine if their use is helpful to the client.

Farber states that the best practitioners are those who, amongst other things, “have the flexibility to go from the role of therapist to that of patient quite easily without feeling any stigma or weakness of character” (2016, p. 21). While I agree in principle, I believe that it is a fantasy to be able to not feel any stigma. Perhaps it is important that the therapist occasionally experiences the stigma that many patients feel on a daily basis. The onus is not just on the professional to not feel stigma but also on the culture that stigmatizes to be addressed at an organizational and educational level. I suggest that we should be creating a culture whereby we are all encouraged to move freely between the two positions of therapist and patient, occasionally occupying them at the same time and being able to sit with the tension and the discomfort of the hybrid identity in the process.

Another way that clinicians describe having used their wounds is to shift from a skills focus to deeper work. For example, after experiencing the birth of her stillborn baby, Callahan (Callahan & Ditloff, 2007) describes her work shifted from a cognitive behavioural perspective with more of an emphasis on facts to a much more phenomenological one where she tried to understand her patients’ phenomenological experience of their lives and not to defer to her judgement of what was rational until she was able to appreciate each patient’s subjective referencing perspective. Both a professional and a consumer, Schiff (2004) writes how she just wanted someone to sit with her and not be afraid of her, and she asks who could be better at this than someone who has been there themselves. There have been particular times throughout my training when I have felt that, had I not had my experience as an inpatient, I might not have been able to sit with some of the more extreme affects of my patients.

In “The Impact That Changed My Life” (2007), the therapist notes that some of the ways she used her wounds for her clinical work were by incorporating more use of writing techniques for trauma, having found it worked for her. She also described becoming more flexible and

open to different techniques as time went on. I similarly found that it was a combination of methods and experiences that assisted me on my recovery journey, one of those being bodywork and massage. Following my accident, I noticed I was a lot more curious and encouraging of everything patients brought in to try and help themselves and having experienced the power of writing I also incorporated this more into my work.

4.9 Self-care

To engage in self-care practices, one needs to acknowledge one's wounds or susceptibility to future wounds and be open to receiving care. Farber suggests that psychotherapists often "care more for their patients than they do for themselves, making their work more hazardous" (2016, p. 61), and Carroll, Gilroy and Murra (2003) suggest that therapists can be some of the worst patients. Ivey (2014) notes that provision of psychological care "presupposes an understanding on the part of the therapist of what it means to be cared for, to discern the others needs and empathize with the mixed feelings evoked by the dependency that being cared for requires" (p. 99). Ivey suggests that not having experienced this for themselves could hamper the clinicians' ability to develop this type of relational caring for their clients.

Smith and Moss's (2009) review looking at psychologist impairment, states that organizations are still significantly lacking structured support for psychologists. A survey in 2006 by the American Psychological Association reported that 59% of graduate psychologists believed that their training didn't encourage or promote self-care (Muncey, 2006b: cited in Smith & Moss, 2009). One reason we don't engage in self-care can be the lack of encouragement to express doubts or concerns about ourselves throughout training and our career. The trepidation of acknowledging something which may negatively impact on one's professional practice or perceived capability is one of the main barriers to accessing support and, in the worst-case scenario, according to Emerson and Markos (1996), can potentially result in a deliberate avoidance of reflective practice.

Smith and Moss (2009) note how often psychologists fail to identify their own impairment – a number of reasons for this having been outlined throughout this thesis, such as shame and denial. I think I have always excessively worried about "damaging" clients. I believe it was this fear that led to my naturally withdrawing myself, whilst lacking "insight". Knowing I wasn't fit to practice, at the time believing that it was due to my back injury, I emailed my line manager and supervisor saying that I would not be back to work for a while and requested that they informed and managed my patients in my absence. I said it was my back

not because I was ashamed, as I was very unboundaried, but because this was the narrative that I was living at that moment in time. Upon returning to London, still very “manic”, I also terminated my studies on the Doctorate. The following year I truly challenged myself, perhaps too harshly, if I was really ready to re-apply.

This is something I argue needs to be worked on. Not only is it a problem because self-care is an ethical imperative for psychologists (Barnett, Baker, Elman & Schoener, 2007) but also self-care is integral to both the survival and, importantly, the success of wounded healers (Conchar and Repper, 2014). Adams (2014) challenges therapists to “take a step back and consider their own well-being as a vital first step to promoting change in their patients” (cited in Farber, 2016, p. 4).

4.10 Narratives and power

An awareness that some narratives have more power over others has been one of the most salient themes for me during this research. Reclaiming one’s narrative has been at the forefront of psychiatric survivor movements. Burstow (2004) quotes one psychiatric survivor movement (Support Coalition International, 2000), which calls “upon all people who have used mental health services to heal each other by telling our stories,” (p. 144). Writing and telling stories is one way to counteract the fact that, once you become “a mental patient, you are no longer a credible narrator of your life story” (Bassman, 2001, p. 30). Burstow (2004, p. 149), highlights how “1. our opinions as clinicians are generally over respected; 2. the opinions of survivors are generally under respected and often downright dismissed”. One professional with lived experience in Richards et al.’s (2016) study noted how they were “completely disempowered and not believed on the basis that I was ill” (p. 6). An example of this can be seen in my Narrative chapter (See H, P. 99).

White and Epston (1990), in a foundational book on narrative therapy, have said we experience problems when the stories of our lives as others have invented them do not accurately represent our lived experience. Therapy then becomes a process of telling and retelling the story of our lives and experiences. Given mental health problems and diagnoses, similarly to physical illness, challenges a person’s sense of identity, in therapy the individual “attempts to restore order through the use of story” (Foster et al., 2006, p. 45). Schiff (2004) describes how she researched “mental illness” and the medications she was taking in order to understand and communicate with the doctor’s lingo. By doing this she describes how she

was able to advocate for herself. This use of language can be seen in the Narrative chapter, where I describe using psychological terminology in order to make me feel as if I was maintaining some sense of control (See E, p. 89).

Reading autobiographical narratives of those suffering from “psychopathology” can augment and embellish mental health professionals and the public’s humanity by offering precious qualitative insights into what it is like to live in a mind afflicted by “mental illness” (Hankir & Zaman, 2013). When reading Chadwick’s (2001) narrative of one of his “psychotic episodes”, I found myself noting a number of similarities between his experience and mine, particularly how everything seemed connected and made sense to him, but for the outsider it was disjointed. He describes this certainty of meaning in his “delusional” state, which is something I vividly remember from my own experience. I was abruptly shifted from one creation of meaning to another as I was presented with new material. This was one of the rare times in my life when I completely “went with the flow”. I believed that everything would turn out fine with the utmost manic conviction! (I do miss it at times). Indeed, I believe the power of my own belief in this narrative was a huge factor in my survival. During my time restrained in the cell, it wasn’t hope that got me through, it was a fierce belief that “my father will rescue me”. Had I not had this as my narrative, reflecting back, things could have got seriously out of control. If I believed I was trapped, I would have likely become more “insane”, setting up a vicious cycle where I could have potentially harmed myself in desperation, like the other inmates shouting and throwing the beds around.

Robinson describes his experience of “schizophrenia” movingly: “they told me I was sick, very sick. I needed expert help” (Muncey & Robinson, 2007, p. 82). This, for me, vividly describes a moment in time when a person’s own power and freedom is lost: here he is being told how it is. It begs the question, how might people’s lives develop if they are responded to and storied in a more human, compassionate and curious way, and what stories might they go on to develop about themselves? It brings me back to where I started, Rosenhan’s research “On Being Sane in Insane Places” (1973). Something that still bothers me today is the statement on my medical records from the time of my admission: “she believes she has a special power that can cure illnesses of mental patients” (Appendix 8). Depending on the way you look at it, this could be true. What I vividly remember is telling the doctors that it is something we all have within us, we just don’t use it, as we can’t fully trust it and we get caught up in theory. Yet they left that rational communication out of my record. Someone not from a psychological or medical background might have, in fact, not thought my expression

was one of a “grandiose” nature but simply part of a journey towards healing. In Batu they call a type of “psychotic” experience “Blessed Madness” as part of an initiation to becoming a healer (Lemelson & Suryani, 2006). Funnily enough, when I told a colleague that one of my “delusions” was that I thought I was a spiritual healer, they looked at me with a straight face and very rationally said – maybe you are. I guess it really does depend on who is telling and who is listening to the story.

Adame and Knudson (2007, 2008) write how many of the survivors of the psychiatric system they interviewed rejected the notion that the problems in their lives and altered consciousness experiences were because of a biochemical imbalance. It was important for them to connect their problems instead to political, societal and existential ones. This is in stark contrast to myself, who initially was clinging to the steroid-induced diagnosis (see p.101). We all view people and interpret experiences through our unique lens developed predominantly from our past experience. The danger is encountered when the person doing the viewing and narrating is not aware that they are rigidly holding on to their singular view.

One salient example can be seen in the different narrations of my episode. In my father’s insurance claim the reader will see how he mentions my academic career a number of times and highlights how it is an episode that is not related to anything in my past (Appendix 7). This is in stark contrast to the medical report from the first psychiatrist (Appendix 8). Having been misdiagnosed at the mental asylum in Batu as having “Bipolar Affective Disorder”, when I arrived the next day at the mental hospital in Apolaniati my medical documentation stated I had a history of “Bipolar” (Appendix 9). Luckily, I was in a privileged position to contest this. My psychiatrist in London believed it was steroid-induced, and I was fortunate enough to receive proper support and treatment from him in the UK, where I was eventually listened to and my experiences were validated. I dread to think what would have happened if I didn’t have the resources that I did. The cost of my evacuation alone is sickening, and it is scary to think how easy it is for one’s life trajectory to be shifted based on one potentially mistaken narrative of your life, by someone else. Once you get stuck in the system, like the participants in the Rosenhan (1973) study demonstrated, it can be hard to get out.

Adame and Knudson (2007, 2008) describe how consumer survivors, through the open exchange of their experiences, develop a collective sense of strength and solidarity, and how the feelings of anger directed toward the psychiatric system, through their dialogues, becomes the catalyst for protesting, advocacy, social action and change. Indeed, my reading of these texts became a strong catalyst for me, and something that I returned to throughout

the development of this thesis for energy and courage, particularly at times when I felt my own shame rising. Burstow (2004) highlights that there is an obligation, not only as fellow human beings but also importantly as responsible professionals with power and privilege, to speak out. She believes that survivors, through these stories, are able to reclaim and celebrate ways of being. I end this chapter with a quote by Bassman (2001) who writes about his embarrassment and disappointment at the almost complete absence of psychologists from political arenas where psychiatric survivors “have had to speak out without allies” (p. 32). Let’s change this.

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Chapter 5: Discussion

The aim of this thesis was to shed light on and examine two experiential phenomena: life of a wounded healer in professional training and a life-altering experience of being admitted to a psychiatric institution. I wanted to use my struggle with this dual identity, a professional and someone with lived experience, to create much-needed dialogue about our various wounds. I critique the culture from within, using my experience to analyse the cultural norms and practices amongst Mental Health professionals, with the desire to “facilitate social consciousness and societal change” (Adams, Jones, & Ellis, 2015, p. 33). I respond to the gap in the academic literature of first-hand accounts of inpatient psychiatric treatment (Short, Turner, & Grant, 2013, p. 41), contributing to and extending existing theory and research, also demonstrating the value and place of autoethnography in the field of Counselling Psychology.

5.1 Autoethnography as legitimate research

Strawbridge and Woolfe (2010) note the speed at which Counselling Psychology has developed from a section within the British Psychological Society (BPS) in 1982, to its own division, only 12 years later in 1994. Davey (2010) has described counselling Psychology as positioning itself between the therapeutic practices of Psychotherapy and Counselling and the orthodox science of Psychology (cited in Thorpe, 2013). Indeed, “locating counselling psychology, professionally and intellectually, is complex” (Strawbridge & Woolfe, 2010, p. 3). Within an era of evidence-based practice, I feel there is a greater pressure to prove ourselves as “scientific”. This notion is supported by McLeod (2011), who describes a continual sense of a need for Psychology to maintain its legitimacy as a science. I believe that counselling psychologists, trainee counselling psychologists in particular, may feel they need to prove themselves as “scientific” given that as a profession it is younger than, for example, Clinical Psychology and doesn’t have a firm established identity. This can create anxiety and questioning of one’s legitimacy; however, it also means there is scope to be more creative and challenging of the status quo, developing a constantly evolving scientific–reflective practitioner identity. Woolfe & Strawbridge (2010) also note that we must examine and refine what we conceive to be science, research and evidence if these are going to be claims to our competence, and they highlight how as a profession Counselling Psychology has had a critical edge to it, proposing alternative approaches. This thesis is an example of my own

engagement with these questions and a demonstration of how autoethnography can be one of those alternative approaches.

I demonstrate my experiential concerns about both the credibility of Counselling Psychology as a science within a climate of evidence-based practice and the production of credible scientific research. Stepping away, not only from positivist research methods but also from more traditional qualitative research approaches, was nerve-racking. My notion of what research is has shifted dramatically since the start of my training. I have been finding myself on the continuum between the “art and science of psychotherapy” (Roth & Fonagy, 2005). Both clinical practice and this research process have taught me how I must live on this continuum, within the tension, without necessarily over relying on either/or but trusting my intuition as a product of the in-between.

Behar describes autoethnography as occupying an intermediate space that has yet to be defined, and as “a borderland between passion and intellect, analysis and subjectivity...” (1996: cited in Denshire, 2014, p.15). Denshire discusses how the discomfort is part of the autoethnographic process as the researcher steps outside of their usual frame (2014). I also found a struggle with embracing this intermediate space. I struggled to let go of the traditional positivist routine, providing a (false) sense of security in the “known”, and to embrace the more creative postmodern literary turn (Sparkes, 2000). My struggle engaging with this new approach, particularly using myself in research, progressed simultaneously with my increasing trust in the use of myself as a clinician and managing the ambiguity in my development, or my constant forming and reforming of my professional identity. Wosket (1999) importantly reminds us that our journey as therapists towards our own personal integration of multiple and shifting theories, and the way we make use of ourselves parallels the work that is done by our clients. I believe identity formation is in a never-ending constant flux; however, there are periods of greater and periods of lesser uncertainty. For example, I have highlighted the particular challenge for me of “coming out” as a practitioner with lived experience before fully belonging to a professional body. There is a fantasy, with some reality attached to it, that post qualification I will feel more secure within this identity.

5.1.1 Evaluation of the research

Gingrich-Philbrook (2015) notes how criteria developed for the evaluation of autoethnographies needs to be used with caution, highlighting that too much focus on criteria can constrain innovation. As Sparkes (2017) suggests, I found comfort and reassurance

throughout this research process from reading other people's criteria, for example those proposed by Le Roux (2017), Richardson (2000) and Bochner (2000). Le Roux (2017) explored autoethnography as a scientifically accountable research method, discussed issues of rigour and validity and gave an overview of, and proposed a number of, criteria to judge the integrity of autoethnography (p. 204):

1. subjectivity
2. self-reflexivity
3. resonance
4. credibility
5. contribution.

Richardson (2000) lists five factors for reviewing personal narratives in academia (p. 254), some crossing over with Le Roux's criteria for evaluating autoethnographies:

1. substantive contribution
2. aesthetic merit
3. reflexivity
4. impact
5. expressing a reality.

Bochner (2000) also has a number of criteria for successful autoethnography (pp. 270, 271):

1. concrete details
2. structurally complex narratives
3. qualities of authenticity and honesty
4. standard of ethical self-consciousness
5. a moving story.

The inclusion of the Narrative – my noteworthy story (Richardson's first factor) – ensures that I am visible in the research and demonstrates my desire for self-understanding. I have explored my felt tension between my different identities, and how I have begun to feel more comfortable within a hybrid identity. Responding to Le Roux's second criterion and Richardson's third, I have demonstrated throughout this thesis what McCorkel & Myers have termed strong reflexivity (2003: cited in Anderson & Glass-Coffin, 2013, p. 72), particularly in the Narrative chapter (see evaluation 5.1.2 below). The difficulty in shifting between a

demonstrative, reflective voice and an academic voice is evident in the Narrative chapter. Including both the Narrative and my interaction with empirical research enables the reader to engage at both an emotional and intellectual level. It also demonstrates the messiness and chaos of my lived experience and the parallel research process, which Spry states “requires a pluralism of discursive and interpretive methods” (2001, p. 727). Reed-Danahay (1997) describes how autoethnography produces evocative stories that create the effect of reality and seeks fusion between social science and literature. I believe I have achieved this fusion, although there are a number of limitations (5.2, p.142), and I hope that by speaking from both positions, that of the lived experience and that of the academic critical voice, I create questions in the mind of the reader.

Within Le Roux’s fourth criterion, credibility, she states that there should be evidence of verisimilitude. Ellis (1991) describes verisimilitude as “a feeling evoked in readers that the experience described by the author is lifelike, believable and possible.” I have endeavoured to be fully transparent with my thoughts and processes (see section 2.7.1, methodological reflexivity, p. 52) so that the reader can make sense of my sense making. I also provide the reader with multiple forms of data, for example photographic evidence and medical documentation, alongside my written accounts.

With regards to Le Roux’s fifth criterion, and Richardson’s first, I am contributing to the literature on the subject matter, and also to the field of Counselling Psychology by demonstrating the particular value and feasibility of autoethnography as a method for our profession. I hope that, through liberating myself and tracking this journey, I have offered readers perhaps another way to liberate themselves. By sharing my vulnerability, creating an evocative story and suggesting changes to practice and training, I hope I have started to make a contribution to societal change. Personally, the contribution that for me has the greatest importance is that through this autoethnography I have joined those other professionals with lived experience who have been brave enough to speak out and challenge the stigma that exists within the profession.

Ellis (1991) suggests that we should ask ourselves questions throughout our autoethnographic project, such as have we learnt anything new from the process of writing our story or does the story produced offer a way to improve our life or the lives of our readers. I have undoubtedly learnt new things from this project, but more importantly this text has offered me a way to improve my life. In fitting with my new-found belief in the power of stories, I have thus decided to demonstrate a part of this process with a final story, which the reader will find at

the end of this chapter (p. 153). This autoethnography has made a significant impact on my life and career path, meeting Richardson's fourth criterion – impact. Importantly, this thesis has enabled me to identify myself as a practitioner and academic with lived experience. This shift has so far led to my accepting to give a lecture on hybrid identities and the wounded healer on a foundation degree course, to speak at a conference organised by the New Savoy in partnership with the British Psychological society on psychological staff wellbeing and to speak about my lived experience at a debate on the future of psychiatry in the House of Commons. I cannot speak about the impact on readers; however, anecdotally, I believe my discussion of the research project amongst peers has had an impact and encouraged some to be more forthcoming with their own reflexivity in their research.

5.1.2 Evaluation of the narrative

With regards to Richardson's second factor (above) for reviewing personal narratives, aesthetic merit, I believe I have achieved this by spending a considerable amount of time trying to allow myself to go with the flow and enable the space and self-compassion to be more creative. I have created a structurally complex narrative (Bochner's second criterion, above) by employing specific writing techniques, recommended by Ellis (1999), such as my use of dialogue and scene setting, flashback and internal monologue, and dramatic recall. This was done to take the reader on a journey: showing rather than telling (Ellis, 2004). This also was used to demonstrate how the mind does not work in a linear or logical order but in a staggered, shifting, jumping and intertwining way. With regards to "validity", I believe this attempt to demonstrate how there are multiple different pathways that one can take to make sense of things is similar to what Lather (1993), in her checklist of transgressive validity, calls rhizomatic validity. This is described as producing a multiple-branching structure that subverts traditional hierarchical (arborescent) forms of knowledge, offering "proliferations, crossings and overlaps" (Lather, 1993, p. 58: cited in Watson, 2009, p. 528).

In the Narrative, my strong reflexivity (Richardson's third factor, above) is demonstrated through the use of switching between the past and the present – caught in the middle of my traumatic experience (left aligned text) and reflecting on the impact (right aligned text). Providing the reader with my reflections while doing the research has resulted in the creation of, what I believe to be, an evocative, engaging and moving story (Bochner's fifth criterion, above). I also believe that by choosing autoethnography and writing from my own, at times painful, subjective place I have demonstrated another type of transgressive validity – voluptuous validity. Lather describes this as a moving beyond a necessity for objectivity

(masculine discourse) to embrace the feminine discourse where “authority then comes from engagement and self-reflexivity” (1993, p. 683: cited in Watson, 2009, p. 528).

5.2 Limitations

With regards to the on-going reflexivity and the very nature of autoethnography, a quote that very much applies to my experience of this research project is that “researchers cannot know what to explore until they have finished exploring” (Bateson, 1972: cited in Berger, 2001, p. 507). One of my limitations was subsequently a difficulty knowing when to stop. I became so engaged with all the reading, discovering topics of further interest, that I ended up finding it hard to condense everything. It was a challenge to synthesize the reading, to make it fit within the word count. At times, I felt overwhelmed by the process and I struggled managing my excitement to read and communicate more, with the practicality of time constraints and work pressures. Although this is a limitation, it also demonstrates my struggle between the multiple identities and felt demands – patient, practitioner, evocative storyteller and academic writer. Another related limitation is the clarity of the research and way in which I incorporated the narrative and theoretical components. As I engaged with the creative element, becoming rather resistant to the more academic tone, my excitement and overwhelming feelings of having so much to say meant that I struggled to maintain the coherence that I wanted. The Narrative chapter was deliberately fragmented, but I found it was a struggle with so much choice and creative licence, alongside my anxiety to make sure that it was “academic” or “scientific” enough, to convey the theoretical parts. Now the research is “complete” I wish I could have been braver in embracing and arguing for more lived experience as equally legitimate knowledge. However, I’m aware that writing for a Counselling Psychology doctorate and not having an example of an autoethnography for one was a legitimate constraint.

During the writing of this thesis, I had a number of challenging life events which were not necessarily limitations per se. Sometimes events were inspiring and I was moved to write, other times it was anger that motivated me to write through a powerless situation (see J, p. 103). However, other challenging life events were more hindering. At times, I felt very raw and exposed when thinking about publishing, and I could become quite anxious. Other times I felt a profound meaning and purpose to my work, which bolstered me. I found a lot of the writing therapeutic, so this helped during those difficult moments.

Another limitation of the approach is the level of self-care required to engage in such a reflexive and self-exposing process. I was fortunate to have an excellent supervisory experience, and my connection to Alec Grant provided me with an immense amount of emotional support and encouragement as I went through the process over the two years. However, the fact that it is such a personal and emotional topic, process and identity-shifting journey meant that completion of the thesis was hard to do while working and living. It is valuable to be aware of this limitation for future trainee psychologists considering this method. Owing to the immersive nature of the research, I couldn't just dip in and out of it. I needed to put aside blocks of time in order to become fully engaged in the process: it became a way of being.

Upon reflection, post completion and during the viva process, I became aware that I didn't include feminist literature and this is something that would have been an interesting and very valuable adjunct. I also became aware that I didn't focus on my gender, I wasn't aware both at the time of the experiences and when writing about them, what being a woman in this context meant. Looking at my experience through a gendered lens I would have found things that are currently absent in my thesis, and if I did this I certainly wouldn't have produced what I have today. Equally I could have taken an age or race lens. Indeed, there are so many different lenses one can look through and not one that is right, each one enabling me to see and produce different knowledge. However, I do wish to acknowledge the lack of this and a brief reflection on what might have emerged had I taken a gendered lens. My first thought is that there exists a perception of men as more violent than women or structurally bigger and stronger. I happen to be a very petite woman and therefore in my time in the asylum I imagine I didn't cause significant threat to the professionals working there or the other patients. This 'threat' being also in the eye of the perceiver and not an actual threat per se. Had I been a large man who became angry at being restrained and fought back it is likely that professionals would have reacted to me very differently.

Another factor that I did think about during the time of the accident, post-accident and in the write up and deliberately chose not to write about at length because of the emotional distress and discomfort it could cause was my fear that sexual boundaries could have been violated. This is not to say that this couldn't happen to a man but being a small woman restrained and tied to a bed by four large men I didn't feel safe, I felt safer with the presence of female nurses. Both during the time and post trauma, for a significant amount of time post incident, I

repeatedly asked if ‘anything’ had happened, alluding to a crossing of sexual boundaries. It was immensely scary having been drugged and not remembering large chunks of my time spent in the cell. My fear is likely to have been heightened by my petiteness and my femaleness in contrast to the large and powerful males that were exerting control over me.

5.3 Ethics

As mentioned in the Methodology chapter (2.8 Ethics, p. 54), ethics are more complicated than they first seem in autoethnographic research (Etherington, 2007; Tolich, 2010). I have addressed this by engaging in continual monitoring and discussion with my supervisor throughout the process. I was aware of my ethical obligation to those who were not “participants”, and consequently I made sure to continually explore the potential impact of this narrative on those who are implicated by my story. Richardson (2000), Le Roux (2017) and Bochner (2000) all state that the autoethnography should have the qualities of authenticity and honesty. I have checked and changed some details and omitted a fair amount in order to be as ethically sound as possible while not compromising the truth and what I feel I need to portray to the reader (Medford, 2006). I noted at what points the writing brought up painful aspects of my past and, as discussed in Barlow and Grant (2016), I also maintained some protective psychological boundaries by taking out some of the more disturbing parts of my experience.

Although not directly discussing autoethnography, in a recent journal article Bondi and Fewell (2016) remind readers of the cross-fertilization between research and practice, as there is a close link between the ethical reflexivity one develops in relation to their clients and the way researchers approach their research ethically. There was a parallel process of being “ethically self-consciousness” (Bochner, 2000, p. 274) and being a clinician with an ethical duty to care for oneself. The necessity to engage in self-care throughout writing this piece of work strengthened my already developed awareness of the need to self-care in order to best help my clients. I hope, if anything, that readers will be encouraged to engage in self-care, not seeing it as something shameful or a weakness to hide but as a fundamental part of being human.

5.4 Implications

5.4.1 Research

In their seminal text, Lincoln and Denzin (2005: cited in Morrow, 2007) describe moments within the research field. Owing to word count limitations I am unable to go through them here but I have provided a document that briefly outlines them, which the reader will find in Appendix 10. They predicted that the future 8th moment would contain, amongst others, a theme of social science becoming reconnected to its social purpose. Morrow (2007) explains this means “social scientists must move beyond mere academic inquiry, to renew, reclaim, or discover their social justice roots” (p. 224). As a methodology and method, autoethnography does connect us, as psychologists, back to our social roots.

Morrow suggests that qualitative research “may bring new or unexpected knowledge to the fore” (2007, p. 211). I argue that engaging in autoethnographic research has multiple benefits, particularly for our profession. It challenges and critically explores current research practices, and it can augment training, stimulating those conducting the research to be increasingly more self-reflexive. It can be a normalizing process that creates and stimulates much-needed dialogue within the profession around difficult yet ever present topics, and it can also be seen as an attempt to explore and reduce the power divide between the layperson and “us”, the professionals and researchers who don’t talk about our own “stuff”.

This research has been the start of my own continuing commitment to my social responsibility, which I have, ashamedly, previously overlooked. It is far too easy to focus all of the training attention on becoming a sound clinician, grappling with individual patients and coursework. However, I believe being a good clinician is not good enough. Being aware of the unjust societal struggles some of our clients face yet ignoring the existence of these issues beyond the individual (i.e., in society) simply because the problem seems insurmountable is unacceptable. Just as I have been inspired by such activists as Bassman (1997) and Fisher (1994), I hope that the readers may be inspired themselves to jump on the bandwagon or create their own initiatives. Burstow (2004) argues that it is time to join them.

5.4.2 Mental Health services

The aforementioned theoretical literature and empirical research, alongside my narrative, demonstrates the necessity for employers to address organizational challenges that the wounded healer may encounter. I demonstrate that we can and do engage in discrimination of our colleagues with past or current mental health difficulties and that we don’t know how to

intervene and assist those who are struggling in the here and now (O'Connor, 2001). In their review, Conchar and Repper (2014) describe one of the important challenges as being how to manage a wounded healer's disclosure. I hope to have emphasized throughout this thesis the importance of maintaining an awareness that it is not solely those professionals who come into the profession as a wounded healer, there has to be more awareness that we are all human, and with that comes human suffering. Anyone at any time, irrespective of their past, can become stressed, distressed, emotionally disturbed or overwhelmed, and if this isn't attended to risk becoming impaired.

The fact that we don't actively talk about and encourage the use of a therapist's wounds or self in the workplace could be portraying the message that it is not appropriate and that they are not accepted – or, worse, the clinician may feel that part of themselves is a dirty little secret. Keeping secrets, I feel, is a slippery slope to real problems. When the clinician is doing something behind closed doors, which they feel they can't discuss in supervision, we have a problem. This can be undoubtedly detrimental to the client in many ways, but it also damages the clinician, who may feel a dissonance between what they say and what they do, with a greater gap between their personal and professional identities. I note in the Themes chapter (p.109-124) that by not encouraging transparency there is a risk, especially for those clinicians more prone to self-stigmatization, that clinicians reject their wounded identity (along with all of its special healing attributes) in favour of a professional identity, becoming overly reliant on theory and the application of technique and relegating the identity of the wounded one onto the client.

Although current policy calls for “lived experience” in both training and practice, a lot needs to be understood and implemented before we can successfully achieve this. Services are not well equipped for professionals with mental health problems (Conchar & Repper, 2014; Richards, Holtum, & Springham, 2016; Rooke-Mathews & Lindow, 1998). There needs to be a profound shift in the profession on a number of levels, from the organizational right down to each individual working in every team. This is made difficult because of the limited amount of research exploring how wounded healers experience the vast number of challenges in practice, how this impacts on their identity construction and how it impacts their clinical work. I hope to have touched upon this with my own lived experiences of being a trainee wounded healer in the Narrative chapter and with my further elaboration of this in the Themes chapter, linking it to the available literature. More extensive research is now needed that focuses on certain dilemmas in depth.

5.5 Future recommendations

Our attitudes as psychologists towards people with mental health problems have been under-researched when compared with the research on psychiatrists and social workers. I join Servais and Saunders (2007), stressing the necessity for future research exploring our attitudes towards not only patients but also colleagues who are experiencing or have experienced mental health problems or distress.

I am in agreement and have mentioned throughout this thesis that, owing in part to a fear of disclosure, there is a lack of understanding regarding what it means to “use our wounds”, and it is therefore necessary to create a supportive environment for staff to discuss their wounds and to feel encouraged to be themselves should they wish to do so (Conchar & Repper, 2014).

5.5.1 Counselling Psychology

Deegan (1996), a psychiatric survivor and mental health professional, described how the field should focus more on the wisdom of people with first-hand experiences of mental distress. She also calls for the training of clinical psychologists to move towards a more qualitative and person-centred understanding of the subjective experience of emotional distress. As counselling psychologists, this is the core of our philosophy as practitioners, and we are thus in a unique position to demonstrate the value of this and to continue fighting for and encouraging this shift.

I believe that counselling psychologists in particular have an important role to play in the treatment and experience of patients with serious mental health problems. Many, such as Bassman (1997), have noted how psychologists are under-represented in working with patients diagnosed or hospitalized with “severe mental health problems”. I have noted throughout my reading of other people’s experiences how many psychiatric inmates, and wounded healers (including myself) have shared that they really wanted someone just to listen to them and talk things through. I believe the process of psychiatric hospitalization or, the incorporation or rejection of a “diagnosis”, and the necessary re-narrating of one’s identity that follows can be made much less daunting if there is someone trained specifically to attend to the individual’s own subjectivity and narrative at a time when there are likely to be a significant number of other narratives being given more power.

5.5.2 Tackling stigma

More students and academics who have had experiences of psychological distress should acknowledge the “hybrid nature of their identities”, as it would be a “really good emancipatory, anti-stigmatising practice” for those mental health professionals and the people they help (Barlow and Grant, 2016, p. 33). Barlow and Grant further discuss how, via teaching, we can try alongside colleagues to make a small contribution towards re-addressing “them us cultures”.

5.5.2.1 *Training and education of future psychologists*

Throughout this research I’ve made a number of recommendations with regards to the training of future psychologists. I demonstrate the act of “othering”, which we engage in as a profession, and how it is vital that educational and training programmes assess how they are dealing with this. I show how training may unintentionally enhance negative attitudes or othering, for example by relying on external and “not us” service users to talk about mental distress. The Health Care Profession Council (HCPC, 2014) guidelines explicitly state that the training of mental health professionals should involve service users as contributors for their relevant lived experience. Yet there was no service user involvement throughout my three years of doctoral training. We also need to do more than what Ion, Cowan and Lindsay (2010) have called token service user involvement: it needs to be meaningful and core to the values of the training.

I suggest that training programmes should encourage those professionals who have wounds to safely and confidently disclose, should they wish to, so that the theoretical and practical material may come alive (Charlesworth & Ferrigon, 2016). Should this not be plausible, a joint training programme with a lecturer and a service user could be an alternative. I recently attended a training course designed to improve mental health professionals’ understanding of and attitudes towards patients with a certain “disorder”, which was co-facilitated by a mental health professional and service-user (see Narrative, N, p. 107 and also below, p. 153). I have been impressed by the impact that this three-day training has had on professionals’ understanding of this highly stigmatized “disorder” and the subsequent implications of this deeper understanding in the therapeutic, or anti-therapeutic, exchange.

I suggest that training institutions should develop a specific module on stereotyping and stigmatization in more depth. This shouldn’t be a tick-box criterion but an in-depth

exploration of our own attitudes and what it is like to experience being stigmatized. In my opinion, more experiential learning would benefit the profession.

5.5.2.2 Training reflexivity

Self-reflection and appraisal, according to Yalom (1998), is one of the foundational principles of the profession of psychology. Ivey suggests that the professional goal of reflective practice which is tied to insightfulness and understanding of oneself can be attained through a number of different activities that are more “constructive and relevant than individual therapy discharged in a perfunctory manner” (2014, p. 98).

I feel a lot more can be done on training programmes to encourage trainees’ reflexivity. While I can see the intention of the requirement for a reflective diary, I know not many trainees properly engage with this process and that it’s monitoring is often insufficient, and rightly so to protect privacy. One of my main suggestions as a way to get around this and to enhance this aspect of our training is to use autoethnography. My recommendation, stemming from this research, is that autoethnography is taught as part of the research methods module in year one and trainees are required to write an autoethnographic piece of work throughout years 2 and 3 to track their development as trainees. It would be beneficial for students to track their shifting self-development resulting from their engagement in personal therapy, interaction with taught theories and the experience of clinical practice. Should trainees then be interested and “brave enough” to develop it into a publishable piece, it would add much value to the scarce literature and empirical research that looks at the development of therapists’ identities. I believe that training in autoethnography will also be of benefit when approaching the doctoral thesis. Those who do not use it as their chosen method, having been versed in the literature and epistemology of the method, will be able to critique research of others and importantly their own in fundamentally new ways.

I am not the first to highlight the benefit of using autoethnography within our profession: Ellis (1999) has highlighted how it can be beneficial for training, and Thorpe (2013), while not explicitly discussing autoethnography, notes the value of conducting qualitative research as an augmentation to the learning of counselling psychologists. Egeli (2017) very recently provides a discursive article on autoethnography and its value for the counselling psychology profession. Hocoy (2005) describes the parallels between ethnography and psychotherapy, believing that “Ethnography provides a valuable option or supplement in the instruction of psychotherapy” (p. 104). Having observed that the trainees’ immersion in the ethnographic

process has the potential to result in a paradigm shift for the trainee or a radical change in the way that they view the world, Hocoy developed a model for training institutions that I encourage those interested to read. He states that “this new perspective may be one that deconstructs the existing paradigm for mental health and psychotherapy” (p. 112). I can testify that my own immersion in this methodology did indeed create a multitude of paradigm shifts for me in my own personal life and training (see p. 150, this chapter). It is because of this that I agree with Hocoy (2005) on the value of ethnographic training, but I suggest autoethnography as a more feasible starting point for Counselling Psychology doctoral programmes. Engaging in a new research approach and learning as I went along had its benefits and its limitations. A lot of time was spent learning and it was a push for me to actually start writing. Although I believe there is a necessary anxiety that comes with autoethnography, I think it would be beneficial for future training courses to incorporate auto/ethnography in research methods modules. This would help the process – especially with regards to completing on time.

5.5.3 Managing impairment

I agree with Smith and Moss (2009) that one of the first steps to preventing impairment should be education, and I further suggest that trainees should be educated about personal and professional characteristics that can increase their vulnerability. There should be training and education also regarding the management of impairment in colleagues or peers. A module that focuses on this can give an overview of early signs of impairment and how to recognize this both in the self and in others, with the possibility of role-play regarding how to confront one’s colleague or supervisee. Currently coverage of impairment and wellness during training is not mandatory for accreditation by the American Psychological Association (APA; Schooner, 1999: cited in Smith & Moss, 2009). If we don’t discuss issues such as our own distress and potential impairment then the high level of stigma associated with it is likely to continue, resulting in a hesitancy for psychologists to speak out about their concerns. I agree that the distressed or impaired psychologists should not be demonized or “othered” (Smith & Moss, 2009). Instead, an open atmosphere and culture of acceptance that encourages concerns to be vocalized and addressed compassionately can greatly benefit the clinician and aid the reduction of the stigmatization that exists in the profession. One hopes this may then filter out to the general public’s attitude towards those suffering with mental health problems. This is why I have highlighted the importance of self-care and awareness training as

something *for everyone* as a preventative measure. This idea is not new and has been made by others before me (Cain, 2000; O'Connor, 2001).

These recommendations would be valuable for the profession as we move to including more service users as providers of mental health treatment. It would be relevant also for those already working in the system but struggling to “come out”, or for their line managers and supervisors who don't quite know how to approach the wounded healer professional or, in particular, the wounded trainee. We need to start talking and, once started, not stop, about the challenges of being a wounded healer and figuring out ways to best support them and create professional cultures where lived experiences are valued and seen as assets rather than hindrances.

5.6 Reflections

Muncey (2010) notes one methodological issue in the critique of the approach being that of self-indulgence (Delamont, 2009). In response to the criticisms that the approach is narcissistic (Sparkes, 2000), I have used this reflexivity section to transparently acknowledge the personal gains that the project brought to me. Jones, Adams and Ellis (2015) refer to an essay by Herrmann (2012) highlighting how autoethnography gives the researchers an opportunity to “write through painful, confusing, angering and uncertain experiences” (p. 34), and this was indeed therapeutic. Bochner (2013) has beautifully described traumatic epiphanies as unexpected blows “of fate that call meanings and values into question” (p. 52). The experience of being an inpatient had indeed challenged “the construction of meaning I put together for myself” (Ellis, 2004: cited in Jones et al., 2015, p. 34). Through this process I constructed new meanings and simultaneously discovered my own ability to, at times, remain without meaning, or in the edgelands (Muncey, 2010). The ability to disclose and actively use a part of my subjective life, which until then had not been acknowledged, was beyond refreshing. I would go as far as to say that it was necessary in order for me to continue working in the profession. After disclosing my hybrid identity of patient–practitioner, I was able to engage with the “institution” in a different light. I no longer felt a frustration or desire to speak out during lectures when we were studying “patients”. The tension I felt having these different “identities”, a theme found in my analysis, while not disappearing, was explored and acknowledged, and thus became easier to live with.

The acceptance and encouragement that I received from my academic institution greatly empowered my development as a practitioner and as an advocate for patient rights. Engaging

with a methodology that encouraged a high level of self-reflection and awareness of myself as someone who interacts in a social world, I became increasingly interested in existential therapy, and my reading for this study infiltrated into my training as a practitioner. I also began to embrace “writing as inquiry” (Wright, 2009) and the use of a diary as therapeutic. This is something I have continued to use post research.

Writing about fieldwork, Hones (1998) describes how thinking, writing and rewriting led him to new understandings of his experience and how his experience in the field engaged him in a conversation in which he simultaneously discovered himself and “the other”. In this autoethnography, I have conceptualized my fieldwork as my training environment: my interaction over the past two years with tutors, institutions, placements, clinicians and patients, to name a few. I have been continually discovering myself as I interact within these contexts and reflect on my previous ways of thinking. I have also been fortunate to discover others in this process. For example, I hadn’t ever properly engaged with activist movements or research. It wasn’t something that I frequently came across in published research, and this is yet another reason why more accounts of lived experience need to be published in accessible places. It should not be that only those who know to look for it can find it; there should be a greater presence in the profession and in the academic and clinical texts we read in training.

This autoethnographic journey has enabled and encouraged me to challenge my felt tension between my professional and personal identity. It has provided a means of understanding for myself as to why I struggle within my hybrid identity, and this in turn has provided a *more secure* (though not a definitively secure) base to tackle my resistance to the unknown, both professionally and personally. My newfound interest and passion for existential therapy, sparked by this research process, has been one way for me to live within the tension and learn to just be. It has enabled me to embrace a completely new genre of writing for academia. By reading other autoethnographies, in learning how to do my own, I have been helped to “communicate” with those who are different to me. I have sat uncomfortably, reading painful prose, and been forced to engage with emotions that I might have otherwise shied away from. By reading about other people’s struggles and sensing their bravery, I have been forced to look inwards and examine parts of myself I would rather not have divulged. Importantly, I have felt inspired and obliged, in a sense, to make myself more vulnerable in my writing, with the hope that my readers will be equally encouraged. It is hard to read other people’s experiences of being an in-patient or a wounded healer, be touched by their painfully

poignant writing and then to sit back and not join in. It has encouraged me to have a cause and to “write to right” (Bolen, 2012, p. 676: cited in Jones, Adams, & Ellis, 2015).

5.7 Conclusions

It is difficult to narrow down my findings or discoveries into a single concluding paragraph. I hope that by this point the reader has started to make their own conclusions, having engaged with the Narrative and my discussion of those themes that were pertinent to me. The difficulty of a succinct conclusion stems from the fact that this autoethnography has led me to gain a greater understanding of a number of interlinking areas. For example, I have demonstrated through the Narrative and links to the literature that stigma amongst mental health professionals exists, be it stigmatization of patients or fellow colleagues with past or current mental health problems. I have also demonstrated how I am an active participant in this, and how it is unavoidable given our human tendency to categorize and compare; however, with awareness, the impact of this can be minimized. I have demonstrated the power of narrative, both in terms of its use as a legitimate research method and the necessity of paying attention to the power that is given to some narratives over others and the subsequent ramifications of this. I have shown the therapeutic value for me in narrating this traumatic event and my subsequent experience of living with it, and I have found that the description of hybrid identities sits well with me, providing a frame for the confusing and often contradictory discourses I encounter. I noted the necessity of self-care amongst professionals and that, when acknowledged and openly discussed, one’s past or current experience of mental health problems can be of great value to their clinical work, and at times should even be celebrated. However, I also noted that more open discussion is needed with further research and debate regarding what it means to “use one’s wounds” and the impact of disclosure of professionals’ mental health problems from a patient’s perspective. I am in agreement with O’Connor (2001), who states that there is a lack of training for psychologists on how to manage personal difficulties and on what the likely sources of difficulties can be (from the clinician’s background, reactions to on-going life challenges and the inherent difficulties of the clinical work itself). I conclude that autoethnography can and should be used in Counselling Psychology research and that it can have an important role in education and training.

This thesis, the Narrative in particular, has hopefully been a “live” example for the reader where I have not presented a happy ending but have demonstrated a shift in my thinking and

meaning-making as I go on to continue life as a human who is bound to experience further distress throughout her career. Ellis (1991) describes the autoethnographic project as one that will never be complete, quoting Richardson who writes that one strives to “get it contoured and nuanced in a meaningful way” (Richardson, 1994: cited in Ellis, 1991). I hope to have done this for the reader. I could continue writing, and there is further self-reflection that occurs as this research is marked – lets not even begin to think about the reflections that will come from the publication of my research and the reaction of readers. However, I have strived to produce a meaningful, although deliberately fragmented, understandable and accessible text.

5.8 A final story

November 2016: discussion with research supervisor, City University London

Towards the end of my thesis (I had just produced a rough draft), we spoke about the language or constructions used around my “accident”. She was interested in why I had clung on, as I’ve described in the text, to the steroid explanation. She asked me, what is wrong with it simply being an experience? This enabled me to feel freed in a way, although slightly anxious: what does it mean, actually, if I just had an experience... This thought stayed with me and I left the meeting still reflecting on it...

The following day: training event, London

For the second part of the afternoon training we were asked in groups to think about some ways that we could tackle stigma.

I am in a group with two potential trainee psychologists. I notice I am more cautious about their reactions to what I say than with other mental health professionals. This really strikes me. Why is this? Is it too close to home? I tell my group about my thesis being on mental health stigma amongst professionals, but hold back about my own status and the thesis being an autoethnography.

This was not only because they were future psychologists but also a kind of vigilance because it was too close to home. It was also in part because I was feeling like I might be attracting too much attention, monopolizing the space.

Here we go again. The fear of grandiosity

We are asked to tell, in the larger group, our ideas about tackling stigma. My group speaks first and they reel off a number of ways, but I am quiet. I'm debating. How do I explain mine?

I can feel my chest getting tighter and a familiar burning sensation starts. I'm feeling like a hypocrite. I am feeling an affinity with the service user and a desire to get alongside them.

I look around the room at all the varying professionals, and the statistics from the reading I did last night for my literature review are running through my head. How many of these people have struggled themselves? How many are struggling now?

I'm shaking. My voice is wobbly. I start to speak.

As I'm writing this I am brought to tears. Not crying – just moved.

Me: “I happen to be tackling stigma in my thesis, which questions stigma amongst ourselves as mental health professionals and how I believe we all have a patient within us and that we need to acknowledge that more freely.”

Service user: “Can you say more, how are you doing that?”

Me: “Through my own experience as an inpatient.”

As I am writing this and reliving it in my head the tears have increased: they are tears of joy.

Service user: “Wow, so you are a flag bearer! Is it working?”

Me: “It is! There's a ripple effect, whenever I discuss it in the classroom or at a conference....”

After this discussion, we continue with the tasks of the day and the service user comes to speak to me during the tea break.

Service user: Thank you for sharing your experience

I hate the term service user, and having to write it lots in this segment is annoying me.

Me: “Thank you. It’s the first time I’ve disclosed the fact I was an inpatient to professionals, not pre-empting what I will say.”

Service user: “Oh, wow. So, how did it or how does it feel?”

Me: “Really good. I feel proud and brave. I didn’t hide behind the diagnosis of it being steroid-induced – for the first time ever, I have left that out.”

As alluded to earlier, Ellis (1991) states the importance of tracking or demonstrating that change. For me, I owe my change to the process of my thesis, through the encouragement of others on my journey and the reading around others who have been brave. I feel I’ve accepted and integrated the experience and allowed myself to sit with it and not distance myself by medicalizing it via the steroid narrative. In no way am I presenting a complete or resolved ending. This feeling of bravery and self-acceptance will wax and wane as I continually interact with the world and my different contexts. But I have been moved in a way that I didn’t expect by this process, and it is truly beautiful.

I start to cry again whilst typing the word “beautiful”. These are happy tears of

resolve,

accomplishment

and

resilience.

5.9 An ending, for now...

It is rather symbolic for me that the working towards and completion of this thesis happened to be at the same time that I work my way into the fourth anniversary of my trauma. Each year that passes I am hit powerfully with emotions during this time and I reflect on how far I

have come. I decided, therefore, that my submission date should be the 4th year anniversary of my date of discharge from the mental hospital in London.

Martin (2011) questions if “the achievement of the status of chartered psychologist really does transform us beyond the prosaic limitations of ordinary mortals” (p. 10). My achievement of the status as a chartered psychologist, via engaging in this research process, assures me that I am certainly not going into the profession with that belief. While it is highly significant for me that I am becoming a chartered psychologist, it is something I would not have believed four years ago locked in a cell or, after release, locked in my own mental cell of self-doubt. I am shredding any sense of superiority. I am discharging myself from the chains and shame of my trauma as I encounter the world as a professional, and one who celebrates her woundedness. I desperately hope to hold onto this.

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PART B

The wounded healer: challenging stigma by embracing our hybrid identities

I am embarrassed to admit that, upon receipt, my subscription journals are placed neatly on the shelf as I assure myself that I *am* going to read them – but then I don't. As a trainee, my time is limited: something I'm sure will resonate with many readers. However, I was drawn to the article this month by Reicher and Haslam (2017) on writing for impact. Reading this in conjunction with figuring out the publishable piece for my thesis portfolio, I knew I wanted to write for *The Psychologist*. Only later did I start to get nervous about the wide exposure that publishing here might bring – perhaps it would be better if it was destined for life on the shelf, as so many of mine are. But I do want to change the system from within, partly by outing myself, and that would require the article to be read, not put on the shelf.

In this article, I will look at the stigma of mental health problems amongst mental health professionals. I will provide the reader with some extracts from the narrative chapter of my doctorate thesis, an autoethnography exploring the wounded healer phenomenon, and I will introduce the topic of disclosure and encourage debate as to why it is so hard in a profession which is supposed to be empathic and understanding. I hope to touch upon a few recommendations for tackling mental health stigma amongst professionals and for creating a culture of acceptance in the profession, which not only is a necessity but is also an exciting opportunity to advance the profession.

This excitement, followed by caution and slight panic, is a frequent feeling I have experienced over the past two years while writing my thesis. As I have progressed through the writing up of my research, I have become more comfortable with this rollercoaster of emotions – although it never disappears. For example, recently I was asked if I identified as an academic with service use experience and if I would consider giving a lecture on a foundation degree in a London University. I jumped at the opportunity – this is clearly my destiny, I'm going to be brave and take a stance – if I didn't do it I couldn't criticize others for not doing it. I was excited for all of about 4 hours, planning what I would say in my head, thinking about the impact it could potentially have. How wonderful it would be if things really began to shift in the Psychology profession during my career. Then it started to sink in: I am not qualified yet. I really should qualify before I am bold and take a stand, exposing myself. What if I am giving the lecture on a bad day? No wonder many professionals, such as

Dr Marsha Linehan² and Ronald Bassman,³ wait until much later in their careers to disclose: they first established themselves as credible clinicians and academics. I toyed with the idea of delaying things, waiting until I graduated. But then, later that evening, reading for my literature review I came across another activist piece written by a psychiatric survivor. I became invigorated again: round and round I go.

Another opportunity comes up – to speak at a conference on practitioner well-being about the stigma of mental health amongst professionals. Again, I jump at the opportunity and then start to doubt myself. I umm'd and ahh'd before leaving the conversation sheepishly by asking for a week to consider. I later call a friend for advice, who tells me I have to do it – it's what I'm writing my thesis for, to make an impact. So, here I am. Preparing my thesis, my lecture slides and myself (my bravery) to speak at a conference. All of these experiences are rather handy while I attempt to write about stigma amongst mental health professionals for this article.

I shall begin in the same way I began my research presentation the first time I disclosed my ex-inpatient status to academic peers. The morning of the presentation I suddenly realised I didn't know how to “drop the bombshell”. I was thinking about myself but also my peers – I didn't want to shock them and I didn't want the bomb dropping to take away from the main purpose of the presentation, to discuss my chosen methodology. I decided to wing it – I often go into presentations knowing the material but not rehearsing, as I find it comes out more naturally that way. The first slide of my research presentation contained the photo below (Figure 1).

² Dr Linehan developed one of the predominant evidence-based practice treatments Dialectic Behavior Therapy (DBT) and disclosed her own diagnosis of Borderline Personality Disorder towards the end of her career. Interested readers can find an article discussing her life and work including her disclosure in an article by Carey (2011).

³ Ronald Bassman is a Psychologist and survivor of the psychiatric system, being diagnosed at the age of 25 with schizophrenia, paranoid type and later chronic type. He is a co-founder of the International Network Towards Alternatives for Recovery (INTAR) amongst other advocacy involvements. He writes passionately about his experience in a number of articles and books. Readers can find some references at the end of this article.

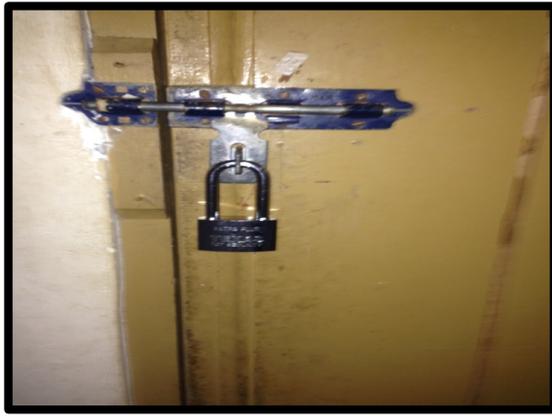


Figure 7: My cell padlocked from the outside

Without thinking, I started the presentation by saying, “I’ve chosen this image here because it is the padlock that was used to lock me up when I had a steroid-induced hypomanic episode in South East Asia last year”. I continued with the presentation – my academic voice largely being used – and then finished with a question and answer session. I was so grateful for the positive feedback and encouragement I received, particularly from staff. It was good to feel encouraged and not to have my voice shut down, and to feel part of a university that is forward thinking and open to creativity. At the end of it, I sat down and felt such a great release, as if I had “come out” of my metaphorical closet, no longer having to sit in lectures and squash my patient voice and identity. (This is a small section of the narrative from my thesis.)

Mental health amongst professionals

The paradigm of the “wounded healer” encapsulates psychologists who have their own experience of mental health problems. The mythological image of the wounded healer is a ubiquitous yet under-researched concept. I suggest one of the reasons shame exists for psychologists who have a lived experience of distress is the association to the wounded healer paradigm of the narcissistic person who comes into the profession to heal themselves or to satisfy their own needs. This combined with a climate of regulation and assessment of fitness-to-practice is a powerful cocktail. This shameful and narcissistic narrative, certainly, was one that I kept repeating in my head on bad days when I questioned myself. What is also well known, though not often talked about, is the high levels of distress that exist amongst mental health professionals. Increasingly, we are seeing more written about professional burnout and vicarious traumatization. These, however, are distresses caused by the profession

and do not speak about the distress that was already present for the clinician when they joined the profession, or importantly and often forgotten the distress that clinicians can experience as they go about their daily life. It is often forgotten that we too are human: we suffer break-ups, losses, traumas. In response to one professional openly speaking about his breakdown, some other professionals noted that they too want to come out of the false closet of professional immunity (Martin, 2011).

While there seem to be two extreme positions – either the clinician has a prized benefit or they have hidden narcissistic needs – often it is because of a mixture of both narcissistic and altruistic reasons that we choose to come into the profession. There is an increasing volume of literature supporting the more “positive” reasons for people coming into the profession, such as wanting to provide others with the same experience of care and support that one has experienced oneself. Most of the research to date notes that wounds are only beneficial if they are acknowledged and worked through, or are being worked through. Rosenberg, Getzelman, Arcinue and Oren (2005) define resolved woundedness as an ability to think about one’s wounds in a relatively undefended way without becoming overwhelmed. A deepened understanding or awareness of what recovery means is also likely to enable us as a profession to monitor fitness-to-practice concerns more effectively and to encourage the provision of a reflective open space for professionals to grow and develop personally without fear of subsequent misperceptions of impairment.

Why aren’t we talking about it?

Unfortunately, the concept of the wounded healer and all the benefits that lived experience can bring to the profession might not be used to its full potential because there is a lack of understanding surrounding the implications of what it means to be a wounded healer; many professionals still don’t disclose for fear of being perceived as impaired (Sherman & Thelen, 1996). It is important to distinguish between the wounded healer and the impaired professional (Zerubavel & Wright, 2012). Even further, we must distinguish between the impaired professional and the incompetent or unethical professional. This is difficult to do, but one crucial difference to keep in mind is that impairment means the individual in that time and space is impaired yet there is potential to recover, and with that regain an adequate or potentially higher competence.

Othering

As mental health professionals, we were and are exposed to the same stigmatizing and prejudicial attitudes as others, much like one cannot avoid breathing in polluted air. It is a natural phenomenon to use in-group/out-group comparison to enhance self-esteem. In a study looking at clinical psychologists' attitudes towards mental illness, Servais and Saunders (2007) described how "othering" occurs when people with a mental illness are characterized as easily recognizable and different, and oneself is characterized as normal and not susceptible to illness.

Frequently, it is assumed that we (psychologists) are above or immune to personal pain, and it can be hard not to buy into this. Martin (2011) aptly asks why anyone would want to explore bits of themselves that can be so easily allocated to others? Acknowledging our vulnerability or potential to become vulnerable is especially difficult if there is a perceived stability of the identity that we inhabit. Viewing ourselves as similar to the patients that we work with is likely to cause us distress because we are no longer able to deny the possibility that we too might suffer. Unlike the general public, we are faced with the pain and distress of other people frequently, potentially making the need to detach greater.

Richards et al. (2016) note that research looking into the experiences of mental health professionals with service user experience indicates a number of challenges, such as the experience of stigma, prejudice and discrimination. I argue that by not encouraging disclosure and an open discussion about our wounds or potential to become wounded we are engaging in a battle: objectify or be objectified.

So, what can be done?

There is currently a lot more coverage than ever before in the media about mental health stigma, alongside a significant number of campaigns – those in the United Kingdom will be aware of the Time to Change campaign and the slogan "1 in 4 of us has a mental health problem". Although I encourage and applaud their efforts, I am saddened when I think about the amount of time, energy and cost that goes into challenging the general public's stigmatizing attitudes when those suffering are still coming into contact with stigmatizing professionals. I argue that, if we cannot address the stigma that exists within the profession, we cannot realistically hope to tackle it amongst those outside of the profession: those who don't have the same volume of contact with people with mental health problems or the

specific awareness, training and knowledge that we do. Importantly, in our highly regarded role as “Doctor”, we are in the prime position to make significant changes to the perception of the value of accessing support and treatment, but sadly we are often modelling inappropriate and damaging opinions and behaviours to the general public.

In their review of the literature that discussed whether having personal experience of psychological problems helps or hinders mental health practice, Conchar and Repper (2009) conclude that, rather than trying to understand the impact of a clinician’s wounds on clinical practice, we need to support staff who have mental health problems. Further research on the benefits, challenges and experiences of mental health professionals with lived experience of mental health problems, is desperately needed. The more I have been open about my past experience the more others have begun to talk about their personal experiences or experiences of family members with mental health problems.

Research demonstrates that those anti-stigma campaigns that are most beneficial amongst clinicians are those which are delivered by someone within the same profession who has lived experience of mental health difficulties. This is sadly owing to the increased credibility given to a professional over the credibility of lived experience alone.

My thesis, which uses an autoethnographic approach, is my attempt to start tackling stigma from within. Many note that it is through being shocked and then inspired that true paradigm shifts occur: I have shared a small segment of my narrative alongside the picture of my padlocked cell, which can be very evocative. My thesis, which describes my lived experience as a professional in training with experience of mental health problems and the mental health system, demonstrates not only a story of recovery but also one of success. Often, those who are successful find their experiences easier to hide and don’t come out. More stories of recovery and success are needed.

What do we do with the wounded healer?

Evidence suggests most psychologists are vulnerable to distress and impairment, thus there needs to be an understanding that as psychologists we will have, if not already have, life crises. We are human. It is our responsibility to monitor and seek assistance for our problems and to report impaired colleagues. It is concerning that studies for example Rosenberg et al. (2005) have found we are not only failing to intervene but also that we are engaging in diffusion of responsibility by claiming we don’t know whose duty it is, when it is quite clear

that we are ethically bound to report impaired colleagues [Health and Care Professions Council (HCPC) code of conduct]. There needs to be a clearly defined process for how to manage trainees or employees who demonstrate signs of impairment. Training needs to be given at all levels in response to the question, “what do we do with the wounded healer?”. One suggestion is for trainees to engage in role play, for example of an intervention with an impaired colleague or of raising concerns about a supervisees fitness to practice.

Often supervisors can over-scrutinize a clinician’s work, which is detrimental to the clinician, and potentially their clients, but is stemming from the supervisor or line manager’s anxiety rather than an actual concern for the well-being of either party. In a study of clinicians who had previously experienced being psychiatrically hospitalized, Cain (2000) found that those professionals who judged their supervisors to be safe and non-judgmental received quality clinical supervision, compared with those clinicians who remained silent because of stigma.

More than token service user involvement

HCPC (2014) Guidelines explicitly state that the training of mental health professionals should involve service users as contributors for their relevant lived experience. Within higher education there is a great benefit of having academics who also identify as ex-service or service users. Ion, Cowan and Linsay (2010) have noted that, by hiring service users from outside the institution, othering is being perpetuated.

I suggest that there should be a dedicated “Wounded Healer” module that would explore the reasons why some individuals might have been attracted to the profession, how trainees can successfully engage in self-care practices and, importantly, how to make best use of some of the gifts that having past wounds brings to clinical practice. By tackling it at a preventative stage rather than it becoming a required intervention, we can enhance practice and hopefully stop many distressed therapists from becoming impaired. Some have suggested, and I agree, that a self-care component should be added to the assessment of a psychologist’s competence (Fouad, Grus, Hatcher, Kaslow, Hutchings, Madson & Crossman, 2009).

The importance of story

The task of psychotherapy has been conceptualized as a re-narrating of a fractured or disorganized life story (McCleod & Lynch, 2000). However, many mental health survivors

frequently report that their stories aren't recognized as relevant to their treatment. I join others in the call for more stories that depict what life with mental health problems is actually like. Narrating ones lived experience is an opportunity to story and re-story one's life, taking control and becoming empowered.

Conclusion

There is an urgent and inescapable necessity to develop anti-stigma interventions amongst professionals. I hope to have demonstrated how, in our profession, by being silent we are being held back in terms of advancing our treatment and understanding of mental health problems impeding how much we can truly help our clients. I join the call to progress a culture of candour, which not only can prevent issues of impairment but also can firmly establish patterns of self-care early on in a trainee's career, which will be of use as we all engage with the struggles that humanness brings. We all need to do our bit, lived experience or not, to tackle this issue. Conveniently demonizing colleagues who are distressed or impaired must stop.

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Writing for Impact: Autoethnography as a Method in Counselling Psychology

In this article, I will explore the use of autoethnography as a research method in Counselling Psychology. Although I write about its particular salience to the epistemological and philosophical underpinnings of the profession of Counselling Psychology, it is not to say that its use cannot be extended to other psychology divisions. Below is a section of dialogue to introduce the reader to autoethnography: all names are pseudonyms. Throughout the article I will provide the reader with examples of what I learnt through the process of my autoethnographic doctoral thesis: the aim being to depict and describe just *one* of the ways of doing autoethnography. Following this is a discussion on the benefits and limitations of the method – considering its value in social science research.

Setting the scene

I have had to change my research project for my doctorate in Counselling Psychology rather last minute because of the infeasibility of my initial research. I discuss finding a new research topic with my father as we drive to a family Christmas gathering.

Father: Why can't you write about your Batu story?

While travelling in Asia 4 years ago, I experienced a steroid-induced manic episode and was locked up in a mental asylum. I documented my time spent as an inpatient with photographs and personal writing.

Me: Because it's not research!

Father: But, you could be interviewed by Dr Stephane. You have all your photographs and conference notes – it's a unique story and position.

Me: I know. I want to, and I want to tell it. I feel it's important I don't just throw away all that I learnt and I am continuing to learn from it – but that is more like a book, not a thesis.

Father: Couldn't you interview yourself?

Me: Don't be absurd.

Still during the Christmas holidays, I am trying to find an area that is meaningful and interests me enough that I can throw myself into it and make the pending deadline. I decide that mental health stigma amongst professionals is one area that I feel passionate about, particularly following my Batu story referred to above. I start a literature search and come across an article entitled “The Dilemma of the Wounded Healer”. I put it down, feeling empowered to write, and start jotting things down. A week later, I come up against a problem: I don’t think I can do research into mental health stigma amongst professionals. I am alternating between frustration when I read the literature and then empowerment, feeling a rush of energy. I think I have too much to say about the matter and I’m going to be “contaminating” the research. How can I possibly sit opposite a participant and ask about their experience of mental health stigma in the profession without a whole host of my own emotions bursting to come out?

I hate to admit it, but two years on and my father is right. I am using my story as legitimate research for my doctoral thesis. So, how did I do this? First, let’s look at what autoethnography actually is.

Autoethnography

Autoethnography designates such a wide array of textual practice that Ellis and Bochner (2000: cited in Muncey, 2010) suggest that it is both impossible and undesirable to arrive at a single definition. However, Chang (2016) defines autoethnography as “a qualitative research method that uses a researcher’s autobiographical experiences as primary data to analyse and interpret the sociocultural meanings of such experiences” (p. 444). It is a method that provides a unique insider’s perspective that no other research method could “easily, if ever, reveal” (Jones, Adams, & Ellis, 2015, p. 32). The use of personal experience to examine and critique cultural experience is the binding characteristic of all autoethnographies.

Autoethnographies tend to be on a continuum, evocative on one end and analytic on the other. Analytic autoethnography (Anderson, 2006) places the emphasis on analysis, still including the researcher as the researched, whereas, on the other end of the spectrum, evocative autoethnography “uses stories to do the work of analysis and theorizing” (Ellis & Bochner, 2006, p. 436): the main goal being an evocative piece of literature that invokes the reader with a desire to engage with the text, by feeling and empathizing.

Benefits

Autoethnography is a particularly relevant method for the new style of *The Psychologist*, both in delivering research in a more journalistic style and writing for impact – or writing to evoke a response in the reader. Foster, McAllister & O’Brian (2006) note how it is a research method which makes knowledge more accessible and which places a greater value on ordinary rather than scientific language. They suggest that autoethnography is a “form of resistance to the researcher becoming the ‘other’” (p. 49). Autoethnography is a direct challenge to othering practices in academia. It includes the voice of the researcher as another representative form and challenges “silent authorship” (Sparkes, 2000).

Autoethnography has the potential to enable people to gain a new understanding about the human experience – let’s face it, we are a curious lot. Autoethnographies attempt to stimulate emotional and intellectual curiosity in the reader, which can trigger them to reflect on their own life and, importantly, on their practice. Sharing personal insights and traumatic experiences, making shameful and often silenced experiences known, readers are offered an opportunity to resonate with the text and find solace. Autoethnography can also benefit the researcher as they write through painful, angering and uncertain experiences.

As a method, autoethnography provides the researcher and the readers an opportunity to enhance their lives. In my case, it encouraged me to be more compassionate towards and trusting of myself, to sit more comfortably within the tension of a hybrid identity (of both professional and psychiatric survivor) and to take up advocacy work in an area that I believed in, which subsequently added to the meaningfulness of life. As a result of my research I have been asked to give lectures on the wounded healer, been invited to speak at a conference on the wellbeing of psychology practitioners and undertaken training so that I can then train other professionals working with patients with personality disorder from a model of equality. Most importantly, it allowed me to tackle self-stigmatization and to embrace my traumatic episode as a tangible experience, rather than explain it away with a medical narrative.

Limitations

It takes a lot of courage and resilience to undertake an autoethnographic project, both for the process of the research – which often necessitates the researcher to relive painful events from their past – but also in the completion and subsequent publication of the research. The researcher is revealing themselves to the public. I will never forget, before fully committing

myself to the project, advice I read that suggests the researcher should imagine walking around with a sandwich board that displays all of their innermost secrets.

How was this for me? I was rather arrogant at the start of the project. I remember a lecturer asking if I would cope, to which I quickly responded, “Yes: I have had EMDR [Eye Movement Desensitization and Reprocessing therapy] to treat the PTSD [post-traumatic stress disorder] symptoms from the trauma and I’m in therapy. It will be fine”. However, as the work progressed, I became acutely aware of my need to stop defending against vulnerability. I also couldn’t control the life events that occurred while I was undertaking the project, and there were times when my levels of resiliency dipped as a result of external factors, for example illness in the family. The usual feeling of being overwhelmed with clinical work and academic assignments while trying to complete a thesis were exacerbated at times, given the personal nature of the project. The necessity to be able to embrace the unknown was testing during those periods when my stress levels increased, and there were periods where my anxiety and self-doubt would be triggered.

Engaging in a new research method and having to learn as I went along had its benefits and its limitations. A lot of time was spent learning, and it was a push for me to actually start writing. One of the main limitations was a difficulty in knowing when to stop. This meant that at times I felt overwhelmed by the process and I struggled managing my excitement to read more and my passion to communicate with the practicality of time and work pressures. I think including auto/ethnography as a taught research method in training courses would benefit the writing process – especially with regards to completing on time. However, the necessary creativity and anxiety, as well as making it authentic, are obstacles that will always be there and which I do feel are essential.

Perhaps the main limitation is the difficulty of the method to gain acceptance as a credible research method. Indeed, Holt (2003) argues that the researcher must have a strong belief in this type of research because of the criticism and potential rejection of it as scholarly work. However, I am hopeful that this is now changing: there has been a significant rise in its use in Social Science research over the past two decades Chang (2016).

Ethics

Ethics are complicated in autoethnographic research, more so than it seems at first. As the researcher is the only “participant”, the access to data may seem less of an issue, but there are many inherent ethical considerations unique to the approach. Self-care is a prime issue when

embarking on an autoethnographic project. By offering such an intimate, detailed account of my own life and how I make sense of it, I was opening myself up to criticism from the readers. In addition, other autoethnographers have noted that writing about trauma can be unsettling and potentially distressing. Others, however, highlight the therapeutic value of writing through these painful memories (Willig, 2009; Wright & Cunningham, 2013). It was thus important to constantly measure if the benefits of the research, to others and myself, outweighed the struggles.

Berry (2006) raises an important ethical consideration: it can create uncomfortable feelings in the reader and it can be an unwanted gift. The reader is not the only consideration: one needs to consider all of the people that could be implicated in the story. Being the only participant does not mean that others are not implicated in my project; stories are never “made in a vacuum and others are always visible or invisible participants” (Chang, 2008, p. 69). No matter how much we try to change locations and use pseudonyms, it is impossible to protect the identity of certain individuals that play a role in our life stories. For example, in my autoethnography, my father features quite a lot in my narrative. This was a struggle for me in deciding how much of it was “my” story and how much of it I needed to leave out. There are no clear guidelines, but some suggest offering those implicated an opportunity to read through the text and to assess if they feel comfortable with the material to be published. This can become further complicated when autoethnographers are writing about people who may have harmed them in life. It can be hard, for example, to think sensitively about protecting the identity of an ex-partner who perpetrated domestic violence, or a father who sexually abused an author. When thinking about the impact on others it’s important also to not overlook the power that some stories have to create uncomfortable feelings in the reader. These, are all factors that need to be continually explored, and returned to, throughout the process.

Similarities to Counselling Psychology

Counselling psychology positions itself between the orthodox science of psychology and the therapeutic practices of psychotherapy and counselling. As a discipline, it has been described as having a critical edge to it and is known for proposing alternative approaches. Pugh and Coyle (2000) maintain that non-traditional research is characteristic of Counselling Psychology. There is a tension present in Counselling Psychology between its focus on the quality of the therapeutic relationship over and above the use of specific techniques, in an era of evidence-based practice. The current climate of accountability, standardization and

manualized treatments means this tension affects how, amongst other things, we define science. Navigating this tension in my autoethnography was a parallel process to managing this in my clinical work. Much like the acknowledgment that “being” is more central than “doing” in Counselling Psychology (Strawbridge & Woolfe, 2010), autoethnography became a way of life rather than solely “doing” research.

For me, the development of my professional identity as a scientist–practitioner was simultaneous with my embracing autoethnography as a valid and legitimate methodology. As we acknowledge that we can no longer believe we are objective observers as therapists, who do not impact on patient’s mental processes, I argue that the researcher can no longer be seen as an objective observer who reports direct lived experience. I would also go one step further by suggesting we should be celebrating the subjectivity of the researcher and the specific knowledge this may bring.

As a method, autoethnography requires the researcher to embrace their own vulnerability: a way of understanding one’s emotions and improving social life (Adams, Linn & Ellis, 2015). Autoethnographic work can also be seen as a form of modelling: to be both open and vulnerable, and to demonstrate a way of thinking and of being curious about how this impacts on one’s engagement with life, research and clinical material. How can we ask our clients to embrace and explore their vulnerability if we are unable to do it ourselves?

Perhaps most important of all, is the potential for autoethnographic research to promote Counselling Psychology’s social justice agendas. It has, for example, encouraged me to no longer ignore the stigma and injustices that I am witness to personally and in practice. Richardson (2002) suggests that individuals’ collective stories can have the power to change the mental health system. I have been, through my writing, moved to action or to write to right as Bolen (2012) beautifully puts it.

Tolerating uncertainty

In a fascinating and thorough overview, Thorpe (2013) describes the overlaps between some of the basic attributes and skills employed by counselling psychologists and qualitative researchers. He argues that the experience of conducting qualitative research is one way to augment the training of post-graduate Counselling Psychology students. In my thesis, I argue that autoethnographic research as a particular form of qualitative research can augment the therapeutic skills and reflexivity of the trainee. As qualitative researchers and therapists alike we must develop an ability to tolerate uncertainty, to relinquish control and to widen our

focus on to the client and not explicitly technique and theory. In autoethnographic research we are required to be open to multiple and unexpected emerging themes and to trust the creative process.

Autoethnography might be particularly useful as a form of learning. One of the rationales for mandatory personal therapy during training is its role as a profound socialization experience. I argue that the practice of qualitative research, autoethnography in particular, can also serve as a socialization experience, and might bypass some of the challenges and ethical issues that mandatory therapy evokes. A discussion of the ethical difficulties with mandatory therapy are beyond the scope of this article, but I direct those interested to a recent article on the subject by Ivey (2014).

Critiques

Autoethnography has been contested within the social sciences, and its status as a legitimate form of research within the traditionally dominant discourse of objective post-positivism has been one of tension (Sparkes, 2000). Delamont (2009) argues that autoethnography violates two basic tasks of the social sciences. The first of these proposed failings, according to her, is that introspection is not a substitute for data collection. In autoethnography there is creative licence as to how traditional or evocative one wants to make their work. My autoethnographic thesis incorporates multiple data sources, which are not solely introspective. For example, I incorporated the use of official documents and photographs. However, I believe that even if I had only used introspection this would still constitute valid research. When performing more traditional qualitative research we are collecting the narrated introspection of participants. Alongside this is the critique that autoethnography is self-indulgent. In response, Richardson (1994 cited in: Anderson, 2006) notes that writing in scientific language, thus making the text only available to a select few, is in itself a form of self-absorption. I have tried to present this article in non-scientific language.

The second task it fails to achieve, in Delamont's view, is to move the discipline forward. This, I believe, is her biggest mistake. Autoethnography has an immense potential to move the discipline of Counselling Psychology forward. We are naturally storytellers, and in our clinical work we look at how people live their lives through the stories they tell.

Autoethnography can inform practice and offer a deeper understanding of a culture that readers might not otherwise be able to access. The reading of autoethnography can move individuals into action, be it by further reading in the topic area or developing a greater

curiosity and, importantly, empathy for a particular group. Moreover, I argue that, most importantly for the progression of the profession, it can enable and improve the reflexivity that is required in practice.

Conclusion

In conclusion, I hope to have offered the reader food for thought regarding what constitutes “proper” or “legitimate” research. I have noted how doing my autoethnographic thesis was a significant learning process that changed me as a professional. My final story, at the end of my thesis demonstrates the transformation and ownership of my experience that I gained through the process of re-storying. Reading other autoethnographies can engage and ignite one’s curiosity or empathy for others. Re-narrating one’s story using autoethnography is one attempt to address the power differentials that are present in research and clinical practice. I have highlighted a few of the benefits and limitations of this method, in particular the need to engage in self-care and the complexity of ethics. I conclude that autoethnography is a legitimate and particularly valid methodology for psychologists, and it is congruent with our desire to make a social difference.

Further reading

For those interested in autoethnography or thinking about starting an autoethnographic project, I recommend the following as incredibly helpful starting points:

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Appendix

Appendix 1

N.	Item	Date	Format	Description	Notes
1	doctor bill	11/01/2013	receipt	believe from visit to neurosurgeon	
2	notes to myself	n/a	my writings	written in Dr. X office when trying to explain something to him	reading it get a sense of being rushed trying to get it across. Don't know who number 3 is unless it is (hotel concierge) spelt wrong
3	notes to myself	n/a	my writings	written whilst in Apolaniati hospital	I made a to do list. Name of Drs. I also listed tests I wanted taken whilst there. Also a request for a badge
4	envelope from Hotel	n/a	random	blank envelope	inability to throw things away?
5	tourist tickets	n/a	tickets	collection of all tickets from trip	some of them I don't remember, others serve as a trigger to remember elements of the trip.
6	boxing ticket	n/a	tickets	boxing ticket from Bangkok	completely forgot about it but when remember have the gloves, remember going alone to get cash in the street. Buying the gloves alone. We were in a rush for birthday dinner. I had a beer- very unlike me
7	notes to myself	n/a	my writings	emails of two people I cared about the most Hotel Batu	should I contact them? Remembering calling for days from london hospital dying to sopeak to someone there
8	envelope from Hotel	n/a	random	envelope with Conrad written on it- storing things I organized	organize-reorganized contantly need to keep control
9	notes to myself	n/a	my writings	crazy writings from Hotel envelope	picture taken saved
10	notes to myself	n/a	my writings	notes made when reached full delusion state thinking I was a spiritual healer	feeling now about it shame but also confusion as to how it spiralled out of control so quickly (need to scan and save)
11	envelope from	n/a	receipts	? to sort ?	?

	hotel				
12	baggage reclaim tag	02/01/2013	tickets	bagage reclaim tag for flight out to Bangkok	looking at it and not remembering the flight out at all. Apart from few brief memories that come back to me looking through C friends email suggestions for trip and getting excited/wanting to do it all
13	hotel and travel receipts				
14	medical report	16/01/2013	medical report	report from Batu	diagnosis: affective bipolar disorder current manic episode with psychotic symptom<-- still get sick and worried reading this. Angry as some of the things said in the report don't seem true to what I was trying to explain. Don't understand the part about "expressing her feeling over control".
15	ticket	n/a	flight itinerary	itinerary with my tickets	writing on it trying to change the
16	MAC receipts		receipts		feelings about buying a computer because I wanted to stay there friend being anxious at my overspending only went to get an iPhone. Listening to music by Yoga almost forgot I had seen her before I left. Reason for printing it were for insurance purposes
17	medical report	31/12/2012	medical report	From Dr. (GP) before leaving on trip. Printed on hotel paper	Dr. GP confirming that I was taking medication with me.
18	medical report	31/12/2012	medical report		
19	medical receipt	14/01/2013	medical receipt	Apolaniati Hospital	My MRI scan and consult with neurosurgeon. Wasn't sure but the date tells me it is as it happened 2 days before my admission to Batu. Dr coming for dinner that night.
20	medical receipt	16/01/2013	medical receipt	specialist consultation psychiatrist	Dr. X. Host of feelings mainly the deceit. Also just realized must have paid this at some point.

21	medical report	14/01/2013	medical report	report from MRI	playing around nicknaming the man polar bear. Asking them what machine it was they were using (me being cocky). Playing around with the personal history. Concierge staying with us Amy* saying he probably wants to go home. Why was he with us in the first place thinking about it now?
22	medical report	24/01/2013	medical report	report from MRI Apolaniati	funny to read. It was probably all in my head. Called me a cheerful young lady who gave an excellent history. "acute delirium"

Appendix 2

Goffman, E. (1961). *Asylums; essays on the social situation of mental patients and other inmates*. Garden City, NY: Anchor Books.

Preface

My immediate object in doing field work at St Elizabeth's was to try to learn about the social world of the hospital inmate as this world is subjectively experienced by him.

It was then and still is my belief that any group of persons- prisoners, primitives, pilots or patients develop a life of their own that becomes meaningful, reasonable, and normal once you get close to it, and that a good way to learn about any of these worlds it to submit oneself in the company of the members to the daily round of petty contingencies to which they are subject.

The limits, of both my method and my application of it, are obvious: I did not allow myself to be committed even nominally, and had I done so my range of movements and roles, and hence my data, would have been restricted even more than they were. Is this truly the case?

The world view of a group functions to sustain its members and expectedly provides them with a self-justifying definition of their own situation and a prejudiced view of non-members, in this case doctors, nurses attendants.

Since almost all professional literature on mental patients is written from the point of view of the psychiatrist and he, socially speaking, is on the other side.

Reviewed drafts of papers helpful corrections regarding errors along with useful suggestion that my point of view and method should be made explicit.

Introduction

A total institution may be defined as a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life.

The main focus is on the world of the inmate. A chief concern is to develop a sociological version of the structure of the self.

P. 15

Every institution captures something of the time and interest of its members and provides something of a world view for them; in brief, every institution has encompassing tendencies. Their encompassing or total character is symbolized by the barrier to social intercourse with the outside and to departure that is often built right into the physical plant, such as locked doors, high walls..

P. 16

There are places established to care for persons felt to be both incapable of looking after themselves and a threat to the community, albeit an unintended one.

P. 17

The central feature of total institutions can be described as a breakdown of the barriers ordinarily separating these three spheres of life. Each phase of the member's daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. nurse trying to get me to join in the activities .

P. 18

Surveillance- seeing to it that everyone does what has been clearly told is required of him, under conditions where one person's infraction is likely to stand out in relief against the visible, constantly examined compliance of the others. Medication checking

Inmates often see staff as condescending, highhanded, and mean. Staff tends to feel superior and righteous: inmates tend, in some ways at least, to feel inferior, weak, blameworthy, and guilty.

P. 19

The persevering, nagging delusional group- who were termed 'worry warts' 'nuisances' and 'bird dogs' in the attendants slang.

Talk across the boundary is restricted so too is the passage of information, especially information about the staff's plans for inmates. Characteristically the inmate is excluded from

knowledge of the decisions taken regarding his fate. Each situation this occurred, different reasons for it.

P. 20

Such exclusion gives staff a special basis of distance from and control over inmates.

When either grouping refers to the views or interests of 'the institution' by implication they are referring (as I shall also) to the views and concerns of the staff.

P. 21

Suffer extremes of boredom.

Individual who was work-oriented on the outside tends to become demoralized by the work system of the total institution.

P. 22

In our society they are forcing houses for changing persons; each is a natural experiment on what can be done to the self.

The Inmate World

P. 23

Round of activities taken for granted until the point of admission to the institution.

A round of experience that confirmed a tolerable conception of self and allowed for a set of defensive maneuvers, exercising at his own discretion, for coping with conflicts, discrediting's, and failures.

If the inmate's stay is long what has been called disculturation may occur- an untraining which renders him temporarily incapable of managing certain features of daily life on the outside if and when he gets back to it.

The full meaning for the inmate of being 'in' or 'on the inside' does not exist apart from the special meaning to him of 'getting out' or 'getting on the outside'.

P. 24

Upon entrance he is immediately stripped of the support provided by these arrangements. He

begins a series of abasements, degradations, humiliations and profanation of self. His self is systematically, if often unintentionally, mortified.

In many total institutions the privilege of having visitors or of visiting way from the establishment is completely withheld at first, ensuring a deep initial break with past roles and an appreciation of role dispossession.

P. 25

It may not be possible to make up, at a later phase of the life cycle, the time not now spend in educational or job advancements, in courting or in rearing ones own children.

We very generally find staff employing what are called admission procedures, such as taking a life history, photographing, weighing, fingerprinting, assigning numbers, searching, listing personal possessions for storage. Arriving from Apolaniati multitude of bags packed and unpacked by others my sense of control completely taken away. No time to settle or nest need to rummage through it.

P. 30

Loss of a sense of personal safety is common and provides a basis for anxieties about disfigurement. Beatings shock therapy etc may lead many inmates to feel they are in an environment that does not guarantee their physical integrity. Being surrounded by murderers, not being allowed to lock the door, mixed ward, Apolaniati man coming into my room and walking about, fear of shock therapy, fear of restraint and needles.

P. 32

But in total institutions these territories of the self are violated; the boundary that the individual places between his being and the environment is invaded and the embodiments of self profaned.

Mental patients cannot prevent their visitors from seeing them in humiliating circumstances.

Collective sleeping arrangements and doorless toilets. No toilet- whole around the edge of the room male patient opposite.

P. 33

Inmate is never fully alone; he is always within sight and often earshot of someone, if only his fellow inmates. Prison cages with bars for walls fully realize such exposure.

Unclean food, messy quarters, soiled towels, shoes and clothing impregnated with previous users' sweat. My case mattresses lack of sheets urine stains. Lucky Hilton sheets brought the next day, food with flies.

P. 34

Toilets without seats. Did I even use the toilet in Batu?

P. 35

Contamination lying near the dying- needles dog flies

When the inmate loses control over who observes him in his predicament or knows about his past he is being contaminated by a forced relationship to these people for it is through such perception and knowledge that relations are expressed. Upon admission, one's on-person possessions are pawed and fingered by an official as he itemizes and prepares them for storage.

P. 39

shock therapy patients assisting treatment of other patients.

P. 42

A permissive atmosphere is felt to encourage the inmate to project or act out his typical difficulties in living which can then be brought to his attention during group therapy sessions.

P. 45

This obligation not only puts the individual in a submissive or suppliant role 'unnatural' for an adult but also opens up his line of action to interceptions by staff.

Even the canteen staff seemed to share the opinion that civility was wasted upon lunatics, and would keep a patient waiting indefinitely, while they gossiped with their friends.

P. 47

A margin of self-selected expressive behavior. When this is used as evidence concerning the state of one's psychiatric conscience.

Certain bodily comforts sig to the individual that tend to be lost upon entrance into a total institution- quietness at night, a soft bed- chanting all night, people being sectioning in the night screaming head banging throwing things.

P. 43

Denied the liberty of making small adjustive movements- restrain

Especially in mental hospitals and political training prisons, the statements he makes may be discounted as mere symptoms, which staff giving attention to non-verbal aspects of his reply. Questions have you washed yet are you wearing both socks- accompanied by simultaneously searching by the staff which physically discloses the facts making these verbal questions superfluous. Medicine checking

P. 50

Further, curtailments of the self occur in all three, when where the inmate is willing and the management has ideal concerns for his well being. Persons can voluntarily elect to a total institution and cease thereafter, to their regret, to be able to make such important decisions.

Thesocial arrangements must be 'read' by the individual and others for the image of himself that they imply. But as I have argued the relation of this cognitive process to other psychological processes is quite variable.

Mortification or curtailment of the self is very likely to involve acute psychological stress for the individual...

P. 51

...sick with his world or guilt-ridden in it mortification may bring psychological relief. The psych stress often created by assaults on the self can also be produced by matters not perceived as related to the territories of the self such as loss of sleep insufficient food or protracted decision making. So too a high level of anxiety or the unavailability of fantasy material such as movies, books may greatly increase the phsychological effect of a violation of the self boundaries.

Appendix 3

Theme here present in my work. When risk impedes on my clinical work. Is it the one thing that blocks us from actually helping? X

Microsoft Office User November 01, 2016
Link here the literature on risk. The reference saying samartians better as they don't hold responsibility can be truly human.

The nurse doesn't believe my story about being locked up in a cell and tied to a bed for hours on end. I try to tell her so she can understand why I am so scared. She thinks I am psychotic. I again call my father (repeat pattern, spoilt only child, patient father). He comes to visit in

Microsoft Office User
At this point enter the research literature around narrative? Politics of storytelling?

They leave and I manage to untie the right leg restraint with the free hand. The more I am becoming free the more reassured I am. I feel proud. I keep thinking of the memory of me in a cot and this alongside how I will tell this part of the story to my mother when I am out gives me hope. Once I'm fully free I'm wondering around the cell. I see X peeing in his cell, I now discover that the toilets are in fact the whole in the ground surrounding the walls of the cell. How was I suppose to pee in front of him?! I'm glad I peed in the bed. Better option of the choice.

Microsoft Office User
HOPE literature on hope, its cornerstone in recovery. How we can hold hope as professionals or destroy it. Wounded healer one advantage noted in most of the literature is the ability to be hopeful – cite reference about more hopeful for patients

The security guard comes past and opens the padlock. I walk out of the cell for the first time. Yay! Where's Amy? I'm being freed!! We need a picture of this!

They (the guards) come and there are two of them now. I am very excited to have a picture of me being freed. They are enthusiastic too. They say yes yes lie on the bed and we will take a picture. I start to realize their enthusiasm is different from mine. It is fake. It is manipulative. They begin to restrain me again. No no im fine, really we don't need it to be that realistic for the picture. Then I realize this isn't for a picture, I wasn't free. I was being tied up again. This time there is less protest. I have learnt that protesting makes things worse.

Microsoft Office User
References on how one should behave in a mental hospital

place in medicine is confused now. *Uncertainty is the only clarity I have*. I get the results and am told I will be fine but should have steroids injected into my lower spine so I can travel.

31st December 2012 I take a diazepam⁴ on my way to the clinic. I am needle phobic. I go in and lie down on the table. My father watches the procedure through the window. I know I need to keep very still but it hurts and I wriggle away. It takes longer. The procedure is over, I get dressed. I ask the doctor if I can drink that night (its new years and I'm going to a dinner party). He tells me I should be fine. I am dazed and confused. I put it down to the fear of needles and perhaps the diazepam I took. I go to the dinner party.

(Later I am told my friends thought I was stoned (even though they all know I don't do drugs).

2nd of January
I fly to Bangkok. Still to this day I don't remember the flight. I have a few memories, perhaps I did remember but these memories got over powered by the trauma. Or maybe this was part of the early symptoms? I don't know. What I do know is this;

I experience a steroid induced hypo-manic episode.
I don't know I am experiencing a hypo-manic episode.

I think I'm happy, not sleeping because of jetlag.
In psychiatric or medical model terms I have "lost insight" X

Microsoft Office User
Come back to this. Potentially have it as the name of theme? Or title. Link this to how it is difficult to stay with the uncertainty, this thesis, my ongoing learning clinically is all teaching me about this and my discomfort but also creativity and joy in the unknown. Link to art and science and also how can we expect patient to go somewhere we haven't yet been? (Kotter??)

Microsoft Office User
Ethics- consider changing location? Vietnam?

First research presentation at Uni

Listening to others research presentations like there is a switch in my mind. It feels like there is something missing in each- why are people doing the topics they chose. Why cant we embrace it. Is it necessary and healthy to be the other way? Transparent? Why? Could reflective transparency ever really end?

Research presentation felt like coming out freedom after, great release. Sitting in lectures with a secret is now gone. Is this what it feels like for gay people who haven't come out?

Microsoft Office User

Put the date? Literature links in here about disclosure

Microsoft Office User

Write here about my experience of "coming out" put here the links I have in my notes from the bound journals about similar to being gay. Potentially see if can find email to Alec describing my experience of presentation. Ask his permission to include. Or just include my bit?

Appendix 4



Psychology Department Standard Ethics Application Form: Undergraduate, Taught Masters and Professional Doctorate Students

This form should be completed in full. Please ensure you include the accompanying documentation listed in question 19.

Does your research involve any of the following? <i>For each item, please place a 'x' in the appropriate column</i>	Yes	No
Persons under the age of 18		X
Vulnerable adults (e.g. with psychological difficulties)		X
Use of deception		X
Questions about potentially sensitive topics		X
Potential for 'labelling' by the researcher or participant (e.g. 'I am stupid')		X
Potential for psychological stress, anxiety, humiliation or pain		X
Questions about illegal activities		X
Invasive interventions that would not normally be encountered in everyday life (e.g. vigorous exercise, administration of drugs)		X
Potential for adverse impact on employment or social standing		X
The collection of human tissue, blood or other biological samples		X
Access to potentially sensitive data via a third party (e.g. employee data)		X
Access to personal records or confidential information		X
Anything else that means it has more than a minimal risk of physical or psychological harm, discomfort or stress to participants.		X

If you answered 'no' to all the above questions your application may be eligible for light touch review. You should send your application to your supervisor who will approve it and send it to a second reviewer. Once the second reviewer has approved your application they will submit it to psychology.ethics@city.ac.uk and you will be issued with an ethics approval code. You cannot start your research until you have received this code.

If you answered 'yes' to any of the questions, your application is NOT eligible for light touch review and will need to be reviewed at the next Psychology Department Research Ethics Committee meeting. You should send your application to your supervisor who will approve it and send it to psychology.ethics@city.ac.uk. The committee meetings take place on the first Wednesday of every month (with the exception of August). Your application should be submitted at least 2 weeks in advance of the meeting you would like it considered at. We aim to send you a response within 7 days. Note that you may be asked to revise and resubmit your application so should ensure you allow for sufficient time when scheduling your research. Once your application has been approved you will be issued with an ethics approval code. You cannot start your research until you have received this code.

Which of the following describes the main applicant? <i>Please place a 'x' in the appropriate space</i>	
Undergraduate student	
Taught postgraduate student	
Professional doctorate student	X
Research student	
Staff (applying for own research)	
Staff (applying for research conducted as part of a lab class)	

1. Name of applicant(s).

Alika Jane Goodwin

2. Email(s).

alika.goodwin.1@city.ac.uk

3. Project title.

Us vs Them inpatient or fellow inmates – an autoethnographic exploration

4. Provide a lay summary of the background and aims of the research. (No more than 400 words.)

This research is a highly subjective account of my own personal experience. I use this narrative in order to critique contribute and extend existing theory surrounding the Wounded Healer concept and inpatient treatment. My aim is to shed light and create dialogue surrounding the experience of the wounded healer identity with a focus on inpatient subculture and treatment and subsequent professional training. This research looks at the concept of the wounded healer and what this means with regards to the development of stigma, disclosure and subsequent impact on clinical work. Alongside this it also looks at the subjective experience, questioning the identity of an inpatient (myself), and responses to treatment received using a recovery/survivor story of an inpatient stay. The use of self as researcher enables an in-depth exploration that can shed light on the interaction between self and culture. I hope to also demonstrate the potential value of this research method for the profession of Counselling Psychology.

5. Provide a summary of the design and methodology.

This research will have only one participant, myself (the researcher). I will be using my own written accounts and clinical documents alongside photographs and literature. The data analysis is through my own interpretation and interaction with theory. It is a highly subjective and reflexive research piece. The ethical issues to be considered are self-care and protecting the anonymity of any people or institutions that I write about.

6. Provide details of all the methods of data collection you will employ (e.g., questionnaires, reaction times, skin conductance, audio-recorded interviews).

The majority of textual data is likely to be generated by myself in the form of a narrative surrounding my experience of the event and subsequent ramifications. This will also include diary extracts, letters and technological data (emails, instant messaging histories, texts). This writing will also include personal writings from others (see below, section 16). Alongside my personal writing I will include official documents.

A large part of my data collection will also be my response to passages of written text by others, for example journal articles or book chapters.

Data will be self-observational, for example my feelings at the time of the project when interacting with others, and self-reflective, where I am more actively analysing and evaluating my experience in the past.

7. Is there any possibility of a participant disclosing any issues of concern during the course of the research? (e.g. emotional, psychological, health or educational.) Is there any possibility of the researcher identifying such issues? If so, please describe the procedures that are in place for the appropriate referral of the participant.

N/A I will be disclosing psychological issues; however, these are in the past and known already to others (occupational health, personal therapist, supervisor).

8. Location of data collection. (If any part of your research takes place outside England/Wales please also describe how you have identified and complied with all local requirements concerning ethical approval and research governance.)

Data will be collected in England, mainly from my own records held at home or from clinical documentation requested from professionals who took part in my care.

9. Details of participants (e.g. age, gender, exclusion/inclusion criteria). Please justify any exclusion criteria.

N/A

10. How will participants be selected and recruited? Who will select and recruit participants?

N/A

11. Provide details of any incentives participants will receive for taking part.

NA

12. Will informed consent be obtained from all participants? If not, please provide a justification. (Note that a copy of your consent form should be included with your application, see question 19.)

I shall apply the same ethical considerations to myself as the participant: I know, and will remind myself, that I have the “right to withdraw” at any point in the project.

13. How will you brief and debrief participants? (Note that copies of your information sheet and debrief should be included with your application, see question 19.)

I am the sole participant, but for reflective purposes and self-care I will be regularly engaged in “debriefing”. This will include writing down my experience of the process and occasionally checking in with my supervisor on my psychological process.

14. What potential risks to the participants do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

N/A (see below)

15. What potential risks to the researchers do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

Given I will be exploring a traumatic experience and the emotions triggered through the exploration form part of the data, I will inevitably be impacted upon by this project. It has been noted as highly therapeutic; however, self-care is of utmost importance. I aim to monitor this closely and have thus set up a system of care should anything arise that I feel is too difficult. For example, I am currently in weekly therapy and the feelings that are brought up whilst doing this research will be taken there and discussed. My clinical supervisors are aware of my traumatic experience and my decision to write about it, so should anything be unsettled within my clinical work this can also be talked through. It will be important for me to liaise with my research supervisor and personal tutor and to flag up any concerns that I have whilst being open to their potential concerns and recommendations.

16. What methods will you use to ensure participants' confidentiality and anonymity? (Please note that consent forms should always be kept in a separate folder to data and should NOT include participant numbers.)		
<i>Please place an 'X' in all appropriate spaces</i>		
Complete anonymity of participants (i.e. researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification.)		
Anonymised sample or data (i.e. an <i>irreversible</i> process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates.)	x	
De-identified samples or data (i.e. a <i>reversible</i> process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location.)		
Participants being referred to by pseudonym in any publication arising from the research	x	
Any other method of protecting the privacy of participants (e.g. use of direct quotes with specific permission only; use of real name with specific, written permission only.) Please provide further details below.	x	
They are likely not to be included in the research but should I include personal exchanges I will follow confidentiality and anonymity. This data will only be included if there is specific permission, no names will be used and the person will not be identifiable.		
17. Which of the following methods of data storage will you employ?		
<i>Please place an 'X' in all appropriate spaces</i>		
Data will be kept in a locked filing cabinet		
Data and identifiers will be kept in separate, locked filing cabinets		
Access to computer files will be available by password only	x	
Hard data storage at City University London		
Hard data storage at another site. Please provide further details below.		
18. Who will have access to the data?		
<i>Please place an 'X' in the appropriate space</i>		
Only researchers named in this application form	x	
People other than those named in this application form. Please provide further details below of who will have access and for what purpose.		
19. Attachments checklist. *Please ensure you have referred to the Psychology Department templates when producing these items. These can be found in the Research Ethics page on Moodle.		
<i>Please place an 'X' in all appropriate spaces</i>		
	Attached	Not applicable
*Text for study advertisement		x
*Participant information sheet		x
*Participant consent form		x
Questionnaires to be employed		x
Debrief		x
Others (please specify, e.g. topic guide for interview, confirmation letter from external organisation)		x

20. Information for insurance purposes.

(a) Please provide a brief abstract describing the project

Insert Abstract here

Please place an 'X' in all appropriate spaces

(b) Does the research involve any of the following:	Yes	No
Children under the age of 5 years?		X
Pregnant women?		X
Clinical trials / intervention testing?		X
Over 5,000 participants?		X
(c) Is any part of the research taking place outside of the UK?		X

If you have answered 'no' to all the above questions, please go to section 21.

If you have answered 'yes' to any of the above questions you will need to check that the university's insurance will cover your research. You should do this by submitting this application to anna.ramberg.1@city.ac.uk, before applying for ethics approval. Please initial below to confirm that you have done this.

I have received confirmation that this research will be covered by the university's insurance.

Name Date.....

21. Information for reporting purposes.

Please place an 'X' in all appropriate spaces

(a) Does the research involve any of the following:	Yes	No
Persons under the age of 18 years?		X
Vulnerable adults?		X
Participant recruitment outside England and Wales?		X
(b) Has the research received external funding?		X

22. Declarations by applicant(s)

Please confirm each of the statements below by placing an 'X' in the appropriate space

I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.	X	
I accept the responsibility for the conduct of the procedures set out in the attached application.	X	
I have attempted to identify all risks related to the research that may arise in conducting the project.	X	
I understand that no research work involving human participants or data can commence until ethical approval has been given.	X	
	Signature (Please type name)	Date
Student(s)	Alika Jane Goodwin	14/04/15
Supervisor		

Reviewer Feedback Form

Name of reviewer(s).	
Email(s).	
Does this application require any revisions or further information?	
<i>Please place an 'X' in the appropriate space</i>	
No Reviewer(s) should sign the application and return to psychology.ethics@city.ac.uk , ccing to the supervisor.	Yes Reviewer(s) should provide further details below and email directly to the student and supervisor.
Revisions / further information required	
To be completed by the reviewer(s). PLEASE DO NOT DELETE ANY PREVIOUS COMMENTS.	
Date: 4.6.15	
Comments:	
1. In section 16, I recommend that 'anonymised' sample is replaced with 'de-identified' sample. 2. There needs to be a "Plan B" for the research in the event that you decide to withdraw yourself as participant because of the role the study plays in your qualification.	
Applicant response to reviewer comments	
To be completed by the applicant. Please address the points raised above and explain how you have done this in the space below. You should then email the entire application (including attachments), with tracked changes directly back to the reviewer(s), ccing to your supervisor.	
Date: 5 th June 2015	
Response:	
I have spoken with my internal supervisor and we have agreed a suitable plan B project should I wish to withdraw in order to complete my doctorate. I will do a narrative analysis of people speaking about their own mental health disclosures from blogs, websites, books.	
Reviewer signature(s)	
To be completed upon FINAL approval of all materials.	
	Signature (Please type name)
	Date

Supervisor		
Second reviewer	Julianna Challenor	4.6.15

Appendix 5

January, pre-hospitalisation: email to an ex-course director that I forwarded to every professional I could.

Dear X,

I hope you are doing really well and have had a happy new year and the new lot of MSC students are exciting and challenging intellectually learning from the material. I am writing to you for two reasons. First of all you have all been on my mind lately and whilst it was deffinatly the right choice to leave I do miss you all. So I wanted to tell you this. Everytime before I go into my personal development group at university outside it there is a noticeboard and a leaflet advertising the two masters degrees and i miss you all and whilst i dont regret leaving I wish to be involved with you somehow as you have all helped me on my learning process in many ways.

My second matter is that the research i was working on when I started at X College and whilst i was with you was paused due to my ill health. I was misdiagnosed 3/4 times over the past 2 years and only finally got to the bottom of it when I arrived in Batu last week and randomly happened to meet a healer (irreevant but the one from eat pray love movie with Julia Roberts) and apart from the intese spiritual and transferential aspect he touched my leg saying doctor hospital. what he didnt know was that i already had an appointment at the hospital the following day as had in order to fly to Batu had an epidural and steroid injection into my spine so i could fly safely pain free. So i went to the neurosurgeon (probably the 4th or 5th ive seen in the past 3 years and he solved the mystery within minutes. It was only by looking hollistically that he was able to combine all the misdiagnoses into one diagnosis which explains all. I am going back to the healer tomorrow with my Batunese brother (in there tradition once you are there in there family home you become a brother or sister for life) and he is translating all this to the healer. Incidentally the doctor I ended up seeing randomly happened to be the best friend of the healers grandson as they did their medical training together. Thus tomorrow after the discussion with the healer I will be going back to the hospital to do one final check to understand exactly which surgery is needed as we left it I believe that it will either be a minor keywhole spinal surgery or a full blown spinal fusion with metal scaffolding throughout the spine. I am not scared to have the surgery (whereas 2 years ago i was petrified as I had a gut feeling it was not right and I am touched by my

experience here because it is what my research is about and why i applied to your Msc in the first place- cross collaboration and holistic healing. but it is also why i left because i struggled to not have clinical interaction and i lacked the spiritual more heavily psychoanalytical group level of theory and practice which was missing. Whilst i found your course interesting- especially the psychoanalytic discussion groups and the module where we had the cross collaboration in which I wrote the paper on PTSD and nightmares from a psychoanalytic and neuroscientific approach. I did enjoy some of the neuro stuff mainly because I learn through active engagement and listening (which sadly I taught myself during the year that i was not accepted onto the course therefore it was slightly repetitive yet still good to refresh the material). I find this all important part of my journey and I would like very much for X and X and X and anyone who is interested to participate in this joint collaboration research/book series.

At the moment I am working on it with X and X and at university probably professor X and X as part of my phd, hopefully the healer and my Batunese brother who is translating and also writing a chapter on why their culture works why they are the happiest and why so many travellers come here and end up staying and the importance for them of how they deal with mental health and how they live in communities and for them what it means to be psychology unwell (all fascinated as it is rare and if they do they go to a healer). This is something i have always known but until experiencing it personally i have been blocked in my research work as the magical is unexplainable unless there is cross collaboration.

This is why it is my deepest wish that anyone on your side who wants to can get involved. Im hoping we can set up a large group conference/ or group session whichever feels most appropriate to all the different parties- maybe it doesnt even need a name. but to discuss this and research all together. Im happy to write the neuro part myself but i think it is better if it is done by someone with a high reputation in the field especially because if what i am certain is true is true then the potential for healing and changing the evidence based practice regulations in the NHS will be excellent. not only that but world wide. There is always so much talk about need to multicultural etc but i feel its not really done adequately. Also i do not have the funding to carry out the neuro investigations I would like to do. I would like X to be involved as I believe it links to what i discussed in my interview with him and what he is interested in too i believe- in terms of the impact of the relational element of therapy and cortisol levels and the ability for the brain plasticity in healing through the relationship

(attachment- whatever we all wish to call it from our varying stances we are all trying to discuss the same concept).

I also met X a few months ago at a conference and discussed my ideas with him also they were not as advanced as I hadnt been to Batu yet but he said there is a lack of research in this field which is desperately needed thus I am writing to him too. I hope that as many people as possible can get involved and that together we can all find a way to fully understand the healing process from all angles. Thus my goal is for anyone interested to respond to an email and forward this on to anyone else they believe would be interested and arrange a conference meeting somewhere somehow- ideally Batu but I think this highly unlikely at present but hopefully in the future.

My personal goal is to do this and then set up a clinic here in Batu and elsewhere where training can exist from all angles- MBT, group analysis, CBT, Systemic, Neuroscience and neuropsychology etc. My main struggle in my education and training has been the lack of collaboration as I believe greatly we are all trying to do the same thing in different ways and trying to provide research to prove which one is better or which one works which is easier for some than others because each approach is unique and each healing unique to the individual making it challenging yet not impossible if we all work together. I have struggled consistently by the various titles given- clinical psychologist, counselling psychology, integrative psychologist, psychotherapist, psychoanalyst, group analyst, client centred therapist. It has been a personal struggle until now. I do not fit into any one category but all and this is why so many probably choose to be integrative. Yet one must be careful being integrative as there is a purpose and reason for evidence based practice. So if we can create a cross collaboration amongst all professionals not only does it create an immense amount of creativity but also a chance to actually finally properly heal people the way that is best suited for them but most importantly doing this in a way which is ethically sound yet flexible protecting the client whilst also healing the client in a human way through the relationship be it called whatever each of us want to call it.

With my very best wishes to you all and I am excited to hearing from you soon and hope that this is something you would like to get involved with. I suggest those who do send me an email to X and we can create a list and start organising a space time and location to get creative.

Thus so far involved:

I go on to name a number of professionals who I work with and whom I think will be involved in the research. I include their C.V. You can imagine how long the email was.

Appendix 6

Diary Extract:

Go in feeling quite anxious, I'm anxious re research. I bring it up and am describing it and in a sense feel like I need to justify why it's a good idea yet I start to get teary. He asks me whats wrong and I think I say something like its being here. It's a trigger and it's the anniversary I have had lots of triggers but I feel it is a good thing to do and will ultimately be therapeutic but im worried that well one thing. He asks what it is and I say im worried that what if it wasn't the steroids.. I had only just believed myself for the past year about the steroid diagnosis but the more I speak about it and the more opinions I got I started to freak out and realize if I write about it and submit it then this might be a question on everyones mind and what if it wasn't the steroids-I will feel like a fool. He says he's also been thinking about this- my heart races and my chest tightens. He says it was deffinatly the steroid but he has been querying whether the steroid induced episode made something dormant express itself. He cannot completely rule out a Bipolar diagnosis.

My life shattered at this point I went into a hopeless pit of despair I tried to contain it i blurred out much of what he was saying and in my head jumped to- right the past 3 years have been a lie or not the reality I only just built up. I cant write my thesis on this now. Now my reality is gone. I need to take time out I cant possibly finish my essays this week (3 due in the same time breaking point for many) I cant imagine anything moving it just all feels static and panicked. As I write it I am getting a bit of that stuck feeling back.

He asks me what im thinking and I say im shocked that I have recently been feeling so much better and on top of things. The anxiety medication has been working, my flat is finished so I am not stressed by builders work is going well im feeling more contained dealing with high risk, ive made decisions about different placements. I got the best research supervisor possible and its all fitting into place.

I say him saying that- is crippling.

He goes on to say things about how some of the most talented people he knows are bipolar.

Probably says more but I've blurred it out.

It is not this it is the fact that my whole reality and subjectivity has been taken to pieces and I had only just recovered from the trauma and the shame and what I felt to have been 2.5 years taken out of my life. I was 25 when I went to Batu. Part of me left myself there and ive been desperately searching for it since. I had now finally found myself again different of course but acceptant of the accident the treatment everything proud of my disclosure to others and my ability to be me. That had all just flown out the window. I could see myself now sitting in my dads consulting room crying unable to breath. Like I had done many times when I returned from Batu. When I didn't know who I was and what I would do when I had no aim or purpose as I couldn't be working as I was in recovery.

He tells me he isn't changing anything he is not saying I am bipolar hes just expressing whats in his mind and he would be a bad clinician if he didn't think about alternatives and opinions and had a closed mind.

I agree completely but this is my worst nightmare. I felt good today past week things had improved I was determined to get my essays done and felt hopeful now im just runingn in quick sand.

Have a lot of conversation with myself in my head. Stop being dramatic. If you let yourself get upset over this you will spiral and you wont get any work done whatsoever. I also feel like a huge fat hypocrite. Stigma mental health shame we should all be open about it- I want to hide this cant face having to potentially tell people what ive thought all along might not be the case.

Appendix 7

Telephone [redacted]

Fax [redacted]

Mobile [redacted]

e-mail; [redacted]

London [redacted]

assistance
Claim

Monday, 04 February 2013

Dear Sirs

Please find some details about the claim reference above.

1. I enclose the flight ticket for my daughter's holiday in [redacted] and [redacted].
2. My daughter is a very bright student of psychology, has a first class degree in psychology, two masters, several other course qualifications and had just started her PhD at [redacted] University last September. She has started to see her first psychiatric patients.

3. Her holiday began in [redacted] and it was very pleasant and relaxed. Seemed to be going brilliantly. A day or two after her arrival in [redacted] she started to feel more and more manic (and she never takes any illegal drugs – which was confirmed by her blood tests). By January 13th she was exhibiting signs of hyper mania which was a great surprise to all of us who know her. She saw a psychiatrist in [redacted] who immediately transferred her to the state mental hospital. She was restrained and injected as if she had been “sectioned” although such an order does not exist in [redacted] believe. The hospital where she was had no facilities except to restrain and medicate patients.
4. I immediately made plans to rescue her, travelling from [redacted] to London, to [redacted] and [redacted] arriving on Friday January 18th
5. On my way I spoke to her psychiatric colleagues who advised me I had to get her to London as quickly as possible for her own mental health.
6. I alerted the [redacted] insurance company of the likely claim and setup the paperwork. I started to organise SOS assistance from [redacted] to [redacted] and once I arrived in [redacted] I completed that process so

that I could evacuate her to [redacted] on Saturday 19th. She was sedated and with an escort medical support.

7. Her psychiatrist colleagues advised me that I could not fly with her under sedation for such a long flight (13.5 hours) from [redacted] to London and therefore I must wait and attempt to stabilise her in [redacted] she was admitted to the psychiatric ward of the [redacted] on Saturday 20th. She received further treatment there and other tests to ensure that she was not suffering from anything else which could have precipitated it.
8. By Thursday January 24th the medical team in [redacted] felt that she could travel with me un-sedated provided I carried medication with me and so we flew from [redacted] London. I checked her into the [redacted] hospital on Friday 25th where she is still and inpatient although I hope she will be released in a few days.

I can provide more details as necessary but the above is an essential outline.

4,640.00	flight to
220.00	hospital
8,761.00	evacuation
2,635.21	
7,296.00	
632.55	hotel /
3,490.00	flight home
80.00	taxi
27,754.76	total

Please note that I have sent the medical certificate to the GP and am waiting for that to be returned but I can confirm from her colleagues / psychiatrists etc that this is definitely a new and unconnected episode from anything previous in my daughter's life – which is also highlighted as such on the hospital admission document in which you have. She has not yet seen her GP since she returned from overseas as she is still hospitalised under the treatment of a psychiatrist

Yours faithfully

Appendix 8



MEDICAL REPORT

File number : 024883
Name : _____
Age : 25 years old
Sex : Female
Nationality : United Kingdom
Admission date : 16/01/2013

Diagnosis : AFFECTIVE BIPOLAR DISORDER CURRENT MANIC EPISODE WITH PSYCHOTIC SYMPTOM (F31.1)

Recent History :

_____ was referred to _____ mental hospital with chief complaints has bizarre delusion. She believes that she has a special power that can cure illnesses of the mental patient. She said that she is a spiritual healer and she is not allowed to take oral or injection medication. She also believes that she owned the hotel in _____. According to his friend, patient seems talk too much and looks too excited. She was also expressing her feeling over control. She has been diagnosed with depression and anxiety and has history back disorder. She take medication Sertraline 100 mg, diazepam 5 mg, Zudol 50 mg, Diclonax SR 65 mg and tramadol 50 mg but she stopped her medication about one week ago.

Allergy : Not known drug allergy

Examination 16/01/2013

- **Vital sign** : Level of consciousness alert
BP : 150/100 mmHg P : 80x/min RR : 20x/min Tax : 36.8 C
- **Psychiatric examination :**
 - General appearance : looks calm
 - Mood/affect : Elation
 - Thought process : Flight of ideas (+), bizarre delusion (+),
 - Perception : hallucination (-)
 - Instinctual drive : insomnia (-), hypobulia (-), raptus (-)
 - Psychomotor : in normal limit
- **General examination**
 - Eyes : no anemic, no icteric, PERL
 - Throat : pharynx not hyperemic, no JVD

Appendix 9



WA 3m

2/1/13
Psychiatrist 11C
United Kingdom

51822... 200040451 20/01/2013

Dear Doctor,

Re:

was recruited from
on 20/1/13

She has a past history of Bipolar Affective Disorder treated in UK.

She traveled to on 2/1/13 & apparently developed signs of hypomania there. She was admitted to a hospital in & treated with Serenel 200mg b.i.d., Escitalopram 10mg M & Longepson. When she arrived in he must have stabilised

She was cooperative & responsive. She spoke of her religious experience in & she had little insight into her experience there. I was treated with Serenel 200mg b.i.d. & Escitalopram 10mg M

Typed out letter for clarity

Dear Doctor,
Re: Alika Goodwin

Alika was evacuated from Batu to Apolaniati on 20/1/13.
She has a past history of Bipolar Affective Disorder treated in the UK.
She travelled to South East Asia on 2/1/13 apparently develop..... Hypomania there.
She was admitted to a hospital in Batu and treated with Seroquel 200mg bd,
10mg....Lorezepam.
When she arrived in Apolaniati her mood for cooperative and responsive. Her
speech ... and her Experience in Batu and she had little insight into her experience
there. I ... treated her with Seroquel 200mg bd.....

Appendix 10

These are notes made from a foundational paper by Morrow (2007). All references are direct copies and therefore cited in Morrow (2007).

1. The traditional period: roughly 1900 through to the beginning of World War II

This was characterized by an emphasis on objective scientific approaches to investigating “the other”, as described above, through the evolution of early anthropological and sociological research.

2. The modernist phase: post-war into the 1970s

This period sought to formalize qualitative methods, attempting “rigorous qualitative studies of important social processes”. The period was described by Denzin and Lincoln (2000) as “a moment of creative ferment” (p. 14). A post-positivist paradigm, branded by a belief in an objective reality, characterized thi period.

3. Blurred genres: 1970–1986

As new paradigms, designs, and methods proliferated, qualitative research gained in credibility. This period was marked by a blurring of the boundaries between social sciences and humanities, possibly one reason that psychology, with its concerns about credibility in traditional scientific terms, has been slow to embrace a more multiparadigmatic approach to qualitative research (Gergen, 2001; Fine, in press [*TCP*, special issue, part 4]; Haverkamp & Young, 2007; Haverkamp, Morrow, & Ponterotto, 2005b; Ponterotto, 2005c).

4. Crisis of representation: mid-1980s to 1990

Here the postmodern age of qualitative inquiry was ushered in, which was more reflexive as well as focused on issues of race, class, gender, culture, and other sociopolitical concerns. With greater awareness of power in relation to participants and cultures being studied, researchers asked themselves whose reality they were portraying. The tension between empirical science and social criticism demanded that scholars closely examined the purposes of their inquiry. This period also introduced a central focus on the new forms of writing that departed from the more traditional “scientific” rhetoric of earlier periods. This focus on writing and presentation pervades the following periods as well (Ponterotto & Grieger, in press [*TCP*, special issue, part 4]).

5. Postmodern period of experimental ethnographic writing

This period was characterized by a “triple crisis of representation, legitimization, and praxis” (Denzin & Lincoln, 2000, p. 17). In addition to addressing concerns of the previous period, it rethought traditional criteria for rigor in qualitative research (legitimization) and asked how qualitative studies were “to be evaluated in the contemporary, poststructural moment” (p. 17). The crisis of representation acknowledged that it was no longer possible to “directly capture lived experience,” as the “social text [is] written by the researcher” (that is, it is always from the researcher’s world view and social positioning that participants’ lives are interpreted and conveyed; Denzin & Lincoln, 2005a, p. 19).

The focus on praxis (reflection combined with action; Friere, 1970) challenged inquirers to integrate theory and activism and to attend to ways of knowing of previously silenced groups to inform scholarship. Beginning with the period of blurred genres, experimental forms of writing and presenting the products of inquiry – including such forms as ethnographic fiction, inclusion of the researcher in the ethnographic text (autoethnography or “tales of the field”), dramatic readings and other creative renditions – have challenged the primacy of the scientific text. Characterized by concerns with social justice and a politics of liberation, action and activist research guided by cultural studies, critical race theory, feminist theory and social constructionism are central. Traditional paradigms of research are redefined, and the field moves away from overarching paradigms in favour of historically situated perspectives of people who have been oppressed. Researchers have increasingly embraced a sociopolitical agenda for their inquiry, utilizing “epistemologies from previously silenced groups” (p. 20).

6. Postexperimental inquiry: 1995–2000

Here, ethnographic alternatives and further break down of the boundaries between the social sciences and humanities were explored. This period continued to explore novel forms of writing that are poetic, autobiographical, conversational, visual, and performative. Radical performances and engagement of audiences began to replace traditional texts in some disciplines.

7. Methodologically contested present: 2000–2004

This period was characterized by “conflict, great tension, and, in some quarters, retrenchment” (p. 20). Research was driven by numerous paradigms, theoretical lenses, and

methods, and the field was and continues to be resource-rich with an “embarrassment of choices” (p. 20). However, in the midst of this richness, qualitative researchers found themselves in a “politically charged space,” . . . “confronting the methodological backlash associated with ‘Bush science’ and the evidence-based social moment” (p. 20). This context has important implications for Counseling Psychology.

8. Eighth moment: 2005 onward

This was cast in future tense by Lincoln and Denzin (2005) and, while still varied and rich as well as methodologically contested, it was predicted to encompass increasing methodological sophistication. In addition, Lincoln and Denzin predicted that four major themes would be addressed in the coming “generations” of qualitative research: (1) the reconnection of social science to social purpose, (2) the rise of indigenous social science(s) crafted for the local needs of indigenous peoples, (3) the decolonization of the academy, and (4) the return “home” of Western social scientists as they work in their own settings using approaches that are vastly different from those employed by their predecessors (2005, p. 1117).

The “reconnection of social science to social purpose” implies that social scientists must move beyond mere academic inquiry to renew, reclaim, or discover their social justice roots. “Decolonization of the academy” (p. 1121). Changing demographics within the academy, particularly the increasing representation of women faculty, faculty of colour, and faculty members from countries other than the United States are influencing graduate education, resulting in less adherence to traditional forms of publication, more interest in innovative theories and methods and more comfort with experimentation. These increasingly diverse scholars contribute substantially to the expansion of new perspectives in research, “traveling the margins and borders, searching for new and innovative forms through which to express non-Western modes of knowing and being in the world” (Lincoln & Denzin, 2005, p. 1122).

9. The Fractured Future

This is where current divisions across paradigms could become further intensified unless some kind of intervention takes place. In this highly charged arena, adherents to positivist and post-positivist paradigms will retrench, attempting to re-establish the hegemony of their methods; at the same time, researchers from other paradigms will pursue socially responsive research and praxis and continue to push forward with a social justice agenda. Although this fracturing is not necessarily the only outcome for the future, Lincoln and Denzin (2005) cite

current trends such as the National Research Council's definitions of appropriate research designs as evidence that such a future is indeed in the making.

Qualitative research in psychology finds itself on the brink of the future eighth and ninth moments while not yet having come to grips with many of the issues in the third, fourth, and fifth moments. Yet constructivist and qualitative scholars in psychology, such as Gergen and Gergen (2000) and Hoshmand (2005), have addressed such issues as reflexivity, multiple voicing, literary styling, performance, narratology, and cultural psychology. Thus, psychology appears to be grappling with many of the same processes as the larger qualitative genre, albeit more slowly.

Given Counseling Psychology's social justice commitments, increased paradigmatic flexibility and expansion will serve us well and may enable the field to avoid some of the fracturing predicted by Lincoln and Denzin (2005). Calls for social justice in Counseling Psychology (Vera & Speight, 2003) require that we embrace new paradigms such as social constructionist and critical theories (feminist, queer, and critical race perspectives) to adequately address emerging agendas. In this call for ever greater methodological diversity in Counseling Psychology, I envision qualitative inquiry as a central tool for bridging community and academe by engaging research participants as co-researchers in matters that concern their everyday lives. Such research would centralize the "voices" of participants (Fine, 1992). Human agency and human rights would become increasingly important topics of inquiry, and research would be transformed into social action (Kidd & Kral, 2005). A central criterion by which we evaluate the research endeavor would be the extent to which it contributes to liberation.

References

Morrow, S. L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist, 35*(2), 209–235. doi:10.1177/0011000006286990

