



Losing the plot: A hermeneutic phenomenological study of
the nature and meaning of psychological distress amongst
third level students in Ireland.

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This thesis has been submitted for the degree of
Doctor in Philosophy

Declaration

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Summary

Psychological distress, or mental health problems, constitute the leading form of disability worldwide (World Health Organisation, 2014). While much is known about the extent, or breadth, of the issue, less is known about what it is actually like to experience psychological distress. This is particularly true of the key life stage of late adolescence/early adulthood – a time when the majority of Irish young people are engaged in higher education (Department of Education and Skills, 2011).

Adopting a hermeneutic phenomenological approach, this study sought to (a) understand the nature of the lived experience of third level students with mental health problems, and (b) understand how these students made sense of, or ascribed meaning to, their experiences. In total, 27 third level students shared their lived experiences as part of this study. Conversational interviews, carried out with a convenience sample of students from third level institutions throughout Ireland, generated 36 hours of audio, or 997 pages of transcript. The data were analysed through a combination of the principles of the hermeneutic circle and Braun and Clarke's (2006) method of thematic analysis.

The students' individual accounts, and the total of 36 thematic features that dominated these narrative landscapes, revealed much about the nature of the lived experience of the students in this study. Moreover, early on in the data analysis process, a pattern emerged in how the students made sense of their experiences. Comprising of four stages, this narrative structure, or 'plot' was drawn on by students in ordering their experiences into meaningful wholes.

This study suggests that understanding, not only what it is actually like to experience psychological distress, but how we go about making sense of these experiences, is essential if we are to move on, or 'recover', from mental health problems. It also suggests that we, as a society, need to think about and understand mental health in a different way. Overall, this study proposes that understanding (both with a small 'u' and a capital 'U') must be placed at the heart of how we respond to mental health problems.

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One learns to know only what one loves, and the deeper and fuller the knowledge is to be, the more powerful and vivid must be the love, indeed the passion.

(Goethe, 1963, p. 83)

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*Note to reader. What is presented within reflects but a portion of the data generated and half of what was submitted for viva voce examination. In order to protect the anonymity and confidentiality of the students who took part in this study, the examiners recommended that volume 2, and references to its contents, be withheld.

Table of Contents

1. Introduction.....	1
1.1 Setting the scene.....	2
1.2 A note on terminology.....	5
2. Hermeneutic Phenomenology.....	8
2.1 Introduction.....	8
2.2 Hermeneutic phenomenology as a philosophy.....	9
2.2.1 Husserlian Phenomenology.....	10
2.2.2 Heideggerian Phenomenology.....	13
2.2.3 Gadamerian Phenomenology.....	18
2.3 Hermeneutic phenomenology as an approach to research.....	21
2.3.1 Examples of Hermeneutic Phenomenological Research.....	29
2.3.2 Limitations of a Hermeneutic Phenomenological Approach.....	32
2.4 Conclusion.....	33
3. Forestructures of Understanding.....	35
3.1 Introduction.....	35
3.2 Entering the hermeneutic circle.....	35
3.3 The historical perspective.....	37
3.3.1 Druids, demons and witches.....	38
3.3.2 The Enlightenment, colonial oppression and ‘The Great Confinement’.....	40
3.3.3 Fear and the moral approach.....	42
3.3.4 Swift’s hospital and the Growth of Ireland’s Asylum System ...	43
3.3.5 Lunacy Laws.....	44
3.3.6 The Emergence of Psychiatry.....	46
3.3.7 Anti-psychiatry and postpsychiatry.....	48
3.3.8 21 st century: A liminal space?.....	54

3.4	Medical perspective.....	56
3.5	Psychological perspective	57
3.6	Sociological perspective.....	60
3.7	Researcher’s ‘Prejudice’	64
3.8	Conclusion.....	66
4.	Methodology	67
4.1	Introduction	67
4.2	The interpretive paradigm	67
4.3	Sampling.....	70
4.3.1	Purposive sampling.....	71
4.3.2	Sample - Size	72
4.3.3	Sample - Access	76
4.3.4	Sample – Overview	77
4.4	Data generation	79
4.4.1	Conversational Interviews	80
4.5	Data analysis	83
4.5.1	The hermeneutic circle as method of interpretation	83
4.6	Trustworthiness	90
4.6.1	Credibility	92
4.6.2	Transferability.....	93
4.6.3	Dependability and confirmability	93
4.7	Ethical considerations	95
4.7.1	Informed consent	95
4.7.2	Confidentiality	96
4.8	Conclusion.....	100
5.	Presentation of Findings	101
5.1	Introduction	101
5.2	The narrative plot	101

5.3	'Pre' narrative.....	106
5.3.1	Introduction.....	106
5.3.2	Childhood trauma.....	106
5.3.3	Difficulties in school.....	110
5.3.4	Perfectionism	114
5.3.5	Existential thinking	121
5.3.6	Drugs and/or alcohol.....	124
5.3.7	'It was clear from a very early age'	126
5.3.8	No reason for it	126
5.3.9	Conclusion	128
5.4	Crisis/Interruption	128
5.4.1	Introduction.....	128
Part A:	Crisis/interruption landscape	129
5.4.2	Crisis/interruption landscape	129
5.4.3	Articulating experiences	135
5.4.4	Help-seeking	138
Part B:	Crisis/interruption features	147
5.4.5	Self-harm.....	148
5.4.6	Suicidal ideation and attempts	150
Part C:	The lived experience of... ..	157
5.4.7	Depression.....	158
5.4.8	Depression and anxiety	161
5.4.9	Anxiety and panic attacks	162
5.4.10	Psychosis.....	163
5.4.11	Bipolar disorder	165
5.4.12	Eating disorders	165
5.4.13	Borderline personality disorder.....	166
5.4.14	Conclusion	167

5.5	Narrative wreckage	168
5.5.1	Introduction.....	168
5.5.2	Narrative wreckage landscape	169
5.5.3	Narrative wreckage features	174
Part A	Intervention.....	175
5.5.4	Psychiatry.....	176
5.5.5	Hospitalisation	181
5.5.6	Diagnosis.....	189
5.5.7	Medication	191
5.5.8	General practitioner	195
5.5.9	Talking therapies.....	197
Part B	Higher education.....	201
5.5.10	Transition to higher education	202
5.5.11	DARE.....	204
5.5.12	University Disability Support Services.....	206
5.5.13	Navigating higher education with a mental health problem	208
5.5.14	Studying a mental health related subject as a student with mental health problems	213
Part C	Living with ‘it’	217
5.5.15	Supportive others	218
5.5.16	Telling people	219
5.5.17	Living with/managing ‘it’	222
5.5.18	Making sense of ‘it’	226
5.5.19	Upside of ‘it’	229
5.5.20	Challenges/roadblocks	230
5.5.21	Helping others.....	232
5.5.22	Conclusion	233
5.6	Post narrative.....	234

5.7	Conclusion.....	240
6.	Discussion.....	241
6.1	Introduction.....	241
6.2	Meaning.....	242
6.2.1	Structuring experiences into meaningful ‘wholes’	246
6.3	The narrative plot.....	248
6.3.1	‘Pre’-narrative.....	249
6.3.2	Crisis/interruption.....	252
6.3.3	Narrative wreckage.....	260
6.3.4	‘Post’ narrative.....	263
6.4	Conclusion.....	269
7.	Conclusion.....	270
7.1	Introduction.....	270
7.2	Conclusions drawn.....	271
7.3	Limitations.....	275
7.4	Future considerations.....	276
7.5	Conclusion.....	277
	References.....	279
	Participant Information Sheet.....	301
	Appendix 1.....	301
Appendix 2	Consent Form.....	303
Appendix 3	Critical Friend Report.....	305

List of Figures

Figure 1 The hermeneutic circle of understanding	17
Figure 2 Sample size audit trail	74
Figure 3 Data generation audit trail	81
Figure 4 The hermeneutic circle as method of interpretation	84
Figure 5 Braun and Clarke's (2006) six step method of thematic analysis as aligned with the hermeneutic circle.	85
Figure 6 Relationship between individual data analysis procedure, hermeneutic circle and Braun and Clarke's (2006) method of thematic analysis.....	86
Figure 7 Data analysis audit trail	90
Figure 8 Visual representation of the narrative plot	102
Figure 9 Narrative plot and presentation of findings overview	105
Figure 10 Time from student becoming aware of 'it' and seeking/receiving professional support	140
Figure 11 Adrianna: Narrative wreckage help-seeking/support	176

List of Tables

Table 1 Psychological Perspectives on Mental Illness (adapted from Peterson, 2010)	58
Table 2 Participants - Overview	78
Table 3 Criteria for establishing trustworthiness (Lincoln & Guba, 1985) and measures taken to ensure trustworthiness in this study	91

List of Abbreviations

AMHS	Adult Mental Health Service
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
DARE	Disability Access Route to Education
DBT	Dialectical Behaviour Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
GP	General Practitioner
HEAR	Higher Education Access Route
OT	Occupational Therapist
SCS	Student Counselling Service
TCD	Trinity College Dublin

1. Introduction

As an undergraduate student, I learned that one in four adults will experience a mental health problem at some stage over the course of their lives (World Health Organisation, 2001). I learned that Ireland has one of the highest youth suicide rates in the European Union (Department of Health & Health Service Executive, 2015) and that an average of 500 people take their lives each year (National Suicide Research Foundation, 2016). Yet, beyond my studies, I had the privilege of listening to the rich and deeply nuanced stories of young people with lived experience of psychological distress. These stories spoke of fear, hurt, anger and shame (Farrell, 2015), as well as strength, wisdom and indomitable courage. The young people offered insight into unique and complex landscapes, sweepingly categorised under the label of mental illness, as well as recounted their journeys across these landscapes, and hopes for what may lie over the horizon. And yet, I struggled to find little more than snippets of these stories in the textbooks and academic journals that filled the college library.

Many authors have highlighted the gap that can lie between stories and statistics (Roberts, 2000; Thomas, Bracken, & Timimi, 2013; Wertz, 2011). And while there is undoubtedly recourse for both forms of knowledge, we are currently in an age that prizes ‘the self-correcting features of modern science’ (US Department of Health and Human Services, 2001, p. 25) above ‘the swampy lowlands of human experience’ (Barker, Campbell, & Davidson, 1999, p. 1). This dissertation does not attempt to resolve this particular epistemological tussle, but aims instead to represent the depth and richness of understanding that lies within narrative accounts of lived experience in a way that upholds the highest standards of ‘rigour’ or quality.

Guided by two research questions, the study seeks to understand:

a) the nature of the lived experience of third level students with mental health problems

b) how students make sense of, or ascribe meaning to, these experiences.

This introductory chapter aims to set the scene for the study at hand. Guided by that word at the very heart of inquiry, the chapter asks ‘why?’: Why mental health? Why higher education? Why lived experience? Why meaning? It then provides an overview to the thesis itself before pausing to reflect on the terminology that will be used throughout.

1.1 Setting the scene

While it is true that one in four of us experience a significant mental health problem at any one time, the reality is that we are all likely to be affected by mental health issues – if not directly, then vicariously through those we love, those we teach or those we care about in one way or another. Just as we all have mental health, we are all vulnerable to experiencing mental ill-health. Psychological distress is non-discriminatory. It affects people of all races, genders, cultures and socio-economic statuses, albeit with certain descriptive epidemiological patterns (Kessler & Zhao, 1999; Rogers & Pilgrim, 2013). This form of distress affects us all economically as well as socially. It is estimated that mental health problems cost the Irish economy more than €11 billion each year, this is compared to the estimated economic cost of obesity of approximately €1.13 billion (Department of Health, 2013). What is more difficult to calculate is the social cost associated with mental health problems such as pain, suffering, reduced quality of life and suicide. We do know, for example, that those who struggle with significant mental health problems are at an ‘increased risk of a range of negative life outcomes’ (Gibb, Fergusson, & Horwood, 2010, p. 127) such as unemployment (Central Statistics Office, 2014; NAMI, 2014), poor standards of living (Gibb et al., 2010; Schofield et al., 2011), physical ill-health (Appleton & King, 1997; De Hert et al., 2011; Lawrence & Kisely, 2010) and premature morbidity (Brown, Kim, Mitchell, & Inskip, 2010; Harris & Barraclough, 1998; Lawrence, Hancock, & Kisely, 2013) than the general population. We also know that the majority (75%) of mental disorders emerge before the age of 25 (Kessler, Berglund, et al., 2005; McGorry, Purcell, Goldstone, & Amminger, 2011) – a time when many Irish young people are engaged in Higher Education.

Higher education marks the ‘developmental epoch’ (Jones, 2013, p. s5) of late adolescence/early adulthood. In Ireland, an average of 65% of school leavers go on to third level education each year (Department of Education and Skills, 2011). Higher education represents perhaps the ‘one time in a person’s life in which work, leisure, accommodation, social life, medical care, counselling and social support are all provided in a single environment’ (Royal College of Psychiatrists, 2011, p. 9). As such it represents a unique opportunity to address mental health issues in a timely manner in order to avoid or prevent the ‘negative life outcomes’ described above. Moreover, considering that students who struggle with their mental health while in higher education are at considerable risk of academic failure and dropout (Hunt, Eisenberg, & Kilbourne, 2010), it appears in the best interest of third level institutions to support students who may be struggling. However, in order to effectively support the mental health needs of a student population, we must first try to understand what it is actually like for them – to understand their lived experience.

It was German philosopher Wilhelm Dilthey (1833-1911) who first made the distinction between the natural and human sciences. Natural science (naturwissenschaften), he proposed, is concerned with *explaining* the world in terms of cause and effect, whereas human science (Geisteswissenschaften) focuses on *understanding* human being in terms of the relationship between part and whole. Understanding (Verstehen), he believed, could only be achieved hermeneutically – that is, through the interpretation of human objectifications (speech, writing, art, music etc.) of lived experiences.

The human sciences form an epistemic nexus that strives to attain objectively engaged and objectively valid conceptual cognition of the interconnectedness of lived experiences in the human-historical-social world.

(Dilthey, 2002, p. 23)

In other words, to understand another human being we must hermeneutically engage with (i.e. interpret) accounts of their lived experiences. Moreover, to understand the human phenomenon of psychological distress we must

hermeneutically engage with accounts of the lived experiences of those with experience of the phenomenon (research question #1).

Objectifications of lived experiences are rarely, if ever, objective. Our accounts, or objectifications, are always, to one degree or another, retrospective and therefore heavily shaped by the meanings we ascribe to them over time. These meanings themselves are constantly evolving as new experiences are interpreted in light of past experiences and in anticipation of the future (Ricoeur, 1991). Martin Heidegger, a successor of Dilthey, suggested that being itself is inherently meaning-laden, and that ‘to raise the question of being (is) to make sense of our ability to make sense of things’ (Dreyfus, 1991, p. 10). Therefore, in order to fully understand (Verstehen) the experience of the phenomenon of psychological distress we must also consider how individuals make sense of their experiences of the phenomenon (research question #2).

These two research questions mark the point of entry into the hermeneutic circle of understanding. The circle itself will be discussed in further detail in the next, **hermeneutic phenomenology**, chapter which will outline the philosophical principles of hermeneutic phenomenology, as well as explore the strengths and weakness of adopting a hermeneutic phenomenological approach to research.

Chapter three delves into the **forestructures of understanding**, or our current understandings, or attempts to understand, the phenomenon of psychological distress. Beginning with an historical overview of how we, as a society, have tried to make sense of, and respond to, the phenomenon of ‘madness’ from pre-Christian Ireland to the present day, this chapter will then proceed to pull out and examine some of the main assumptions of the three dominant professional frames of reference – psychiatry, psychology and sociology.

The means by which the research questions were broached and addressed will be outlined in chapter four, **methodology**. Locating hermeneutic phenomenology within its interpretive paradigm, this chapter considers the methodological concerns of participant recruitment and selection, data generation and analysis, as well as the cornerstones of good quality research – ethics and trustworthiness.

Chapter five presents the **findings** of the data generation process. Centred around the narrative structure, or plot, that emerged in how the students made sense of their experiences, the chapter outlines both the ‘landscape’ and narratives features of each of the plot’s four phases. A **discussion** of what these findings mean in relation to current understandings of the phenomenon of psychological distress will ensue, and the thesis will then draw to a **conclusion** with a reflection on the understandings generated through this study and how these may, in turn, inform future understandings of, and engagements with, the phenomenon.

All in all, the thesis structure itself mirrors the hermeneutic circle of understanding. Beginning with a question, and a thorough explication of the forestructures of current understandings of the phenomenon, the study then moves into the ‘parts’ of data generation and analysis, before emerging to examine these parts in relation to the ‘whole’ in the discussion and conclusion chapters. Before embarking on this circular journey, the language used to describe and convey the phenomenon at the heart of this study will be considered.

1.2 A note on terminology

Silence is the language of God,
all else is poor translation.

Rumi

The language adopted to convey the phenomenon of psychological distress has evolved throughout history in line with popular conceptualisations. From ‘lunacy’ (reflecting early beliefs about the pernicious influences of the moon) to ‘melancholia’ (‘black bile’); from madness (the word ‘mad’ introduced to replace the Old English word ‘wod’ which means demonically possessed or frenzied) to mental illness; the choice and political-correctness of language related to mental distress depends more on the dominant perspective of the time than the experience itself.

For example, following the 1960's critique of psychiatry and the dominance of the medical model, mental illness gave way to mental disorder (Bolton, 2008). However, Beresford (2005) maintains that despite the replacement of terms such as 'mental illness' and 'pathology' with the more euphemistic 'mental health' and 'mental health problems', ultimately their origins, meanings and legal basis are the same.

The phenomenon of 'mental illness', regardless of what it is called, is laden with social prejudice (Scheff, 1966). Whatever language is used to describe those who use mental health services – patients, service users, clients, survivors - the implications, according to Penn and Nowlin-Drummond (2001) at least, are the same. Indeed, Allan (2011) would go so far as to refute the political correctness of *any* term – mental illness, psychological distress, service-user, survivor. Even the authors of the Diagnostic and Statistical Manual of Mental Disorders (DSM) begin by offering terminological caution:

Mental disorders have...been defined by a variety of concepts (e.g. distress, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation). Each is a useful indicator for a mental disorder, but none is equivalent to the concept.
(American Psychiatric Association, 1994, p. xxi)

Foucault (2006), in his critique of the hegemony of the medical model, preferred to use the terms 'insanity' and 'madness' in reference to his belief that we 'confine insanity within mental illness' (p.xiii). Because of its implicit acceptance of the medical model of psychological distress, mental illness remains a highly contested term (Szasz, 1961). However, many legislative documents, even those endorsing a recovery oriented approach, still use the term 'mental illness' (Department of Health and Department of Health and Children, 2006; National Economic and Social National Economic and Social Forum, 2007). The Department of Health and Children's policy document, 'A Vision for Change' (2006), uses the term 'mental health problem' to describe the full range of mental health difficulties that may be encountered, and the term 'mental illness' to describe specific disorders such as schizophrenia, bipolar disorder and clinical depression.

Throughout this thesis I propose to use, interchangeably, generic terms such as mental health problems, psychological distress, and mental health difficulties or, in describing students' experiences in the latter half of the thesis, simply 'it'. These terms 'are acceptable to the majority of service users and neither presume nor rule out the presence of any biological mental illness process' (Tew, 2005, p. 18).

2. Hermeneutic Phenomenology

2.1 Introduction

van Manen (1990) describes how Nietzsche once declared ‘whoever is searching for the human being must first find the lantern’. Nietzsche was referring to the Greek philosopher Diogenes (412 - 323 BCE), a founding father of Cynic Philosophy, renowned for his wit and use of pantomimic gesture. One day Diogenes was reported to have gone out in broad daylight carrying a lit lantern, looking around as if searching for something. When people approached him to ask what he was trying to find, Diogenes answered: ‘Even with a lamp in broad daylight I cannot find a real human being’. When people pointed to themselves he chased them away with a stick, shouting ‘it is *real* human beings I want’. While most people laughed at this pantomimic demonstration, the anecdote has survived because it moved some to reflect on one of life’s fundamental questions: what is the nature of human being? Diogenes’ demonstration raised the point that a human being is not something you automatically *are*, it is also something you must try to *be*. By using the lit lamp in broad daylight, Diogenes highlighted his desire to throw some light on what it means to be a human being. van Manen (1990) believes that, with his lantern, Diogenes showed a commitment ‘not to fancy abstract philosophical discourse, but to practical reflection on the concreteness and fullness of lived life’ (p.5). This chapter aims to examine the ‘lantern’, or philosophical approach, by which the present study aims to illuminate the nature and meaning of psychological distress.

Phenomenology has been described as ‘a philosophy, a perspective, and an approach to practice and research’ (Munhall, 1994, p. 14). Munhall (2012) believes that ‘before we embark on ‘doing’ a phenomenological research study, we must know how to interpret the philosophical underpinnings of phenomenology’ (p.115). Indeed, one criticism often levied at those who adopt a phenomenological research approach is a lack of researcher awareness of the philosophical foundations upon which the approach rests (Converse, 2012; Draucker, 1999; Koch, 1995; Paley, 1997; Porter, 2008).

This chapter aims to explore these foundations. It examines the key contributions of Husserl, Heidegger and Gadamer to phenomenology and, in the case of the latter two, to the union of hermeneutics and phenomenology. Following this, the chapter will attend to hermeneutic phenomenology as an approach to research. Principles guiding hermeneutic phenomenological research, as outlined by van Manen (1990), will be explored, as will the strengths and limitations of adopting a hermeneutic phenomenological research approach.

2.2 Hermeneutic phenomenology as a philosophy

The term phenomenology stems from the Greek *phaenesthai*, to flare up, to appear, to show itself (Moustakas, 1994). As a philosophy, Moran (2000) believes;

Phenomenology is best understood as a radical, anti-traditional style of philosophising, which emphasises the attempt to get to the truth of matters, to describe *phenomena*, in the broadest sense as whatever appears in the manner in which it appears, that is as it manifests itself to consciousness, to the experience.

(Moran, 2000, p. 4)

As a philosophical movement, phenomenology evolved early in the 20th century, a time when many philosophers were turning away from modernist views of the nature of truth and knowledge (Dowling, 2007; Moran, 2000). Herbert Spiegelberg (1960), a prominent phenomenological philosopher, divides the phenomenological movement into three phases (a) the Preparatory phase, (b) the German phase and (c) the French phase. He chose the word ‘movement’ to represent the fluidity and diversity within the philosophy of phenomenology.

Spiegelberg’s preparatory phase refers to the foundational contributions of Franz Brentano (1838-1917) and Carl Stumpf (1848-1936). Brentano’s goal was to reform philosophy in the service of humanity so that philosophy could provide answers that organized religion could no longer supply. Stumpf, Brentano’s student, was the first to demonstrate the scientific value of phenomenology. The second phase of the phenomenological movement, the

German phase, was dominated by Edmund Husserl (1859-1938) and Martin Heidegger (1889-1976). The third phase of the phenomenological movement occurred when, during the Nazi administration, Husserl's papers were transferred to Louvain. Following World War II, the phenomenological movement was carried on by French philosophers, notably Gabriel Marcel (1889-1973), Jean-Paul Sartre (1905-1980) and Maurice Merleau-Ponty (1908-1961). The second phase of the phenomenological movement, as delineated by Spiegelberg (1960), and the phenomenologists that came to define it, form the focus of the remainder of this section.

2.2.1 Husserlian Phenomenology

Edmund Husserl (1859–1938) is considered the founding father of the philosophical school of phenomenology (Draucker, 1999; Kumar, 2012; Maggs-Rapport, 2000). Husserl was driven by the search for the essence, or foundations, of human knowledge; a search which had dominated western philosophy since Descartes (1596-1650) (Koch, 1995). Indeed, Husserl (1998) states 'explicitly that the study of Descartes' Meditations has influenced directly the formation of the developing phenomenology and given it its present form, to such an extent that phenomenology might almost be called a new twentieth century Cartesianism' (p.3). Cartesianism is based on a fundamental distinction between the 'inner' world of the mind or soul, and the 'outer' physical world with which it comes in contact (Thomas et al, 2013). This dualistic view, where the subject experiences, and has knowledge of, the outside (object) world through sense data and resulting mental representations, underpins, not only Husserlian phenomenology, but Western thought in general.

Husserl was fascinated by 'the mystery of subjectivity and the question of the constitution of objectivity; that is, how does consciousness attain to objective knowledge?' (Moran, 2000, p. 61). **Consciousness**, according to Husserl, is the basis of all experience. He devoted his career to the study of human consciousness, describing it as 'the wonder of all wonders' (Husserl, 1970b, p. 18). Indeed, in his seminal text *Logical Investigations* (1970a), Husserl defined his phenomenology as 'the science of the essence of consciousness' (p.33). He believed phenomenology would be the means by which the experience of

phenomena, as they appear through human consciousness, could be studied (Crotty, 1996). He summed up this emphasis on how phenomena appear in human consciousness, as opposed to how they are supposed to appear in accordance with some abstract theory, in his renowned call '*zu den sachen selbst!*', or 'to the things themselves!' (Husserl, 1965, p. 116).

Husserl (1970a) introduced the concept of *lebenswelt* or '**lifeworld**' to describe the world of lived experience, or the world as experienced in the '**natural primordial attitude**' (p.186). This natural primordial attitude is central to Husserlian phenomenology, indeed phenomenology as a whole. Husserl makes a critical historical and phenomenological distinction between (a) the theoretical attitude to life, borrowed from the Greeks, which is the foundation of western intellectual and scientific culture, and (b) the natural pre-theoretical attitude to life driven by the desire to simply wonder at things being as they are (van Manen, 1990). But while wonder is a natural human attitude, 'the modern theoretical attitude tends to turn us into non-participating spectators, surveyors of the world' (van Manen, 1990, p. 182). The phenomenological attitude is predicated upon a sense of wonder, or to paraphrase Merleau-Ponty (1962, pp. vii-xxi) a certain awareness, a certain kind of attentiveness and will to seize the meaning of the world.

During the course of his career, Husserl produced a voluminous conceptual repertoire. However, three concepts dominate Husserlian phenomenology; intentionality, phenomenological reduction and essences (Spiegelberg, 1960). Husserl, following in the footsteps of Brentano, argued that intentionality is the fundamental structure of consciousness (Spiegelberg, 1982). He suggested that every mental act is directed towards some object, this directedness being '**intentionality**' (Moran, 2000). Thinking (imagining, perceiving, remembering etc.) is always thinking *of* or *about something*. Hearing is hearing something, pointing is pointing at something. All human activity is actively oriented, directed by that which orients it. We are not reflexively aware of our intentional orientation to the world. In other words, it is not possible to experience something while reflecting on the experience. Intentionality is only retrospectively available to the consciousness.

Phenomenological reduction, sometimes referred to as eidetic reduction or ‘bracketing’, is a means by which we may discover the essential structures of the lifeworld (*lebenswelt*). van Manen (1990) outlines several stages in phenomenological reduction. First, reduction requires the awakening of a profound sense of wonder towards the phenomenon. This fundamental wonder and amazement, according to van Manen (1990), ‘animates one’s questioning of the meaning of the experience of the world’ (p.185). Second, reduction requires the suspension of one’s subjective feelings, preferences, inclinations or expectations that may obstruct one’s awareness of a phenomenon or experience as it is lived through. Third, one needs to peel away the theoretical or scientific conceptions or thematisations which overlay the phenomenon in question as they prevent one from seeing the phenomenon in a non-abstracting manner. Finally, one needs to see past the particularity of lived experience towards the universal, essence or *eidōs* (Greek meaning ‘shape’) of the phenomenon. Husserl considered the result of phenomenological reduction to be the essence of the phenomenon in question. However, contemporary phenomenologists, such as Merleau-Ponty (1964), stress that the reduction should not be seen as an end in itself, rather as a means to an end. The reduction allows us to return to the lived experience in an enriched and deepened fashion. According to Merleau-Ponty (1964) ‘the eidetic reduction is [...] the determination to bring the world to light as it is before any falling back on ourselves has occurred, it is the ambition to make reflection emulate the unreflective life of consciousness’ (p.xvi).

Husserl believed phenomenological reduction to be the ultimate vehicle to the **essence**, or essential structures, of a phenomenon. The *eidōs*, or essence, of a phenomenon or thing is what makes a thing what it is, without which it could not be what it is (Husserl, 1982). To illustrate this, van Manen (1990) encourages the use of ‘free imaginative variation’ (p.107). Free imaginative variation allows us to comprehend the essence of a phenomenon by asking; is this phenomenon still the same if we imaginatively change or delete this theme or essence from the phenomenon? For example, we presume the presence of children is essential to parenting. To test this essence, van Manen (1990) suggests we try to imagine the experience of parenting such that this experience does *not* include children. This seems impossible. Therefore we

determine that the essence of being a parent is to live in a mothering or fathering relation to a child, regardless of whether that relation is a biological, adoptive, surrogate or another form of relation.

Husserl cast himself in the role of founder of a new and radical movement, ‘a Moses leading his people to the new land of transcendental subjectivity’ (Moran, 2000, p. 2). However, many of his students disagreed with elements of Husserl’s phenomenology. They were unconvinced by the value of reduction, or indeed the possibility of carrying it out, and many felt that Husserl had lapsed back into the neo-Kantian idealism from which phenomenology had originally sought to free philosophy (Moran, 2000). Many of these students embarked on their own paths to understanding, leading Husserl, towards the end of his life, to declare himself a ‘leader without followers’. Indeed, the French philosopher, Paul Ricoeur (1987), once described phenomenology as ‘the story of the deviations from Husserl’ (p.9).

One of the main deviations from Husserlian transcendental phenomenology, hermeneutic phenomenology, was led by Husserl’s student, Martin Heidegger. The term hermeneutic (from the Greek *hermeneuein* meaning to ‘translate’ or ‘interpret’) is thought to be derived from the Greek God Hermes, whose task it was to interpret and communicate messages from Zeus and the other Gods to the ordinary mortals. Heidegger sought to fuse the descriptive orientation of Husserlian phenomenology with the interpretative orientation of hermeneutics. While Husserl is considered its founder, Heidegger is considered the transformer of phenomenology (Moran, 2000).

2.2.2 Heideggerian Phenomenology

Heideggerian phenomenology is primarily concerned with the situatedness of human being-in-the-world (Heidegger hyphenated this link between words to emphasise the inseparability between being in and the world around us). It is this concern that marks Heidegger’s departure from Cartesianism with its ‘notions of ‘mind’, ‘world’ and ‘representation’’ (Bracken, 2002, p. 88). Heidegger referred to this human being-in-the-world as *Dasein*, a German word which literally translates as there-being (da-there; sein-being). In German the word ‘Dasein’ can mean human being although the usual word for human

being is 'Mensch'. Heidegger favoured 'Dasein' over 'Mensch' as it avoided the traditional metaphysical connotations and emphasised the point that its mode of being is not the mode of being of an object. As Schmidt (2006) highlights, 'the mode of being of human beings is to be there, that is, in the world' (p.52). Heidegger (1928/1999) himself took pains to clarify, using quotation marks, that Dasein is "'our' 'own' Dasein' (p.5) – each of us has a mode of being that is Dasein and this mode of being is our own, 'but not in the sense that I am something else, a substance or subject, that has the mode of being of Dasein. Nor am I an individual viewed from the outside' (Schmidt, 2006, p. 52).

'Our own' is rather a how of being, an indication which points to a possible path of being-wakeful.

(Heidegger, 1928/1999, p. 5)

The 'how' of being is our manner of living. It can be wakeful in that we can be aware of this manner of being, or we can be unaware, as if sleeping through life. This is important as it reflects the manner in which our way of being includes a capacity to understand our own manner of being. The means of understanding the being of being, according to Heidegger, is through hermeneutics.

Hermeneutics is the announcement and making known of the being of a being in its being.

(Heidegger, 1928/1999, p. 7)

A second way in which Heidegger diverges from his teacher Husserl is in relation to the very **nature of truth** itself. Husserl, as explored previously, felt that philosophy should focus on essences and procuring a pure description of the things themselves as they are experienced through our consciousness. Heidegger, however, accuses Husserl of presupposing the subject-object divide that has defined modern philosophy (Cartesian dualism) where the ego, as subject, is confronted by external objects. Instead he believes that **meaning** is inherent within lived experience, that 'a subject does not attach meaning to an experienced object, but rather that the meaning is already there as soon as the so-called object is present' (Schmidt, 2006). Heidegger gave an example of this in his 1919 lecture series 'The Idea of Philosophy and the Problem of

Worldviews'. He enters the lecture theatre and looks at the lectern. In his experience he doesn't see a sequence of brown surfaces that meet at right angles nor a small box on a larger box, but rather, all at once, the lectern. The lectern, for him, is not a meaning that he added to the sense data of brown surfaces, as empiricists would argue. Nor does he have the experience of whole lectern by focusing on one aspect of it as Husserl would suggest. Heidegger sees it all at once and in context. He encourages his students to examine their own immediate experience of the lectern as well as imagine what the experience of the lectern would be like for a farmer from the Black Forest or a native from Senegal. For Heidegger the lectern is too high (Heidegger was quite short) and somebody had left a book on top crowding the available space. He experiences the lectern from a particular orientation, with a particular elucidation and from a particular background. The lectern, as he experiences it, already carries a particular meaning – one which he cannot 'forget' nor bracket out. The environment is not laden with objects to which the subject must attach meanings rather the lived environment is at once meaningful. This was perhaps Heidegger's most radical departure from Husserlian phenomenology and his most profound addition to philosophy. Meaning is encountered in the lived experience itself.

While Heidegger considered hermeneutics 'the announcement and making known in language the being of a being (Dasein) in its being' (Schmidt, 2006, p. 58), he considered phenomenology to be the specific 'how of research' (Heidegger, 1928/1999, p. 58). Its aim is to approach objects of investigation 'as they show themselves in themselves' (Heidegger, 1928/1999, p. 58). However, we typically approach an object as it shows itself in itself in the way we are already familiar with it – a way that is usually a result of **tradition**. Tradition does not necessarily provide an accurate understanding and therefore a 'fundamental historical critique' (Heidegger, 1928/1999, p. 59) is required. 'This means a regress to Greek philosophy, to Aristotle, in order to see how a certain original dimension came to be fallen away from and covered up and to see that we are situated in this falling away' (Heidegger, 1928/1999, p. 59). The original dimension Heidegger speaks of must be uncovered – a process which begins by the reader taking a 'step away from the subject matter initially given and back to that on which it is based' (Heidegger, 1928/1999, p. 58). In

other words what is initially presented for hermeneutic explication, what Heidegger calls 'forehaving', 'requires further analysis to uncover the actual structure or concept that permits what is initially presented to be there at all' (Schmidt, 2006, p. 57).

Fore-having (*Vorhabe*) is one the three '**fore-structures**' that, for better or worse, form the basis of all interpretation. 'The interpretation of something as something is essentially grounded in fore-having, fore-sight, and fore-conception' (Heidegger, 1927/1996, p. 150). Fore-having, as mentioned above, refers to what one has before. As Heidegger (1927/1996) points out 'interpretation operates in being toward a totality of relevance which has already been understood' (p.150). We all already know something about that which we seek to understand. The second forestructure, fore-sight (*Vorsicht*), literally means a previous looking toward. Vorsicht "'approaches' what has been taken in fore-having with a definite interpretation in view' (Heidegger, 1927/1996, p. 150). We consciously or unconsciously look for what we might expect, or are primed, to see. The third fore-structure is fore-conception (*Vorgriff*) which means previously grasped in a conceptual sense. 'Interpretation has always already decided, finally or provisionally, upon a definite conceptuality' (Heidegger, 1927/1996, p. 150). Heidegger (1927/1996) makes the point that 'interpretation is never a presuppositionless grasping of something previously given' (p.150) and argues that, even in the most exact interpretation, any claim to a presuppositionless 'what 'is there'...is nothing else than the self-evident, undisputed prejudice of the interpreter' (p.150). This point is critical in that it emphasises Heidegger's thesis that no understanding can avoid these fore-structures of understanding. Even 'theories of direct sense perception or direct intuition merely cover over what actually happens and are the result of a prejudice in the one who claims to be able to understand in this manner' (Schmidt, 2006, p. 72).

Furthermore, if all interpretation begins from a background understanding (forestructures) – a background that determines the questions that can be formulated and 'what counts as a satisfactory interpretation, yet that can never be made completely explicit and called into question' (Dreyfus, 1991, p.200) - then 'how should it produce scientific results without going in a circle?'

(Heidegger, 1927/1996, p. 152). The answer is that understanding *is* inherently circular. It always begins with a projection or anticipation of meaning and proceeds to confirm or alter this projection in a circular fashion. Understanding takes place within the **hermeneutic circle** (*hermeneutischer Zirkel*).

The hermeneutic circle itself reflects an ongoing relation between Dasein's ontological and ontic state (Porter & Robinson, 2011); between the being of a being and that which exists as a consequence of the being of a being; between the whole and its parts. An interpreter approaching a text first approaches the text as a whole. They read a sentence or a paragraph (a part) and immediately begin to form an opinion about this part with respect to an imagined or supposed whole. The interpreter then uses this sense of what the whole must be like to continue to read successive parts and these parts, in turn, are referred back to a sense of the whole – which changes in light of knowing more and more parts (Figure 1).

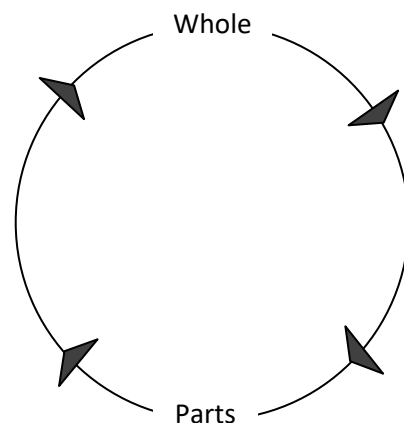


Figure 1 The hermeneutic circle of understanding

To provide a concrete example, consider the following four ‘parts’, pausing to consider the ‘whole’ after each one.

John was on his way to school.

He was worried about the maths lesson.

He wasn't sure if he could control the class today.

It was not part of the janitor's duties.

(Segal, Williams, & Teasdale, 2002, p. 224)

At first, the reader may have imagined a small boy on his way to school but, as each part revealed itself, the whole altered so that, by the end, John was an adult janitor facing a somewhat unreasonable task. The first sentence creates a preconception about the whole which in turn changes in light of each additional part.

While Heidegger was clear about the right way *in* to the hermeneutic circle, he fails to offer a way *out* of the circle, indeed believing that there *is* no way out of the circle. It was up to his student Hans Georg Gadamer to offer a means of exiting the hermeneutic circle and reaching understanding. Gadamer's ideas on this, and other aspects of the relationship between hermeneutics and phenomenology, will be explored in the subsequent section.

Over the course of a long and controversial career Heidegger developed ideas that have exerted a seminal influence on contemporary European philosophy and most particularly phenomenology and existential philosophy. This section focused on a mere five of these ideas; Dasein, the nature of truth, tradition, forestructures of understanding, and the hermeneutic circle – all of which directly shape the research presented in this thesis as well as the manner in which it is presented.

Considered by some to be the most important and influential philosopher of the 20th century (Critchley, 2009), Heidegger's ideas have impacted on areas far beyond philosophy, for example literary criticism (e.g. Ziarek, 1989), theology (e.g. Caputo, 1993), psychotherapy (e.g. Guignon, 1993; Polkinghorne, 1983) and cognitive science (e.g. Dreyfus, 2007; Wheeler, 2005). He was the first to outline the importance, indeed necessity, of hermeneutics to a phenomenology that seeks to understand the nature of being and it is this relationship, the relationship between hermeneutics and phenomenology, that his student, Hans Georg Gadamer, would go on to solidify.

2.2.3 Gadamerian Phenomenology

Hans-Georg Gadamer, in his magnum opus *Truth and Method* (1960), advanced the work of Heidegger, his teacher and mentor. He furthered

Heidegger's notion of understanding as an active enterprise that we engage in in the light of **tradition** or the values, beliefs, rituals etc. handed down to us by society through **language**. Our tradition shapes our **prejudice** – or the pre-judgements that form the anticipatory starting point of all interpretation. Like Heidegger, Gadamer believed that our prejudice should not, in fact cannot, be suspended or omitted from any attempt at understanding. Gadamer takes issue with the negative connotations often associated with the term prejudice and argues that, rather than closing us off, our prejudices are themselves what open us up to what is to be understood. As such he attempts to retrieve a more positive conception of prejudice (*Vorurteil*) that returns to the original meaning of the term as 'pre-judgement' (Latin *prae-judicium*) – a meaning that was lost in the Enlightenment enterprise of reason.

Just as our tradition, language and prejudice influence how we understand the world, our history also has an 'effect' on our being-in-the-world. Gadamer calls this *Wirkungsgeschichte* or 'effective history' and, as with prejudice, if left unattended, our effective history has the potential to limit our capacity for understanding. Therefore our task is to become attuned to the influence of history in shaping our presuppositions and prejudices and enter a mode of being that is conscious of its own historical 'being effected'. Gadamer called this '**historically-effected consciousness**' (*wirkungsgeschichtliches Bewußtsein*).

A person who believes he is free of prejudices, relying on the objectivity of his procedures and denying that he himself is conditioned by historical circumstances, experiences the power of the prejudices that unconsciously dominate him as a *vis a tergo* [force acting from behind].
(Gadamer, 1960/1989, p. 360)

Awareness of our tradition, prejudices and the historically effected nature of our understanding, offers us awareness of our overall hermeneutical situation or what Gadamer calls our **horizon of understanding**. Gadamer defines horizon as 'the range of vision that includes everything that can be seen from a particular vantage point' (Gadamer, 1960/1989, p. 301). Our horizon of understanding represents what we can 'see' or know from our particular point in time and history, and in light of our previous understandings and prejudices.

It is this horizon that we bring to the act of understanding, with understanding itself, according to Gadamer, being the result of a **fusion of horizons** (*horizontverschmelzung*). As Porter and Robinson (2011) highlight, ‘understanding happens through a gradual and perpetual interplay between the subject matter and the interpreter’s initial position – a fusion of one’s own horizon and the horizon of the text or other’ (p.86).

However, Gadamer’s concept of a fusion of horizons has been subject to criticism (Hirsch, 1967). E.D. Hirsch (1967) critically asks ‘how can an interpreter fuse two perspectives – his own and that of the text – unless he has somehow appropriated the original perspective and amalgamated it with his own?’ (p.254). Hirsch’s point is that to fuse horizons the interpreter must first understand the author’s underlying intention (as suggested by Husserl) which they have conveyed via a series of linguistic signs (words), and then they may look to fuse this horizon with their own. He suggests that these are two separate activities and in overlooking the first, Gadamer is betraying his previous ideas around the role of prejudice, tradition and history in determining the understanding that may be explicated. Hirsch supports the concept of prejudice and recognises that interpretations begin with a preapprehension of the whole which affects the understanding of the parts. However he feels the hermeneutic circle ‘is not vicious [i.e. never ending] because a genuine dialectic always occurs between our idea of the whole and our perception of the parts that constitute it’ (Hirsch, 1967, p.259). Hirsch (1967) suggests that exiting the hermeneutic circle is possible because the shared linguistic norms and shared understandings (which he refers to as genre), provide the basis for interpretive hypotheses that can be validated (these notions of validity will be explored in further detail in Chapter 4 methodology). In sum, while Gadamer feels that understanding can be reached through a fusion of horizons, Hirsch argues that this fusion can, and must, be validated. This study proceeds with the perspective that ‘to understand is often a matter of negotiating a tentative truth or belief about what is presumed to be the most accurate meaning, given all of the available evidence. It is rarely ever final’ (Porter and Robinson, 2011, p.86).

Gadamer's (1960/1989) contribution was, in his own words, to address 'the hermeneutical problem disclosed by Heidegger's existential analysis of human being' (p.245). In doing this he worked out the particulars of the relationship between hermeneutics and phenomenology and concretised the relationship between the two. This section outlined six ideas he developed or introduced in *Truth and Method* (1960/1989); tradition (as first proposed by Heidegger); the relationship between language and understanding; the prejudice or pre-judgements we bring with us into every hermeneutic encounter; how these, and our consciousness in general, is shaped by history, and; our 'horizon' and how this may be fused with that of another in order to reach understanding. What unites these contributions is a sense of the importance of bringing the influence of tradition, history and prejudice into our conscious awareness as much as is possible. The next chapter, fore-structures of understanding, aims to do this by explicating the influence of history and prior ways of thinking about the phenomenon, as well as offering insight into the researcher's own horizon of understanding.

2.3 Hermeneutic phenomenology as an approach to research

Hermeneutic phenomenology as an approach to research is a practical extension of hermeneutic phenomenology as a philosophy. It presupposes the same principles: that human beings cannot be *explained* in the way that natural objects can be, but instead must be *understood* (Dilthey, 2002); that understanding is the attempt of one being in its being-in-the-world to understand the being of another being in its being-in-the-world and is, therefore, wholly shaped by the world in which both beings exist; that understanding is an interpretative act, one that is constantly revolving and evolving in a circular fashion between parts and whole, and that this circle can be exited, and understanding can be reached, if only temporarily, through a fusion of horizons.

Hermeneutic phenomenology is at once 'a philosophy, a perspective and an approach to practice and research' (Munhall, 1994, p.14). This section aims to build on the previous, philosophy, section by exploring hermeneutic phenomenology as a research approach. It begins by outlining the approach

itself; looks at what it can and cannot shed light on, in the Diogenesian sense, and; outlines a series of principles proposed by van Manen (1990) to act as guides for those undertaking a hermeneutic phenomenological research journey. This section then concludes by examining the strengths, as evidenced through a series of exemplar studies, and limitations of adopting a hermeneutic phenomenological approach to research.

As an approach to research, hermeneutic phenomenology has been defined as:

the phenomenological and hermeneutical study of human existence: phenomenology because it is the descriptive study of lived experience (phenomena) in the attempt to enrich lived experience by mining its meaning; hermeneutics because it is the interpretive study of the expressions and objectifications (texts) of lived experience in the attempt to determine the meaning embodied in them.

(van Manen, 1990, p. 38)

In more practical terms, the central aim of hermeneutic phenomenological research is to understand the lived experiences of other people and how they make sense of, or ascribe meaning to, these experiences (Finlay, 2011; Munhall, 2012; Taylor, 1994). In contrast to more quantitatively oriented studies, hermeneutic phenomenology does not seek to, as van Manen (1990) puts it, ‘pulverise life into minute abstracted fragments and particles that are of little use to practitioners’ (p.7). Its focus is on understanding.

Understanding is perhaps one of the most important gifts one human can give to another. If we learn not only with our minds but with our spirits, the meanings of experience, we might better be able to say ‘I understand’. People reach out for this, bemoan that no one understands, beg for understanding in their choices. Many practitioners in the mental health care field believe it is understanding or feeling understood that cures the person. Isn’t that what we all wish for – to be understood?

(Munhall, 1994, p. 170)

Munhall (1994) continues by stating that spending billions on health and health care, ‘without reflection as to meaning, is utter foolishness, if not insanity’ (p.178).

The desired end-point of a hermeneutic phenomenological research project is a description which reawakens or ‘re-presents’ the nature of an experience or

phenomenon in a fuller and deeper manner. The purpose of this description is to generate an insight into, and an understanding of, the human condition (van Manen, 1990). It often articulates things we already know tacitly but have not been able to put into words, or as Harman (2007) puts it, it draws ‘something forgotten into visibility’ (p.92).

Drawing something forgotten into visibility requires an openness – a conscious effort to avoid being ‘obstructed by pre-conceptions and theoretical notions’ (van Manen, 1990, p. 184). As Kalfe (2011) puts it, the focus of hermeneutic phenomenological research is on ‘uncovering rather than accuracy, and amplification with avoidance of prior knowledge’ (p.190). Hermeneutic phenomenological researchers acknowledge the impossibility of setting aside our prejudices or ‘historically effected consciousness’ (Gadamer, 1960/1989) but recognise that a fresh perspective cannot be achieved by looking through the prism of existing theory. Accordingly, instead of providing a review of existing understandings, ideas and theories, many hermeneutic phenomenological studies, this one included, refrain from presenting a traditional literature review – at least until the latter stages of the research process (Munhall, 2012; Smythe & Spence, 2012).

The attempt to remain ‘open’ to phenomena has a number of methodological and practical implications for hermeneutic phenomenological researchers. Methodology, stemming from the Greek *hodos* meaning ‘way’ and *logos* meaning ‘to study’, means ‘the pursuit of knowledge’. Method, stemming from the Greek *methodos*, implies the ‘mode’ by which knowledge is pursued. Hermeneutic phenomenology is very clear in the direction of its methodological pursuit of knowledge, but, as this direction is defined by the attempt to (re)awaken or develop a fresh understanding of a phenomenon, it is an approach unenamoured by ‘fixed procedures, techniques and concepts that would rule-govern the research project’ (van Manen, 1990, p. 29). It is an approach that avoids method for methods sake and is not supported by a step-by-step *methodos* or way. Barthes (1986) warns against a preoccupation with method;

Some people speak of a method greedily, demandingly; what they want in work is method; to them it never seems rigorous enough, formal enough. Method becomes a Law...the invariable fact is that a work which constantly proclaims its will-to-method is ultimately sterile...[there is] no surer way to kill a piece of research and send it to join the great scrap heap of abandoned projects than Method,

(Barthes, 1986, p.318)

Heidegger talked about phenomenological reflection as following certain woodland paths towards a 'clearing' where something could be shown or revealed in its essential nature. These paths (methodos), however, cannot be determined by fixed signposts, rather 'they need to be discovered or invented as a response to the question at hand' (van Manen, 1990, p. 29). Indeed, it has been said that the method of hermeneutic phenomenology is that there is no method (Gadamer, 1979; Rorty, 1979; van Manen, 1990). However, hermeneutic phenomenological scholars recognise that in order to encourage researchers to adopt a hermeneutic phenomenological approach in a world defined by the rigorous pursuit of knowledge, the approach needs to be underpinned by some guiding principles. Accordingly, this study follows the guiding principles of Max van Manen (1990), a Dutch/Canadian educational philosopher, on the basis that 'his method [is] the most consistent with phenomenology as a philosophy' (Munhall, 2012, p. 117).

van Manen (1990) outlines six principles which he encourages researchers to consider as a 'set of guides and recommendations for a principled form of inquiry that neither simply rejects or ignores tradition, nor slavishly follows or kneels in front of it' (p.30). These are:

- i. Turning to a phenomenon which seriously interests us and commits us to the world;
- ii. Investigating experience as we live it rather than as we conceptualise it;
- iii. Reflecting on the essential themes which characterise the phenomenon;
- iv. Describing the phenomenon through the art of writing and rewriting;
- v. Maintaining a strong and oriented pedagogical relation to the phenomenon;
- vi. Balancing the research context by considering parts and whole.

Van Manen (1990) offers each of these six methodological themes, which will be explored in more detail below, as ‘practical approaches that may be helpful in doing hermeneutic phenomenological human science research’ (p.30).

i. Turning to the nature of lived experience

A deep interest (inter-esse, to be or stand in the midst of something) in the nature of lived experience, according to van Manen (1990), is the starting point of all phenomenological research. Dilthey (1985) suggests that lived experience is to the soul as breath is to the body: ‘just as our body needs to breathe, our soul requires the fulfillment and expansions of its existence in the reverberations of emotional life’ (p.59). Lived experience is the breathing of meaning. Like the flow of breath, consciousness breathes meaning in a constant to and fro movement between the inner and the outer (van Manen, 1990).

Once a researcher has turned to a lived experience that deeply interests them, they may orient themselves more carefully in the form of research question(s). Hermeneutic phenomenological research questions ask ‘what is the nature of this lived experience?’; ‘what does it mean?’; ‘what is it like?’. This study is oriented by the following questions:

- What is the nature of the lived experience of third level students with mental health problems?
- What meaning do these students ascribe to their experiences?

The foundation of hermeneutic phenomenological questioning, according to Gadamer (1979), is the opening up, and keeping open, of possibilities. The problem, if it could be called that, associated with having a deep interest in a phenomenon, is that we often know too much about the phenomenon. Or, more accurately, we carry a forestructure of understanding (Heidegger, 1962), assumptions, as well as an existing knowledge base, which funnel our interpretation of the nature of the phenomenon, therefore reducing our ‘openness’.

As van Manen (1990), points out, it is not possible to forget or ignore what we already 'know', rather we should make explicit our understandings, beliefs, biases, assumptions and theories in order to prevent presuppositions creeping unnoticed into our interpretations. Phenomenological research is underpinned by the belief that all research is the project of a human being, who sets out from their individual, social and historical context to make sense of a particular phenomenon. It recognises that an objective orientation to a phenomenon is neither possible nor desirable and the forestructure (Heidegger, 1962) and prejudices which shape our orientation to the phenomenon are an integral part of the research process.

ii. Investigating experience as we live it

Hermeneutic phenomenological research aims to renew our understanding of lived experience. Merleau-Ponty (1962) believed that turning to the nature of lived experience requires that we re-learn to look at the world by re-awakening the basic experience of the world. This turning 'to the things themselves' (*zu den sachen selbst!* Husserl, 1965, p.116) can only be achieved by understanding lived experience from the perspective of those 'experienced' in living the phenomenon. As such, while hermeneutic phenomenological data can come in many forms, each form is concerned with investigating experience as we live it (van Manen, 1990).

iii. Reflecting on essential themes

Phenomenological themes, according to van Manen (1990), may be understood as the structures of experience. Data analysis in hermeneutic phenomenological research requires that the researcher reflectively brings to the fore that which tends to be obscure, that which tends to evade the intelligibility of the modern theoretical attitude. Reflecting on essential themes allows phenomenologists effect a more direct contact with an experience as lived.

iv. The art of writing and rewriting

The fourth of van Manen's methodological themes involves communicating lived experience through the art of writing and rewriting. To write, for van

Manen (1990), is to ‘author a sensitive grasp of being itself’ (p.132). As such, the process of writing in hermeneutic phenomenological research acts as another method (*methodos*) of understanding the nature of lived experience. In this sense, writing is at the very heart of the research process (Rorthe, 2000).

The act of writing fixes our thoughts on paper. It seeks to externalise our internal knowledge. Indeed, as Gadamer (1979) reminds us, thought and language derive their contemporary meaning from the same etymological source: *logos* (meaning both word and reason). To write, as Barritt et al. (1984) state, is ‘to learn about the adequacy or inadequacy of your thoughts’ (p.16). It is to measure our thoughtfulness, ‘to measure the depth of things as well as to come to a sense of one’s own depth’ (van Manen, 1990, p. 172). The adequacy or inadequacy of a hermeneutic phenomenological description can be assessed based on the degree to which it reawakens the readers’ basic, tacit, understanding of the experience. A good piece of writing allows the reader ‘to see the deeper significance, or meaning structures of the lived experience it describes’ (van Manen, 1990, p. 122).

Connecting with the nature of lived experience requires the researcher to engage in a complex process of writing and rewriting (re-thinking, re-flecting, re-cognising). This process, according to Sartre (1977), is aimed at creating depth through the construction of successive or multiple layers of meaning. The art of writing and rewriting is the *methodos* by which hermeneutic phenomenological researchers strive to do justice to the fullness and ambiguity of lived experience.

v. ***Maintaining a strong and oriented relation***

Hermeneutic phenomenological research, van Manen warns, is extraordinarily demanding of its practitioners. Without a strong and oriented relation to the fundamental question underlying the research a researcher may be tempted to:

get side-tracked or to wander aimlessly and indulge in wishy-washy speculations, to settle for preconceived opinions and conceptions, to become enchanted with narcissistic reflections or self-indulgent preoccupations, or to fall back into taxonomic concepts or abstracting theories.

In order to prevent such distractions van Manen (1990) advises researchers to develop and maintain a strong and oriented relation to the subject of their research. He believes this cannot be achieved by adopting an ‘attitude of so-called scientific disinterestedness’ rather by ensuring that we are ‘animated by the object in a full and human sense’ (van Manen, 1990, p. 33). A strong and oriented relation allows the researcher to ‘see’ the phenomenon, not just the measurable exemplifications of the phenomenon, but the meaning and significance that is often concealed beneath theoretical overlays and frameworks. He further develops this point with an example from his own pedagogical research area; highlighting the way in which those operating from a positivistic perspective tend to confuse the phenomenon of teaching with what we see teachers *do*. Quoting Langeveld (1965), teaching, states van Manen (1990), requires, not so much that one is able to *do* something, rather that one has to *be* something. In order not to become distracted by the ‘doing’ that surrounds the phenomenon, a researcher must remain strong in their orientation to the fundamental question underlying their research.

vi. Balancing the research context by considering parts and whole.

The final of van Manen’s methodological themes focuses on balancing the research context by considering parts and whole. There is a risk in hermeneutic phenomenological research of becoming so absorbed in the question that one may lose sight of the purpose of the research which, as van Manen (1990) reminds us, is ‘to construct a text which in its dialogical structure and argumentative organisation aims at a certain effect’ (p.33). In order to prevent becoming buried in the writing (the parts), van Manen (1990) believes it necessary to take a step back at regular intervals, and look at the project in its totality (the whole).

These six methodological principles, which van Manen offers to ‘animate inventiveness and stimulate insight’ (1990, p.30), will guide this study’s attempt to capture and describe the nature of the lived experience of third level students with mental health problems as well as the meaning they ascribe to these experiences.

As with all approaches to research, hermeneutic phenomenology has its strengths and limitations. In order to meaningfully represent its strengths, a number of examples of the effective use of hermeneutic phenomenology to illuminate aspects of human being will be outlined below.

2.3.1 Examples of Hermeneutic Phenomenological Research

Hermeneutic phenomenology has been used as a means of understanding many different forms of experiences. Broussard (2005) set out to explore what life was like for women who lived with bulimia nervosa. She felt that nobody could understand why a woman would engage in bulimic behaviours without insight into the woman's life and so adopted a hermeneutic phenomenological approach 'because it was most congruent with the research purpose of interpreting and understanding the experience of actively bulimic women' (Broussard, 2005, p. 43). Broussard collected data via personal diaries, demographic questionnaires and interviews with thirteen women in order to develop an insight into the very private experience of bulimia nervosa. An analysis of the various narratives revealed the self isolation the women experienced as a result of carrying out the bulimic behaviours in secret. They also reported living in fear, both of the negative perceptions and judgement of others and of the thought of living without bulimia and gaining weight. The women described the internal struggle they experienced. In order to pacify this internal struggle, many of the women felt compelled to eat which resulted in guilt, a feeling that they erased through self-induced vomiting. This study offered valuable insight into what it's like to live a life where bulimia makes sense. This insight, Broussard hoped, would help those who worked with, as well as the families of people who live with bulimia appreciate what this life is like from the inside out.

Finlay and Molano-Fisher (2008) used a phenomenological approach to explore the lived experience of rehabilitation following a cochlear implant. The authors sensitively and wondrously captured the experience of Pat, the sole participant, as she learned what sound is and how to hear. Finlay refers to the impact this research had on her and Pat. Pat described the process of being witnessed and listened to as an incredibly empowering experience. She

described to Finlay how she valued the opportunity to talk through and make sense of the surgery and rehabilitation which she felt had derailed her life for a time. Finlay speaks of the positive impact the research and working with Pat had on her and her perception of the world. In addition to changing Finlay's own perception, the research, when published, changed the perception of health professionals working with people considering the option of cochlear surgery. Finlay mentions the many doctors and audiologists from around the world who have contacted her, thanking her and Pat for providing a glimpse into their patients' experience.

Borg and Davidson (2008) sought to explore the everyday experience of severe mental illness. They used hermeneutic phenomenology to examine the experience of finding a place in the world, finding a sense of meaning and purpose as well as a sense of being valued as members of their community. Borg and Davidson carried out two in-depth conversational interviews with seven women and six men who considered themselves as being in recovery or having recovered from severe mental illness. The authors identified a number of themes, the first of which was the participants' concern with 'being normal'. Being normal for participants meant spending time in ordinary environments with ordinary people doing ordinary things such as shopping, paying bills or working in a job. The second theme, which the authors refer to as 'just do it!', reflect the participants' description of recovery as involving action; just 'doing it' regardless of challenges such as the side effects of medication. However, the third theme, 'making life easier', highlights how the participants also recognised the importance of seeking support when they needed it. The participants in Borg and Davidson's study offered valuable insights into the type of support they found 'supportive'. They spoke of how they valued mental health professionals who recognised them as human beings, not just 'patients', and who were able to offer support in all kinds of practical matters, and not just interested in the participants' 'symptoms' and 'illness'. In the final theme, 'being good to yourself', participants talked about how healthy eating and treats such as going on holidays or going to the movies, gave them pleasant experiences and memories to look back to for comfort. These experiences, they felt, were an integral part of the recovery process. Borg and Davidson conclude by highlighting the importance of conceptualising severe mental illness within

the context of everyday life. Recovery, they feel, unfolds within the context of 'normal' environments and activities and not within the 'vacuum' of biomedical diagnoses or symptoms. They suggest practitioners take into account the importance of everyday life and activities in order to support people who experience severe mental illness in leading full and rewarding lives.

A hermeneutic phenomenological approach was used by Nilsson, Naden and Lindstrom (2008) in order to understand the significance of loneliness for people with severe mental illness living alone. The authors used both conversational interviewing and observation to examine the experience of loneliness amongst eight individuals with a diagnosis of schizophrenia. They found that participants felt isolated and excluded from 'normal life'. They felt 'different' and were very much ashamed of this differentness. Shame emerged as a strong theme in this research with the researchers commenting on how participants felt shame at their illness, seeing their illness as a sign of wanting and deficiency as a human being. They spoke of the loss they had experienced as a result of their illness; loss of job, education opportunities, relationships and friendships. Participants in this study spoke of the pain of being an outsider. They found this pain, combined with the torment of loneliness, so strong that suicide was considered a possible release. Most of the participants had attempted to take their own lives at least once. Living alone in a home 'filled with shame' (Nilsson et al., 2008, p. 168), left participants struggling to feel 'at home' there. The authors highlight how this contraindicates the popular drive away from institutions towards community living. They ask if this approach merely rehabilitates people with severe mental illness to 'loneliness' homelessness?' (Nilsson et al., 2008, p. 166). This paper is another excellent example of how hermeneutic phenomenology can be used to explore the depth of human experience. It provides a painful insight into the 'taken for granted' element of the experience of living alone for people with schizophrenia. The authors' conclusion highlights the manner in which the findings of hermeneutic phenomenological studies often challenge dominant political thought – in this case the notion that community living is a positive move for people who experience mental illness. While the authors do not explicitly address

implications, the research itself, by virtue of its powerfully evocative descriptions, succeeds in stirring the reader's consciousness into action.

The above examples are four of many examples of hermeneutic phenomenological research. They were chosen to represent some of the strengths of a hermeneutic phenomenological approach. The first study reflects the effectiveness of hermeneutic phenomenology in offering insight into the complex and difficult-to-understand phenomena such as bulimia nervosa. The second reflects the impact of hermeneutic phenomenological research on participants, the researcher and the wider professional community. The third highlights the importance of capturing the everyday elements of human experience and the fourth represents how a piece of hermeneutic phenomenological writing can reawaken in us the experience of what it is to be human as well as challenge prevailing thought. Each example highlights hermeneutic phenomenology's basic concern with lived experience, in all its ordinariness ('to the things themselves!'), and the depth of perspective that can be gained by attempting to draw into nearness, experiences which have become obscured by passive acceptance.

2.3.2 Limitations of a Hermeneutic Phenomenological Approach

As with all approaches to research, hermeneutic phenomenological research is constricted by a number of limitations. The word limitation, however, gives the false sense that there is an ideal approach, of which this one falls short. Instead, research approaches are better thought of as windows into the same room. The room will look different depending on the researcher's standpoint and what it is they seek to view.

Hermeneutic phenomenology's main limitation is its lack of generalisability. By virtue of its concern with understanding individuals' lived experiences, hermeneutic phenomenological research tends to focus on experiences of a small number of individuals in a small number of settings. Therefore, findings generated using this approach cannot be generalised to a larger population. However, as will be discussed in section 4.6, transferability, or the degree to which a study's findings may be 'transferred' to a similar situation or experience (DiCenso, Guyatt, & Ciliska, 2003), is seen as a more accurate

measure of the applicability of research generated using qualitative approaches such as hermeneutic phenomenology.

A second criticism sometimes levied at hermeneutic phenomenological researchers relates to ‘discrepancies between phenomenological rhetoric and phenomenological practice’ (Paley, 2005, p. 106). Some authors feel that research carried out under the auspices of hermeneutic phenomenology have ‘strayed very far from the original theory’ (Porter, 2008, p. 267) with researchers making claims, particularly relating to generalisability, reality and objectivity, that are beyond the scope of, and often in direct conflict with, the philosophy of hermeneutic phenomenology (Paley, 1997, 2005).

Finally, hermeneutic phenomenology is sometimes seen as lacking practical value. Some would argue that the fact that it does not seek to solve or ‘answer’ a research question makes it a pointless process. This approach does not seek to discover solutions, ‘correct’ knowledge or results, indeed it argues that such things cannot be ‘discovered’ (van Manen, 1990). Some would argue, therefore, that ‘you cannot do anything with phenomenological knowledge’ (van Manen, 1990, p. 45). However, to paraphrase Heidegger, the concern of hermeneutic phenomenology is not whether you do anything with phenomenological knowledge, rather, can phenomenology, if we concern ourselves deeply with it, do something with us?

2.4 Conclusion

Hermeneutic phenomenology is an approach to research that is deeply rooted in philosophy. This approach not only requires a comprehensive understanding of its philosophical origins but requires the researcher to think phenomenologically. This chapter has attempted to outline the philosophical roots of hermeneutic phenomenology and more particularly the contributions of the three main proponents associated with the German phase of the phenomenological movement – Husserl, Heidegger and Gadamer. It then turned its attention to the research approach this philosophical school of thought has inspired and to what, in the Diogenesian sense, what can be seen in the light of the hermeneutic phenomenological lamp. The chapter then

concluded by outlining the guiding principles offered to prospective hermeneutic phenomenological researchers by van Manen (1990) and drawing attention to the strengths and limitations of adopting a hermeneutic phenomenological approach to research.

Armed with an awareness of hermeneutic phenomenology, both as a philosophy and an approach to research, this study will proceed to examine the forestructures that form the basis of interpretation and enter the hermeneutic circle.

3. Forestructures of Understanding

The greatest obstacle to discovery is not ignorance
but the illusion of knowledge.

Daniel J. Boorstein

3.1 Introduction

As outlined in chapter 1, introduction, this thesis is presented in a manner that reflects the activity of preparing for, entering, and exiting the hermeneutic circle of understanding. The first of these activities involves a thorough explication of what Heidegger (1927/1996) termed the ‘forestructures of understanding’ (p.153). It is this activity that forms the basis of this chapter. Beginning with an overview of what Heidegger means by ‘forestructures of understanding’, and why this thesis offers an explication of these in place of a traditional literature review, the chapter proceeds to review how we, as a society, have historically tried to make sense of, and respond to, the phenomenon of madness/mental health. It then turns to examine the assumptions that underlie the three main professional frameworks for understanding the phenomenon, psychiatry, psychology and sociology, before concluding with a reflection on the researcher’s own ‘prejudice’ and how this influenced how she approached the phenomenon.

3.2 Entering the hermeneutic circle

Understanding, as seen in the previous chapter on hermeneutic phenomenology, transpires within the hermeneutic circle. Understanding the lived experience of third level students with mental health problems, and the meaning they ascribe to these experiences, involves entering the hermeneutic circle and proceeding in a circular fashion until, as Hirsch (1967) suggests, an interpretive hypothesis is developed and validated. According to Heidegger (1927/1996) there are two ways of entering the hermeneutic circle – the right way and the wrong way. What separates the two is a conscious awareness of

our presuppositions and prior-understandings, or what Heidegger terms our ‘forestructures of understanding’.

Heidegger (1927/1996) reminds us that interpretation ‘is never a presuppositionless apprehending of something presented to us [rather] interpretation will be founded especially upon fore-having, fore-sight and fore-conception’ (p.123). Collectively known as our forestructures of understanding, these three represent what we already know (consciously or unconsciously) and form the basis for what it is possible for us to understand; ‘[for] we understand in terms of what we already know [because without that] there would be no understanding at all’ (Packer & Addison, 1989, p. 13). According to Heidegger (1927/1996) ‘what is decisive is not to get out of the circle, but to get in it in the right way’ (p.153).

In the circle is hidden a positive possibility of the most primordial kind of knowing, and we genuinely grasp this possibility only when we have understood that our first, last, and constant task in interpreting is never to allow our fore-having, fore-sight, and fore-conception to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out these fore-structures in terms of the things themselves.

(Heidegger, 1927, p.153)

What Heidegger is trying to convey in the above statement is, according to Schmidt (2006), hinted at most clearly in his discussion of fore-conception. There he says that ‘the concepts used in interpretation can be appropriate to the beings to be interpreted or one could try to force beings into inappropriate concepts’ (Schmidt, 2006, p. 74). Forcing beings into existing concepts, whether they are appropriate or not, severely limits the capacity ‘to let what shows itself be seen from itself, just as it shows itself from itself’ (Heidegger, 1927/1996, p. 34).

This brings us to the question as to why not present a review of the available literature currently surrounding the phenomenon – as is more traditionally the case with a thesis or research study of this nature (i.e. PhD). Rather than approach the phenomenon through the prism of existing literature, as is more traditionally the case, interpreters attempting to enter the hermeneutic circle ‘in the right way’ (Heidegger, 1927/1996, p. 153) instead take the opportunity to

explicate and examine their fore-having, fore-sight and fore-conception. This chapter attempts to do just this. Beginning with an examination of how we, historically, have tried to understand the phenomenon of mental health it then attempts to lay out the assumptions associated with three of the dominant modes, or models, of thinking about the phenomenon – medical, psychological and sociological. The chapter then concludes with a more individual overview of the prejudices of the interpreter whose ‘horizon’ was actively engaged in the hermeneutic circle.

But first, attention will turn to what Foucault (1970) refers to as that ‘which is most human in man’ (p.387) – our history. As our history and traditions form ‘the ground and background of all possible meaning’ (Ermarth, 1981, p. 189), its influence must be brought to our conscious awareness so that we may enter the hermeneutic circle with what Gadamer (1960/1989) refers to as a ‘historically effected consciousness’ (p.360).

3.3 The historical perspective

The idea that there can be an accurate history of mental illness, indeed an accurate history of anything, is somewhat of a chimera. History, as Coppock and Hopton (2000) point out, ‘is not some kind of storehouse of pure, uncontaminated ‘truths’ simply waiting for the contemporary researcher to uncover their significance for the present’ (p.13). Rather, to borrow Fulford, Thornton and Graham’s (2006) analogy, history is better conceived as the model of a sculptor, carving out a story. According to historian German Berrios (1996), the model we carve out should be determined by the story which is ‘more suitable to [our] own beliefs and the [subject] under study’ (p.11).

In light of this, the following section is designed, not to provide a factual account of the history of psychological distress (as such a thing would be impossible), rather to stimulate reflective thought. It aims to highlight the various approaches to psychological distress taken throughout the ages and, in particular, the inextricable bind between these approaches and the social, political and religious concerns, norms and values of the age.

3.3.1 Druids, demons and witches

Before medicine, there was magic

(Deutsch, 1937, p.1)

Early civilisations perceived illness, particularly mental illness, as supernatural in origin (Porter, 2002; Robins, 1986; Scull, 2011). The ancient Egyptians considered all diseases as personal demons to be ‘banished’ or ‘driven out’ rather than cured or healed. This banishment was exclusively carried out by priest-physicians who exorcised the physically and mentally ill in elaborate temple-based ceremonies (Deutsch, 1937). The ancient Greeks, like the Egyptians, perceived mental illness as divine or demonical visitations sent down upon human beings by angry deities. In the classic Greek myth, the goddess Hera causes Hercules to be seized by madness in the form of Lyssa, Hercules’ own personal demon.

The idea of madness as a form of supernatural retribution also prevailed in Celtic Ireland. One of the most dreaded necromantic powers of the Celtic Druids was that of causing madness. For this purpose an angry Druid prepared a ‘madman’s wisp’, a ball of straw or grass, which he cursed and flung into the face of his victim who at once became insane or idiotic (Robins, 1986). Belief that madness was a result of being struck by the madman’s wisp existed in Ireland at least until early in the fifth century. References to madmen as those at whom the *dlui fulla* (Fullon’s wisp – Fullon being a celebrated Leinster Druid) was thrown can be found in the *Senchus Mór*, a fifth century volume of the Brehon Laws (Robins, 1986; Kelly, 2005; Commissioners for Publishing the Ancient Laws and Institutes of Ireland, 1865).

The inextricable bind between religion and medicine began to loosen with the development of the Greek spirit of inquiry around the fourth century B.C.E.. Hippocrates (460-370), known as the father of medicine, ridiculed the notion that mental illnesses were supernaturally induced considering them ‘no more divine nor more sacred than other diseases’(Deutsch, 1937). He explained mental illness according to his system of humoral pathology, whereby all

diseases were caused by disproportions of the four humors – black bile, yellow bile, mucus and blood – affecting the heat, cold, dryness and moistness of the body. According to Hippocrates, melancholia, now known as depression, was caused by an excess of black bile (the word melancholia literally meaning ‘black bile’ (Liddell, Scott, & Jones, 1996)). Humoral pathology gave rise to treatments such as purging and bloodletting which would remain popular well into the nineteenth century.

Meanwhile, in Ireland, the advent of Christianity did little to alter the prevailing Pagan beliefs, but merely, as Robins (1986) puts it, ‘put a Christian gloss on existing notions’ (p.4). This gloss painted insanity as the wrath of God as opposed to retribution from the intermediaries of the pagan otherworld. In the Old Testament, the melancholia of King Saul is ascribed to an ‘evil spirit’ sent down by God to trouble him (Deutsch, 1937). In the book of Deuteronomy Moses warns his people that if they ‘will not obey the voice of the Lord your God or be careful to do all his commandments and his statutes...the Lord will smite you with madness and blindness and confusion of mind’ (Deuteronomy 28:28).

The belief in demonical possession, both in its older pagan and newer Christian forms, captured the imagination of the medieval mind. The world and its inhabitants were seen as the chief prizes in a constant battle between good and evil, light and darkness, God and Satan (Deutsch, 1937). Everywhere Satan and his legion of devils were at work striving to ‘possess’ human souls by every ruse possible. Since the insane were largely considered to be possessed, they were brought to priests rather than physicians for treatment. Rites of exorcism became increasingly popular with priests in Vienna credited with exorcising 12,652 demons in the year 1583 alone (White, 1896). According to popular superstition, a favourite practice of the devil was to induce human beings to sell their souls to him in exchange for supernatural powers. Witches, whose supernatural powers included the ability to make themselves invisible, fly through the air, foretell the future and curse their enemies, were considered a constant danger to the community. Seeking out and eliminating witches became not only a religious but a social duty.

For a considerable period church and state throughout Europe pursued the so-called crime of witchcraft with a manic determination; huge numbers of alleged witches were put to death. Many of them were insane persons.

(Robins, 1986, p. 18)

Throughout Europe, people, particularly women, whose mental aberrance or abnormal behaviour failed to meet the Church's and society's rigidly ordained beliefs and practices, were accused of being witches and were cruelly tortured and put to death. This was particularly the case in Protestant countries where the 16th century Protestant reformation had spurred what Robins (1986) refers to as an 'orgy of witch-hunting' (p.19).

Catholic Ireland largely escaped the frenzy of witch-hunting that enveloped England and Western Europe. In fact, Celtic Ireland adopted a more inclusive and pragmatic approach to managing 'the mad'. The Brehon Laws, ancient statutes that governed pre-Christian and early Christian Ireland, outlined considerable provisions for the inclusion and protection of the insane (Kelly, 2005). For example, the Seanchas Mór, or 'Law of Distress', dictated that failing to support or provide maintenance for a family member resulted in a fine; five cows for failing to maintain a madman and ten cows for failing to maintain a madwoman, considerable fines at that time (Robins, 1986). The Brehon Laws regulated and governed Irish society right up until the Tudor conquest of Ireland in the mid-16th century.

3.3.2 The Enlightenment, colonial oppression and 'The Great Confinement'

The Enlightenment, an era of rich new ideas and attitudes dominated by reason, may have marked the end of barbaric witch-hunts but did little to alter the prospects of those with mental health problems. Instead it marked the beginning of a long tradition of segregation and incarceration, or what Foucault (2006) refers to as 'The Great Confinement'.

Both Robins (1986) and Finnane (1981) align the onset of a culture in Ireland where mentally ill people were removed from their communities and incarcerated in institutions with increased control by, and eventual union with,

Great Britain. A century of violence marked by the systematic confiscation and resettlement of Irish land and the implementation of harsh laws aimed at eradicating Catholicism, served to wipe out Celtic traditions and replace them with traditions which Robins (1986) describes as ‘largely Protestant in inspiration’ (p.23).

The protestant ethic, with its emphasis on an ordered society upheld by personal obligation and conformity, viewed deviation from this constricted norm as rejection of acceptable social standards and warranting punishment (Porter, 2002; Robins, 1986). The solution to non-conformity at that time came, as Porter (2002) points out, ‘quite literally in bricks and mortar’ (p.112).

The British ‘segregative response to madness’ (Scull, 1979, p. 30) has been attributed to the rise of industrialism in the late 18th century . The industrial revolution, and what Scull refers to as the ‘commercialisation of existence’, or the formation of a rather crude division between productive and non-productive members of society, ‘prompted the abandonment of long established techniques [such as the family care approach promoted by the Senchus Mór] for coping with the poor and the troublesome’ (Scull, 1979, p. 30). According to Porter (2002) the industrialist mentality viewed institutions as a natural replacement for these long established techniques:

Schools, workhouses, prisons, hospitals and asylums – would these not contain and solve the social problems spawned by demographic change, urbanisation and industrialisation?

(Porter, 2002, p. 112)

Throughout the British Empire, Ireland included, institutions became a panacea for all the undesirable elements of society and, as Robins (1986) points out:

Little distinction was drawn between them. The beggar, the prostitute, the cripple, the scrofulous, the runaway apprentice, the imbecile and the mad were locked up in a variety of penal institutions where all were treated with great harshness (p.24).

(Robins, 1986, p. 24)

This ethos of incarceration quickly led to overcrowding and degradation in already under-resourced Irish jails. In response to growing concerns over

abuses and conditions in these jails, Dean Woodworth of Clogher, a vigorous proponent of the Protestant ascendancy in Ireland, mounted a campaign which led to legislation in 1772 establishing Houses of Industry at Dublin, Clonmel, Cork, Waterford and Limerick. These houses were punitive rather than charitable in design and sought to confine and control ‘sturdy beggars and vagabonds’ as well as give some shelter to the ‘deserving poor’ (Robins, 1986; Walsh & Daly, 2004, p. 14). The proportion of insane in these Houses of Industry grew to such an extent during the late 1700’s that special cells were provided for them (Walsh & Daly, 2004).

3.3.3 Fear and the moral approach

The evolution of institutions presented authorities with a new quandary – how to manage those ‘destined to populate the places of confinement’ (Foucault, 2006, p. 45). Ideas about insanity at the time were limited and abstract. According to Porter (2002) ‘it had long been assumed that the mad were like wild beasts requiring brutal training’ (p.100).

Robert Burton’s *Anatomy of Melancholy* (1621) offered one of the first perspectives on the management of insanity. Burton proposed that insanity was a consequence of Man’s sinful nature and deserving of punishment. The popularity of this view led to the development of treatments such as flogging, starvation, drowning (also known as ‘the bath of surprise’), purging and series of other treatments designed to induce terror (Porter, 2002; Scull, 2011). As late as 1812, Dunstan, the superintendent of St. Luke’s Hospital London, wrote ‘I consider fear the most effective principle by which to reduce the insane to orderly conduct’ (Robins, 1986, p. 24).

However, towards the end of the 18th century, a growing awareness of the link between emotions, social conditions and insanity led to the development of ‘moral therapy’ (Porter, 2002, p. 103). Moral reformers such as French physician Philippe Pinel and Quaker merchant William Tuke, believed that rather than be treated like wild beasts and locked in shackles and chains, the insane should be treated with empathy and kindness. At Tuke’s York retreat for example, the use of violence or restraint was strictly forbidden. There was a strong emphasis on useful occupation and patients were given domestic chores

with increasing responsibility as their health and behaviour improved. In contrast to the prison-like asylums of the time, the York Retreat was bright and welcoming with extensive grounds and a strong connection to the surrounding community (Borthwick et al., 2001).

Moral treatment was heralded as a new dawn in the treatment of the insane. Speaking at the House of Lords in 1852, Lord Shaftesbury claimed that the moral treatment approach was ‘the great and blessed glory of modern science, which, by the blessing of God, had achieved miracles’ (Hodder, 1888, p. 118). The success of moral treatment and new institutions such as the York retreat sparked immense optimism in asylum-based treatment. However, as Robins (1986) points out, moral treatment was ‘little more than a pleasant illusion’ (p.129) in the overcrowded and poorly maintained asylums of 19th century Ireland.

3.3.4 Swift’s hospital and the Growth of Ireland’s Asylum System

Ireland’s first purpose built asylum for the insane, St. Patrick’s hospital, opened in 1757 with money bequeathed by Jonathon Swift. Swift’s original intention was for the hospital to accommodate the pauper insane but financial mismanagement following his death led the Governors to privatise St. Patrick’s, charging ‘boarders’ up to 100 guineas a year in fees (Fuller-Torrey & Miller, 2003).

The proportion of insane occupying the nation’s jails and houses of industry continued to be a source of concern and, following the Act of Union in 1800, a report by a parliamentary committee investigating the needs of the aged and the infirm poor of Ireland recommended the establishment of provincial asylums specifically for pauper ‘idiots and lunatics’ (House of Commons Select Committee Respecting the Poor, 1804, p.3).

It wasn’t until 1810 that a grant was provided to the Dublin House of Industry to establish an asylum ‘for the reception of lunatics from all parts of the kingdom’ (Kirkpatrick, 1931, p. 17). The Richmond Asylum opened in 1815 with the confident assertion that it would ‘supersede the necessity of County Asylums’ (Morley, 1917, p. 338). However it quickly filled to capacity and by

1817 the governor of Richmond noted that ‘applications for admission to our Institution very far exceed the means of receiving them’ (Tuke, 1882, p. 401). Rather than meeting the accommodation needs of the country’s insane, the Richmond Asylum, in conjunction with increased optimism regarding the therapeutic possibilities of asylum-based moral treatment, served only to unearth the considerable numbers of insane whose existence was hitherto unknown to authorities (Finnane, 1981). An ensuing assessment of the true number of insane in Ireland (House of Commons Select Committee on State of Lunatic Poor in Ireland, 1817) led to the construction of a further nine district asylums, marking what Finnane (1981) refers to as ‘the first stage in the foundation of an asylum system in Ireland’ (p.27).

This system would continue to grow at a considerable pace throughout the 19th century. At the beginning of 1837 there were more than 1,600 ‘lunatics’ in the overcrowded district asylums and a further 1,500 in jails, houses of industry and private institutions (House of Commons, 1836). Official concerns regarding the welfare of the insane in houses of industry combined with the social problems presented by the estimated 6,217 mentally disturbed persons wandering the roads as vagrants (Select Committee on the State of the Lunatic Poor in Ireland, 1844) led the government to launch an expansion of the asylum system that would continue until the end of the century. This expansion would see both the extension of the nine existing asylums and the creation of a further thirteen asylums of ever greater proportions (Cork (1852), Killarney (1852), Kilkenny (1852), Omagh (1853), Mullingar (1855), Sligo (1855), Downpatrick (1865), Castlebar (1866), Letterkenny (1866), Ennis (1868), Enniscorthy (1868), Monaghan (1869) and Antrim (1899)). By 1900 there were almost 17,000 persons resident in public asylums throughout Ireland; 56 for every 10,000 of the population compared with 41 in England and Wales and 45 in Scotland (Inspectors of Lunatics, 1901; Inspectors of Lunatics, 1906).

3.3.5 Lunacy Laws

In the early years admission to the new district asylums was relatively straightforward. All those of ‘unsound mind’, as defined by the Lunacy Acts 1821 and 1826, were admitted once accompanied by a medical certificate of

insanity and an agreement that the patient's next of kin would remove him or her when requested (Prior, 2012).

However, public outrage at the murder of Nathaniel Sneyd, director of the Bank of Ireland, by a 'deranged vagrant' (The Times, August 31st 1838, p.3), led to special provisions being made for the detention of 'dangerous lunatics' in the form of the Dangerous Lunatics Act 1838.

According to Prior (2003) the new 'dangerous lunacy' admission procedures offered practical advantages over 'ordinary' admission procedures. Not only were District Asylums compelled to accept dangerous lunatics but the patient had to be transported to the asylum by the police, regardless of the distance. In addition, 'dangerous lunatics' were treated alike and even those who were in a position to pay did not have to do so. This, combined with an almost certain guarantee of a lifetime behind walls, meant that committal under the dangerous lunacy law held 'certain attractions for the family of a patient anxious to be rid of him without further liability' (Robins, 1986, p. 144).

The 1838 legislation, supported by a great laxity in its administration by the justices, became subject to wide abuse (Kelly, 2008; Prior, 2003; Robins, 1986). By 1888, out of a total of 1,821 new admissions to district asylums, only 10 per cent were 'ordinary' admissions (people of unsound mind) with the remaining 90 per cent deemed 'dangerous lunatics' (Report on District, Local and Private Lunatic Asylums in Ireland, 1889; Prior, 2012).

Abuse of the dangerous lunacy law was well known to authorities. A Report of the Poor Law Union and Lunacy Inquiry (1879) notes that 'fully one half [of patients admitted as dangerous lunatics] were found harmless, idiotic, or imbecile, and therefore unsuitable cases to be classified or treated under the denomination of 'dangerous lunatic' (p.9). However, the ease and frequency with which relatives of lunatics used the law to institutionalise their kin remained relatively unobstructed until the mid-1940's (Kelly, 2008; Prior, 2012). According to Prior (2003) whilst there is 'no doubt that at the level of government (politicians and officials), the intention was to remove any potentially troublesome people from public space, it is clear that without the

co-operation of ordinary members of the public, individuals could not have been deprived of their liberty in such large numbers' (p.534).

The Lunacy Laws marked a turning point in Ireland's attitude towards the mentally ill. The Laws' 'paternal charter' (Finnane, 1981, p. 121), which offered patients few, if any, rights combined with a shift in legislative emphasis from the protection of the insane from society (as seen in the Brehon Laws) to the protection of society from the insane, resulted in the Lunacy Laws facilitating the systematic oppression and stigmatisation of the mentally ill.

3.3.6 The Emergence of Psychiatry

The 'institutionalisation drive' (Porter, 2002, p. 122) of the 1800's was by no means unique to Ireland as 'a veritable mania for the construction of new institutions for the insane' (Scull, 2011, p. 48) also swept throughout Western Europe and North America. Medical doctors, according to Burns (2006), 'were put in charge of asylums primarily because they were easy to hold accountable to the board of governors' (p.37). In the absence of effective medical interventions the superintendent's role was predominately administrative and disciplinary. In the 1840's superintendents began to found their own professional bodies and 'the previously heterogeneous congeries of madhouse keepers had instead become a more and more organised group of specialists' (Scull, 2011, p. 50). The new profession struggled to reach international consensus on what it should be called: the French preferred 'aliéniste', the Germans 'Psychiater', while their English speaking counterparts favoured 'Medical Psychologist' or 'Asylum Superintendent'. Ultimately, as a result of the early advancements of German physicians, the profession became known as Psychiatry.

The development of psychiatry was supported and nourished by a variety of sociocultural conditions. First, at a basic level, physicians provided a useful service to the families and communities within which large asylums were located. Second, their presence painted 'a medical gloss' (Scull, 2011, p. 58) on the asylum system, a gloss that, in the wake of a series of significant medical advancements such as Pasteur and Koch's breakthroughs in medical microbiology, generated much social approval. Third, the decline of the moral

approach, an approach that had created optimism in the asylum system itself, allowed psychiatry to suggest ‘that much insanity was, after all, chronic, indeed ingrained, constitutional and probably hereditary’ (Porter, 2002, p. 119) . A new concept of ‘degeneration’, which viewed the insane as ‘degenerate human beings’ (Morel, 1857, p. 5), became increasingly popular in the era of Social Darwinism and resulted in the source of madness being firmly (re)located in the physical body. Finally, supporting the increasingly popular opinion that ‘patients with so-called “mental illnesses” are really individuals with diseases of the nerves and the brain’ (Griesenger, 1867), was the discovery by German Psychiatrist Alois Alzheimer of brain anomalies associated with the disease that was named after him. This, combined with the discovery of an organic source of syphilis induced psychosis, bolstered Psychiatry’s explanation of mental disorder.

While the results of German laboratory-based brain research were impressive and placed psychiatry in the same realm as other biomedical disciplines, it failed to make ‘any contribution whatsoever to clinical care, let alone cure’ (Scull, 2011, p. 68). If anything it only served to generate a very heavily pessimistic view of the long term prospects of the mad. It was partly in reaction to this pessimism, as well as to the dogmatism of biological psychiatry, that new styles of dynamic psychiatry, such as psychoanalysis, took hold and won support (Porter, 2002).

The founding father of psychoanalysis, Austrian Psychiatrist Sigmund Freud, believed that the source of mental disturbance lay, not in the body, but in the unconscious. He postulated that people could be cured by making conscious their unconscious or repressed emotions and experiences. By the turn of the 20th century Freud had developed the notion that the libido, the unconscious sexual drive, was a fundamental human life source and mental distress was the result of disturbances in, largely the suppression of, this energy. The goal of Freudian psychoanalysis was to bring these disturbances to conscious awareness so that the libido energy could be freed up and available for conscious sublimation. While this, and other claims made by Freud, were controversial to say the least, they served to provide ‘a very different perspective on the disturbed thoughts and behaviours of the mentally ill’ (Scull,

2011, p. 74). Yet, for many medical Psychiatrists, the idea that mental disorders could be cured by talking, and that they were rooted in repressed sexual energy, was not just disconcerting but positively absurd. This scorn for psychoanalysis further intensified the commitment of institutional psychiatrists to furthering the biomedical interpretation of madness. This commitment was particularly strong in the US during the early part of the 20th century where Psychiatrists took part in 'a veritable orgy of therapeutic experimentation on the vulnerable bodies of those who had been certified as mad' (Scull, 2011, p. 78). Insulin-induced comas, electricity-induced seizures, malarial mosquitoes (whose use in the treatment of psychosis resulted in its pioneer receiving a Nobel Prize in 1927) and prefrontal lobotomy (which too won a Nobel Prize in 1949) were all well-intentioned but ultimately barbarous attempts to root out the biological cause of mental distress.

Psychosurgery and other shock therapies signal the wish of well-meaning psychiatrists to do something for psychiatry's forgotten patients; they have, in turn been criticised for being grotesque, quackish, brutal and hubristic. Invasive treatments equally reflect the powerlessness of patients in the face of arrogant and reckless doctors, and the ease with which they became experimental fodder.

(Porter, 2002, p. 204)

By the mid-20th century there was growing social malaise at psychiatry's control over and treatment of the mentally ill which, combined with the anti-establishment and liberation culture of the 1960's, resulted in the birth of what became known as the anti-psychiatry movement (Bolton, 2008).

3.3.7 Anti-psychiatry and postpsychiatry

The anti-psychiatry movement began largely as a result of the publication of four pivotal texts between 1960 and 1961: R.D. Laing's 'The Divided Self' (1960); Michel Foucault's 'Folie et Dérison: Histoire de la folie à l'âge classique' (1961); Thomas Szasz's 'Myth of Mental Illness' (1961) and; Erving Goffman's 'Asylums' (1961). These four books provided 'the four-sided platform upon which anti-psychiatry marched into the world' (Hacking, 2004, p.292), a march whose overwhelming success was largely a case of 'right time, right place'.

Scottish psychiatrist, R.D. Laing, along with David Cooper (who first coined the term 'anti-psychiatry'), was the first to challenge psychiatry's view of mental illness as a biological phenomenon. He felt that mental illness could not be treated in isolation from social, historical and cultural factors. Laing, like many of the other anti-psychiatrists, criticised psychiatric diagnoses. The fact that a psychiatrist can make a diagnosis based on verbal and/or behavioural 'symptoms' and then treat these symptoms biologically, highlighted Laing's view that psychiatry is founded on a false epistemology. Using clinical case studies Laing's 'The Divided Self' (1960) focuses on psychosis, a phenomenon he considers the outcome of the 'divided self' rather than a medical condition.

In 'A History of Madness' (1961) French philosopher Michel Foucault charts the history of the treatment of madness from the Middle Ages, through the Renaissance and Classical Age and into the Modern Era. While criticised for historical inaccuracies (Scull, 2007), 'A History of Madness' presents a compelling challenge to the idea of a steady progression in the treatment and understanding of mental illness (Bracken, Khalfa, & Thomas, 2007). Foucault argues that our different historical conceptualisations of madness are not the result of discoveries or advancements, but are social constructions. He reminds us that asylums were originally established for the purpose of exclusion and segregation with Psychiatrists, 'the apotheosis of the medical personage' (Foucault, 2001, p. 256), acting as merely agents of social control.

What we call psychiatric practice is a certain moral tactic contemporaneous with the late eighteenth century, which is preserved in the rituals of life in asylums, covered over by the myths of positivism.
(Foucault, 2006, p. 509).

American Psychiatrist, Thomas Szasz, challenges the very concept of mental illness in his 1961 book 'The Myth of Mental Illness'. He, like many other anti-psychiatrists, feels that the concept of mental illness dehumanises people. Everyone, Szasz argues, experiences 'problems in living' (1961, p. 113), problems, he feels, should not be seen as illnesses. Szasz compares mental illnesses to physical illness in order to show how the former are a 'myth'. Bodily illness, he says, is a deviation from clearly defined factual norms of the 'structural and functional integrity of the human body' (1961, p. 114). It is by

reference to factual norms, then, that genuine bodily illnesses are defined. Mental illnesses, on the other hand, also involve deviations from the norm but these norms, rather than factual or objective, are 'psychosocial, ethical and legal' (Szasz, 1961, p. 114). While Szasz agrees that mental illnesses are a problem, he feels they are 'problems in living' rather than medical problems.

Goffman's 'Asylums'(1961), and his later work 'Stigma' (1963), strongly influenced the twentieth century move towards deinstitutionalisation. Both books became prominent additions to the anti-psychiatric body of work, the work of Foucault in particular, whose 'top down' approach to researching mental illness is complemented and reinforced by Goffman's 'bottom up' approach (Hacking, 2004). 'Asylums' was based on ethnographic data gathered over the course of a year 'on the tissue and fabric of patient life' (Goffman, 1961, p. 7) in St.Elizabeth's hospital, a large psychiatric institution where Goffman posed as a pseudo-employee. The book consists of four distinct studies: On the characteristics of total institutions; the moral career of the mental patient; the underlife of a public institution, and; the medical model and mental hospitalisation: some notes on the vicissitudes of the tinkering trades.

The advent and features of total institutions such as mental hospitals form the focus of the first study. This study explores the power division between staff and 'inmates' as well as the process by which an inmate's self is 'mortified' or shaped 'into an object that can be fed into the administrative machinery of the establishment, to be worked on smoothly by routine operations'(Goffman, 1961, p. 25). Categorisation is one element of this mortification process, or shaping of the self, which continues today. As Hacking (2004) points out, those given a diagnosis (of bi-polar disorder for example), quickly learn how someone with bi-polar disorder behaves, reflecting how 'the use of these categories often has real effects upon people' (p.297).

In the fourth study, 'the medical model and mental hospitalisation: some notes on the vicissitudes of the tinkering trades', Goffman deconstructs the role of the psychiatrist and the patient with reference to the 'expert servicing model' (Goffman, 1961, p. 305). The medical version of this model is composed of four stages: observation, diagnosis, prescription and treatment. The 'expert'

observes ‘the malfunctioning [client] under skilled eyes, ears, and nose’ (Goffman, 1961, p. 289) diagnoses the malfunction and prescribes a form of treatment to ‘fix’ the malfunction. At this point the expert may advise a period of convalescence in which ‘reduced demands are placed upon the object and there is a heightened attentiveness to signs of relapse or insufficient repair’ (Goffman, 1961, p. 290). This cycle ends only when the previously malfunctioning client is deemed by the expert to be ‘as good as new’ (Goffman, 1961, p. 290). Both roles, that of expert and client, are clearly defined and are affirmed by society. Failure to adhere to the prescribed role is often seen as confirmation of the client’s deviance from social norms. Goffman, quoting Szasz, believes mental health to be ‘the ability to play whatever the game of social living might consist of and to play it well’ (Szasz, 1958, p. 188). The mentally ill, in contrast, are those considered incapable of following the rules of this game of social living.

The works of Laing, Foucault, Szasz and Goffman and the anti-psychiatry movement in general stimulated a series of systemic reforms in mental health from the 1960’s onwards. These reforms, which are on-going in Ireland more than fifty years later, include; the closing of asylums and the beginnings of care in the community; the growth of service user, advocacy and ‘patient-power’ movements; recognition and protection of the rights of the service user; increased recognition of the role of psychological therapies and; the re-organisation of mental health services along increasingly multi-disciplinary lines (as opposed to a purely medical model approach) (Bolton, 2008; Fulford et al., 2006; Gillett, 2009).

In Ireland, a Commission of Enquiry on Mental Illness, established in the 1960’s, paved the way for Ireland’s first mental health policy, ‘Planning for the Future’ (Department of Health and Department of Health and Children, 1984) . The authors of ‘Planning for the Future’ (Department of Health and Children, 1984) opened the report by describing a system that had changed little in over one hundred years:

The psychiatric hospital is the focal point of the psychiatric service in most parts of the country. Large numbers of patients reside permanently

in these hospitals. Many of them have lived there for years in conditions which in many cases are less than adequate because of overcrowding and capital underfunding

(Department of Health and Children, 1984, p. xi)

Planning for the Future laid out a philosophy of mental health care that shifted the emphasis away from the institution and into the community (Department of Health and Children, 1984). However, while popularised by the anti-psychiatry movement in the 1960's, many consider the policy shift to community care to have been driven more by fiscal concerns rather than a concern for patient welfare (Porter, 2002; Scull, 2011).

Although the anti-psychiatry movement is now largely regarded as a closed chapter in the history of psychiatry (Tantam, 1991), criticisms of biogenetic approaches and psychiatric power have not simply faded away but rather were replaced by a movement of known as 'critical psychiatry' in the 1980's and 90's and, more recently, by a movement known as 'postpsychiatry'. Led by a group of psychiatrists, postpsychiatry sees the assumptions underpinning 'modernist psychiatry' as just that – assumptions: 'they are the products of a particular cultural change, and as we move beyond the embrace of that culture we need to interrogate those assumptions and seek new ways of understanding and relating to experiences of madness and distress' (Bracken & Thomas, 2005, p. 11). The postpsychiatry movement 'interrogates' psychiatry's ideological commitment to reductionism as well as the social and legislative power afforded psychiatrists in determining the fate and freedoms of vulnerable members of society (Bracken & Thomas, 2001). It also highlights the growing contradiction between clinical and academic psychiatry. This contradiction, according to Bracken (2015), reflects the influence of the pharmaceutical industry in funding and driving genetic and biological research agendas resulting in academic psychiatry becoming 'more or less irrelevant to clinical practice and to the major developments in the mental health field' (Kleinman, 2012, p. 421).

However, during the 1990's, a decade labelled by US President George Bush (1989) as 'the decade of the brain', research-driven biological reductionism was by far the dominant perspective in mental health (Scull, 2011). It was the

‘serendipitous discovery’ (Scull, 2011, p. 105) of chlorpromazine in the 1950’s that triggered ‘the drug revolution’ (Burns, 2006, p.53). A French naval anaesthetist, researching trauma and shock, noticed that the anti-histamine chlorpromazine seemed to calm patients post-operatively without sedating them. Chlorpromazine was then trialled in St. Anne’s psychiatric hospital in Paris in 1952 and within two years was being prescribed to more than two million psychotic patients in North America alone (Scull, 2011). Anti-depressants first came on the market in the 1950’s and ‘by the early 1980’s US physicians were writing 10 million anti-depressant prescriptions a year’ (Burns, 2006, p. 54). The apparent success of these new drugs resulted in the assertion that ‘if drugs which acted on the body modified the symptoms of psychiatric disorders, those disorders must surely be rooted in the body’ (Scull, 2011, p. 109). This biomedical perspective was endorsed and supported by the rapidly growing pharmaceutical industry; patients and their families who, for the first time could be absolved of social responsibility or blame for their illness (Hacking, 2004; Scull, 2011); and psychiatry, whose respectability flourished in the light of the biochemical hypothesis.

The rapid growth in psychopharmaceuticals soon meant that ‘it became commercially attractive to try to distinguish different sub-populations among the mad for whom particular families of drugs seemed to work’ (Scull, 2011, p. 109). The DSM, the American Psychiatric Association’s diagnostic manual, recognised 182 different psychiatric disorders in its 1968 second edition, expanding to 265 disorders in its third edition (1980) and currently, in its fifth (2013) edition recognises more than 300 discrete diagnostic categories. This proliferation of diagnostic criteria, to Scull (2011) at least, seems to correspond more closely ‘to the marketing needs of the pharmaceutical houses than to advances in basic science’ (p.120).

Although, as the 20th century drew to a close, the asylums which had given birth to the profession were closing rapidly, psychiatry continued to flourish on the back of the biomedical explanation of mental distress. It had warded off ideological attacks from psychoanalysis and anti-psychiatry, and although weakened by these and the lack of discovery of any biological markers of

mental disorder, continued to play the leading role in the care of the mentally ill at the dawn of the 21st Century.

3.3.8 21st century: A liminal space?

As we proceed through the early stages of the 21st Century it appears that our understandings of, and responses to, psychological distress have entered an historical liminal space. Stemming from the Latin ‘lemin’, meaning ‘threshold’, a liminal space has come to represent a ‘space between’ where the state of a phenomenon ‘is socially and structurally ambiguous’ (Evans & Kevern, 2015, p. 2). It is a space of ‘pure possibility’ (Turner, 1967, p. 97) where ‘anything might, even should, happen’ (Turner, 1979, p. 465).

Within this space are a series of often opposing elements. First, psychiatry, the profession at the helm of our understandings of madness for more than 200 years, is currently in the midst of ‘a crisis of confidence’ (Bracken, 2015). This crisis has been stirred up, according to Bracken, by the publication of the DSM-5 which undermined the credibility of the profession (Pies, 2013); the revelation of corruption and fraudulent behaviour in the psychopharmaceutical industry (Gotzsche, 2013); the apparent ‘failure of neuroscience to help a single patient’ (Bracken, 2015; Frances, 2013) and; the growing chasm between the neurobiological orientation of academic psychiatry and clinical practice (Kleinman, 2012). However, for each argument that undermines psychiatry, there is counter optimism in the potential of genomics and neuroscience; optimism fuelled by advances in DNA sequencing and functional brain imaging (Insel, 2015). Where once deemed the result of biochemical imbalance, common mental health problems are now becoming conceived more in terms ‘of an underlying disorder in a brain circuit’ (Insel, 2015, p. 5).

Beyond the discipline of psychiatry, social and cultural shifts have stirred the air of silence and compliancy that settled around mental illness during the early parts of the 20th century. The move to community care at the latter stages of the 1900’s removed the walls, not just literally, but figuratively, between ‘them’ and ‘us’. Increased education, autonomy and communication media have provided space for people to tell their own stories of psychological distress

openly and freely. Indeed, individuals are now publicly encouraged to talk about their mental health issues and are reminded that ‘talking is a sign of strength, not weakness’ (PleasePlease Talk, 2016). A growing number of advocacy groups, often supported by the personal testimony of celebrities such as Niall Breslin and Stephen Fry have further reinforced the idea that psychological distress is something that we are all likely to experience at some stage in our lives and is by no means restricted to the unlucky few who have faulty brain circuitry. This liminal space that is the onset of the 21st Century is also filled with a variety of psychological, sociological, psychodynamic, somatic and narrative alternatives to understanding the phenomenon of mental health. Moreover our highly educated ‘free market’ society, supported by ready access to research and information online, positions individuals, perhaps for the first time, to make informed choices about what works for them and their mental health.

In sum, as we move into the 21st Century, our understandings of and approaches to the phenomenon of mental distress have, if not advanced, then evolved. From pre-Christian interpretations of madness as necromantic punishment; to the Enlightenment view that the mad were like wild beasts that required breaking and training to; more recently, the view that ‘madness’ is a symptom of some underlying neurobiological fault or deficiency; our attempts to find meaning in madness have wavered considerably over the centuries. What history teaches us is that, when it comes to the phenomenon of psychological distress, we are not on a steady and progressive march towards understanding. If anything the history of madness reveals a series of ‘scientific revolutions’ (Kuhn, 1996, p. 6), driven more by socio-political forces than advances in understanding. We are currently on the cusp of another ‘revolution’. A revolution, according to Kuhn (1996), is triggered by the emergence of ‘anomalies that subvert the existing tradition of scientific practice’ (p.6). As we have seen, this century has presented a sufficient number of anomalies to generate a ‘crisis in confidence’ in the dominant, biomedical, approach to psychological distress. The next section considers the key assumptions and understandings of this approach and goes on to draw out the assumptions underpinning the two other dominant perspectives in the field of mental health – psychology and sociology.

3.4 Medical perspective

Canst thou not minister to a mind diseased

Macbeth (V iii)

As seen in section 3.3, biological conceptualisations of madness stretch back to Ancient Greece. Hippocrates' humoral pathology attributed all disease, including that of the mind, to imbalances in the four humours – black bile, yellow bile, mucus and blood. Centuries later the basic model itself has altered little. According to McCulloch and colleagues (2005), the medical model views mental illness as 'a disorder of the brain or a disturbance in the functioning of the brain and CNS which should be amenable to pharmacological or physical treatment' (p7). The model itself is primarily the domain of the medical speciality of psychiatry. Psychiatry's practitioners, as in other medical specialities, are trained to identify disorders (diagnosis) in order to suggest treatments (management) and predict the future course of the diagnosed illness (prognosis). Ultimately psychiatrists also aim to identify the physical abnormality (pathology) underlying the disorder as well as its cause (aetiology) so as to develop means of prevention and cure (Semple & Smyth, 2013).

The medical model is currently the dominant model in mental health services. However this, as Rogers and Pilgrim (2013) take care to point out, is because psychiatry is the dominant profession within those services and the model's dominance 'should not be confused with its conceptual superiority' (p.2). As with all models, the medical model has its strengths and weakness. Its strengths lie in terms of its logical and empirical status within a society that inherently values scientific and technological explanations. Moreover, as discussed in section 3.3.6, the biological evidence supporting certain disorders (such as syphilis and encephalitis or the psychological symptoms associated with temporal lobe epilepsy), has done much to further the acceptance of the medical explanation of mental illness. The induction of abnormal mental states by brain lesions, drugs, low blood sugar and fever also point to a biological association.

However, as the maxim goes, association does not necessarily mean causation and, as highlighted in the introductory chapters of the Oxford Handbook of

Psychiatry (Semple & Smyth, 2013), psychiatrists ‘lack knowledge of the aetiology and pathogenesis of most psychiatric disorders’ (p.30). Another significant weakness of the medical model, again as highlighted by Semple and Smyth (2013), is that there are ‘no objective diagnostic or prognostic investigations’ (p.30) for mental disorders. Psychiatric diagnoses are repeatedly criticised for, on the one hand, their lack of reliability and validity (Frances, 2011; Pies, 2013, 2015) and, on the other, their highly reductionistic nature (Bracken, 2015). A third weakness, is the reality that psychiatry’s ‘drug and psychological treatments are often minimally or only partially effective’ (Semple & Smyth, 2013, p. 30). While the authors of the Handbook of Psychiatry hold a great deal of ‘optimism and excitement’ for the prospects of genetic screening, stem cell therapy and functional and diagnostic brain imaging; they also, and perhaps wisely so, remain cautious – ‘there have been false dawns before’ (Semple & Smyth, 2013, p. 30).

Psychiatry is considered by some to be the ‘final frontier’ of medicine (Semple & Smyth, 2013, p. 2). Optimism in genetic screening and functional imaging aside, in its current form the medical model of mental distress is conceptually primitive not to mention contentious (Rogers & Pilgrim, 2013). Given the lack of agreement, let alone certainty, that surrounds all of the key components of the model itself – diagnosis, aetiology, pathology, prognosis and treatment – it is hardly surprising that the profession of psychiatry currently appears in the midst of a ‘crisis of confidence’ (Bracken, 2015).

3.5 Psychological perspective

While the medical model interprets mental distress in terms of genetic or biological disorder, the psychological perspective is more concerned with factors such as an individual’s life experience, conditioning, perception, belief formation and internalised schemas of relationships (Kinderman, 2005). Psychology is the scientific study of behaviour and cognitive processes (Wright, Stern, & Phelan, 2012). Those trained in the psychological model examine aspects of human experience such as emotions, thoughts and actions and apply their understandings in a variety of professional, including clinical,

counselling, educational, organisational and academic settings (Psychological Society of Psychological Society of Ireland, 2016).

The field of psychology itself contains a variety of theoretical perspectives and approaches to the phenomenon of mental distress. Each of these perspectives adopts its own view on the nature of behaviour (general psychology), on how behaviour can go awry (psychopathology), and on how abnormality can be prevented or corrected or both (intervention) (Peterson, 2010). Four of the more popular psychological perspectives – psychoanalytic, cognitive-behavioural, humanistic-existential and family systems – are outlined in Table 1, along with each model’s particular assumptions and views on psychopathology and treatment.

Psychological Perspective	Assumptions
Psychoanalytic	<p>People are energy systems</p> <p>Problems result from the investment of energy in symptoms</p> <p>Treatment releases energy by encouraging insight</p>
Cognitive-behavioural	<p>People are information-processing systems</p> <p>Problems result from inappropriate learning or thinking or both</p> <p>Treatment changes the environment or thoughts or both</p>
Humanistic-existential-phenomenological	<p>People choose and define their own existence</p> <p>Problems result from the failure of self-actualisation</p> <p>Treatment encourages authentic living</p>
Family systems	<p>People are products of their family</p> <p>Problems result from family dynamics and the creation of an unhealthy homeostasis</p> <p>Treatment changes the family status quo</p>

Table 1 Psychological Perspectives on Mental Illness (adapted from Peterson, 2010)

While each of the four psychological perspectives outlined in Table 1 adopts a unique stance, each is united by the desire to understand why people experience distress. Moreover, each, in its own way, is concerned with identifying how the events that have unfolded over the course of an individual's life, and their reactions to those events, have influenced their psychological wellbeing.

In spite of a store of research pointing to the effectiveness of a variety of psychological interventions in mental health (e.g. Abbass et al., 2014; Fonagy, 2005, 2015; Leichsenring & Rabung, 2008, 2011), the psychological perspective has been subject to series of criticisms. The predominant criticism levied at the psychological perspective regards its claim as a science (Lilienfeld, 2011, 2012; Stanovich, 2013). Science is 'a way of thinking about and observing the universe that leads to a deep understanding of its workings' (Stanovich, 2013, p. 8). However, psychology's failure to meet the five basic requirements for scientific rigour – clearly defined terminology, quantifiability, highly controlled experimental conditions, reproducibility and, finally, predictability and testability – leave it open to being classed as unscientific (Berezow, 2012). A second criticism of psychology relates to a lack of theoretical coherence within the discipline (Butler & McManus, 1998; Stanovich, 2013). The diversity of perspectives within psychology, as seen in the diversity of just four of the perspectives outlined in table 1, result not in the single grand theory that underlies many other disciplines, but in a variety of theories, each covering a limited aspect of behaviour (Griggs, Proctor, & Bujak-Johnson, 2002). Psychologists rebut that psychology is 'a loosely federated intellectual empire that stretches from the domains of the biological sciences on one border to those of the social sciences on the other' (Gleitman, 1981, p. 774) and that the vastness of this 'empire' make it impossible to unify its inhabitants under a single theoretical perspective.

Indeed it is the vastness of the psychological 'empire' that gives rise to the third main criticism levied against it – this time mainly from those operating within the perspective itself. Like psychiatry, psychology struggles with a 'researcher-practitioner gap' (Belli, 2010; Tavris, 1998). This gap is the result

of the seemingly opposing goals of psychological researchers and psychological practitioners. Psychological practitioners ‘maintain that research methods and findings capture only a shrivelled image of the real person’ (Tavris, 1998) while psychological researchers point to the very definition of psychology (as the scientific study of behaviour and cognitive processes) in order to highlight the importance of their role (Butler & McManus, 1998; Wright et al., 2012). In spite of these criticisms, psychology remains beside psychiatry on the frontline of understanding and addressing the phenomenon of mental distress (NCCMH, 2011; NICE, 2014).

3.6 Sociological perspective

In contrast to the medical and psychological perspectives, which locate the source of suffering within the individual (in a person’s physical body, brain or mind), from a sociological perspective, the source is external – in the individual’s environment or social situation (Thoits, 2010). Within the sociological perspective there are four main ‘sociological styles’ (Horowitz, 1999, p. 57) of thinking about the phenomenon of mental health/illness: social causation, critical theory, social constructivism and social response. Beginning with social causation, this section serves to outline the key premises of each of these four ‘sociological styles’.

Social causation begins with an acceptance of the existence of mental disorders such as ‘schizophrenia’ or ‘depression’ and then seeks to unearth the social causes of these in individuals. According to Rogers and Pilgrim (2005) the emphasis within a social causation approach is upon ‘tracing the relationship between social disadvantage and mental illness’ (p.12). Forms of social disadvantage commonly investigated from a social causation approach include socio-economic status, race, gender and age.

Emile Durkheim’s ‘Suicide’ (1897/1951), which studied social variation in suicide rates among different social groups, is considered the first systematic study of the social causes of psychological distress (Horowitz, 1999). Durkheim concluded that suicide rates are higher among men than women; among those who are single than those who are married; among Protestants

than Catholics; among soldiers than civilians; and are higher during times of peace than times of war. However, while this landmark study shone a light on the role of social factors in determining mental distress, it also highlights some of the main criticisms levied against the social causation approach. First, studies such as Durkheim's investigate correlations between social factors and mental health problems. Correlations are not necessarily indicative of causal relationships. Second, by unconditionally accepting psychiatric conceptualisations of mental disorder, the approach fails to acknowledge the problems inherent in such concepts. Finally, such large scale psychiatric epidemiological investigations 'cannot illuminate the lived experience of mental health problems or the variety of meaning attributed to them by patients and significant others' (Rogers & Pilgrim, 2005, p. 12).

The second sociological approach to the phenomenon of psychological distress, critical theory, attempts to reveal the effects of social structures on the inner lives of individuals. Rooted in the work of Freud and humanistic Marxism, critical theory was developed by researchers working out of the 'Frankfurt School' of social research. The rise of Nazism and onset of World War II resulted in the fragmentation of the burgeoning Frankfurt School but the continuation of the project to examine a 'critical theory of society' may be seen in the work of scholars such as Habermas (1972), Offe (1984) and Lacan (Elliot, 1992).

The key tenant of the third sociological style, social constructivism (sometimes referred to as social constructionism), is the idea that reality is not fixed, stable, self-evident nor waiting to be revealed, but rather a product of human activity and, in this sense, constructed by humans. The three sub-strains of social constructivism, according to Rogers and Pilgrim (2005), (a) challenge the factual status of mental illness (e.g. Szasz, 1961 - section 3.3.7); (b) highlight the coercive control of social deviance by psychiatry and the production of selfhood by mental health expertise (e.g. Foucault, 1965 – section 3.3.7); and (c) reveal the relationship between the production of scientific/psychiatric knowledge and the pursuit of individual and professional interests (Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 2009). What unites all forms of the social constructivist approach, however, is the central assumption that

the essence of mental ‘disorder’ resides, not in the individual, but in the cultural rules that define what is normal and abnormal (Horowitz, 1999).

The fourth and final sociological style, social response, also locates the source of mental distress in the socially prescribed rules of normalcy rather than the individual themselves. Often referred to as labelling theory, social response is based on one key tenet: people who are labelled as deviant and treated as deviant become deviant (Thoits, 2010). Deviance refers to the breaking of social norms (as in deviating from the norm) and, in the case of mental illness, it is the symptoms that are considered normative violations. Symptoms break taken-for-granted rules about how one should think, feel and behave (Scheff, 1984). For example it is not ‘normal’ to believe that the CIA is tapping your phone, to feel anxious and low all the time or to undress and run naked through the streets.

Labelling theorists, such as Becker (1973) and Scheff (1984), assume that everybody violates social norms at some stage in his or her life. More often than not, these violations are ignored, denied or reasoned away by the rule-breaker and their family and friends. ‘Reasons’ for rule-breaking can be biological (e.g. fatigue, malnourishment, biological abnormality, illness); psychological (e.g. an unhappy childhood, a need for attention, internal conflicts, low self-esteem); cultural (e.g. following subcultural norms that differ from the dominant social norms); economic (e.g. need for money, buying prestige in the eyes of others); and a variety of other reasons or grounds that may account for the deviant behaviour (e.g. carelessness, accidents, basic ignorance of the rules).

However, when individuals’ norm violations are frequent, severe, or highly visible, or when rule-breakers are low in power and status relative to ‘agents of social control’ (i.e. police, social workers, judges, psychiatrists), rule-breakers are much more likely to be publicly and formally labelled as deviant (in this case, mentally ill) and forced into treatment (Thoits, 2010).

As Rosenhan (1973), in his famous paper ‘On being sane in insane places’, shows; once an individual is labelled and is admitted into psychiatric care they

begin to receive differential treatment on the basis of their label. Differential treatment, according to labelling theorists, leads to association with similar deviants which in turn results in socialisation into the subculture of 'mental patient' (Goffman, 1961). The process of being labelled, and of internalising and identifying with the label, acts as a kind of 'self-fulfilling prophecy' (Merton, 1968) and results in the labelling theory maxim that those who are labelled as deviant and treated as deviant become deviant.

Labelling theory has been described as 'a radical sociological explanation' (Thoits, 2010, p. 120) largely because it turns causal thinking on its head. Deviance or mental illness is not inherent 'in' human beings but is created, according to labelling theorists, by social groups who make 'rules whose infraction constitutes deviance' (Becker, 1973, p. 9). While the theory has some obvious limitations, namely the assumptions that a symptom will usually stop if it is not labelled and that labelling and differential treatment are key causes of long term mental health problems, it also has some major advantages. Notably it has sensitised 'agents of social control' to the potential for bias or error in diagnostic judgements. Labelling theory, along with other social movements, has resulted in greater legal measures to make involuntary admissions more difficult and it has raised awareness amongst service providers to the effects of long term hospitalisation and institutionalisation. Finally, labelling theory highlights the deeply destructive and deleterious effects of stigma and negative societal responses on those who experience mental health problems.

Social causation, critical theory, social constructivism and social response are four of the main approaches to the phenomenon of psychological distress within the sociological perspective. Social causation and critical theory are both concerned, in different ways, with the effects of social systems and structures on an individual's mental wellbeing while social constructivism and social response seek to demonstrate how 'mental illness' is not something located within an individual but rather in the society that deems them as such.

This forestructures of understanding section has sought, thus far, to explicate the fore-having, fore-sight and fore-conception that Heidegger believes forms

the basis of all interpretation. It has looked at how we historically have broached the phenomenon of mental health in order to create what Gadamer calls a ‘historically-effected consciousness’ and has examined the assumptions underpinning three of the main theoretical frameworks that have attempted to structure our understanding of the phenomenon – medicine, psychology and sociology. This chapter now turns to examine the ‘prejudice’, as Gadamer calls it, with which the researcher herself enters the hermeneutic circle of understanding.

3.7 Researcher’s ‘Prejudice’

Each of us, according to Gadamer (1960/1989), consciously or unconsciously, pre-judges the world in which we live and engage. This pre-judgement, or prejudice, forms the anticipatory starting point of all interpretation. Both Heidegger and Gadamer press the point that our pre-judgements should not, and cannot, be suspended or omitted from any attempt at understanding and, if we are to enter the hermeneutic circle in the ‘right’ way, we must seek to make conscious and lay out our prejudices. Indeed, Gadamer (1960/1989) suggests that ‘a person who believes he is free of prejudices, relying on the objectivity of his procedures and denying that he himself is conditioned by historical circumstances, experiences the power of the prejudices that unconsciously dominate him as a *vis a tergo* [force acting from behind]’ (p.360). Our prejudices should not be denied for it is our prejudice that opens us up to what is to be understood. What is presented below is a brief description of some of my prejudices that shape how I have approached and entered the hermeneutic circle.

I believe many of us are gripped by a question that we consciously or unconsciously dedicate our lives to answering. For me that question is why would anybody chose to exist in the face of suffering? The particular form of suffering that I find most compelling is psychological distress – the form of suffering that nobody can see yet can destroy a human being from the inside out. It is considered by some to be the ‘final frontier’ (Semple & Smyth, 2013, p. 2) in science, and by others to be an inherent aspect of existence itself (e.g. Buddhism’s four noble truths) – one which we must learn to make peace with

as best we can. Carrying this as a starting question, my life, in one way or another, has proceeded to explore ways of staying alive in the face of extreme pain and adversity. Meaning, I learned from Viktor Frankl, is the root system that connects us with the world – the stronger the root the greater the chances of not being destroyed in a storm.

Personally and professionally I have struggled with the limitations of the medical model in effectively easing the pain of psychological suffering. This is a type of pain that does not respond, in my opinion, in the same way a biological malaise responds to biological soothing – whether it be painkillers to numb sensitive nerve endings or heart burn medicine to neutralise stomach acid. Psychological suffering reaches into the ‘psyche’, or soul, itself – a realm that cannot be reached by a selective serotonin uptake inhibitor or monoamine oxidase inhibitor. That being said I appreciate the place offered by the many wonderful people who operate within the medical model for those with nowhere else to turn.

Perhaps the most significant factor that has shaped my journey, and my thinking, over the last ten years leading into this particular foray into the hermeneutic circle, is my involvement with Headstrong, the National Centre for Youth Mental Health. In March 2006 I was working, rather aimlessly, in a factory in my hometown and, by stroke of chance, I heard a man interviewed on the Marian Finucane radio show. This man was Dr. Tony Bates and towards the end of the conversation Marion enquired about a new venture he was undertaking – a national centre for youth mental health. At that time I was doing the GAISCE Presidents Award to quench the thirst of boredom and was in search for a worthy charity for which to raise funds by running the Dublin marathon the following October. So I called up and offered my services but, after a lengthy conversation, Tony suggested that they didn’t really need my money but instead needed the wealth of insight and experience I could bring as a young person who had struggled extensively with her mental health. And so I became the first youth advisor and over the course of the years that followed was privileged enough to be at the heart of shaping an organisation whose aim it is to change how Ireland thinks about youth mental health. Reflecting on this time and the many wonderful experiences that occurred, I realise that it has left

me with a number of very important and powerful perspectives. First, I have witnessed firsthand the power of voice. I have seen what happens when those who are considered the ‘experts’ are not those with lines of letters after the names but those who are experts by experience. I was at the table when a service was built up around what young people *said* they needed rather than what they were *told* they needed by professionals and those in power. I have learned that it is by listening to experience that we can make meaningful change in the world. Although my role within Headstrong has taken many forms over the last decade what it has given me, perhaps more than anything, is the confidence to stand out of the shade of dominant ways of thinking and doing things. This thesis is a manifestation of this small but powerful gift.

3.8 Conclusion

This chapter has sought to explicate the forestructures that form the starting point of all understanding so that we may be able to enter the hermeneutic circle ‘in the right way’ (Heidegger, 1927/1996, p. 153). What it has not offered is a traditional literature; that which Wolcott (2009) refers to as the ‘practice of simply backing up with a truckload of stuff and dumping it on unsuspecting readers’ (p.74). The literature, or ‘stuff’ as Wolcott calls it, is by no means neglected but woven in to a wider, and hopefully more meaningful, discussion in chapter 7. What this chapter did do, however, was provide a historical overview of how we, as a society, have tried to make sense of, and respond to, the phenomenon of mental health/illness. It then followed with an examination of the assumptions underpinning three of the dominant theoretical and professional frameworks supporting contemporary understandings of the phenomenon; psychiatry, psychology and sociology. The chapter then concluded with an outline of the prejudices the researcher herself carries into the hermeneutic circle of understanding. The next chapter, methodology, describes what happened in this circle.

4. Methodology

To understand the rose,
One person may use geometry
And another the butterfly.

(Caudel, 1929)

4.1 Introduction

A study's research questions form its methodological point of departure. Accordingly, this chapter will begin with a reiteration of these:

- What is the nature of the lived experience of third level students with mental health problems?
- What meaning do these students ascribe to their experiences?

This chapter will commence with an examination of the interpretative paradigm, within which hermeneutic phenomenology is located, before moving on to address the more practical methodological matters of sampling and data generation and analysis. The chapter will then conclude with a discussion of the measures used to uphold trustworthiness as well as the ethical considerations that underpinned this study.

4.2 The interpretive paradigm

Bateson (1972) argued all researchers are philosophers in that 'universal sense in which all human beings [...] are guided by highly abstract principles' (p.320). These principles include beliefs about ontology, or the nature of reality and what can be known about it; epistemology, or the relationship between the knower and what can be known; and methodology, or how the researcher can go about finding out what they believe can be known (Denzin & Lincoln, 2011; Lincoln & Guba, 1985). Thus, one's ontology directs our epistemology which in turn guides our methodology.

The living man is bound within a net of epistemological and ontological premises which – regardless of the ultimate truth or falsity – become partially self-validating.

(Bateson, 1972, p. 314)

This net, containing the researcher's ontological, epistemological and methodological premises, is often referred to as a paradigm (Guba, 1990). A researcher's paradigm acts as a framework, or lens, through which they view a particular phenomenon (Welford, Murphy, & Casey, 2011). Paradigms are human constructions categorised by differences in beliefs about the nature of reality and knowledge construction. They are established by communities of scholars and as such can be neither proved nor disproved (Guba, 1990). There are a number of different research paradigms, the four major ones being positivist, postpositivist, interpretive and critical social theory (Bunniss & Kelly, 2010; Denzin & Lincoln, 2000; Guba & Lincoln, 1994; Schwandt, 1990).

Hermeneutic phenomenology is considered to sit within the interpretive paradigm. The interpretative paradigm evolved from the Heideggerian view of the nature of being-in-the-world and of humans as self-interpreting beings (Appleton & King, 1997; Holmes, 1996). Interpretivists study phenomena through the eyes of people in their lived situations with the ultimate goal of understanding (Ford-Gilboe, Campbell, & Berman, 1995; Weaver & Olson, 2006). Benner (1994) highlights how interpretive inquiry is concerned with articulating, appreciating and making visible the voices, concerns and practices of those who are the focus of the inquiry.

Denzin and Lincoln (2011) state that the interpretive paradigm assumes a relative ontology (there are multiple realities), a subjectivist epistemology (knower and respondent co-create understandings), and a naturalistic (in the natural world) set of methodologies. Ontologically, the interpretive paradigm is based on relativism, a view of truth as composed of multiple realities that can only be subjectively perceived (Weaver & Olson, 2006). Epistemologically, interpretivists believe that knowledge is subjective; that there is no one ultimate or 'correct' way of knowing (Bunniss & Kelly, 2010). This epistemological view of knowledge as subjective has led some to consider

interpretivism a paradox in that interpretivists attempt to develop an objective science from subjective experience (Denzin & Lincoln, 2011). Rainbow and Sullivan (1987) attest that this paradox is based on an objective-subjective split when in fact, as Munhall (2012) points out, ‘objectivity is a subjective notion’ (p.27).

Methodologies associated with the interpretive paradigm, reflecting both its relativist ontology and subjective epistemology, are united by an emphasis on the intersubjective construction of meaning and understanding. Knowledge is generated in interpretive research when ‘relevant insights emerge naturally through research-participant discourse’ (Coffey & Atkinson, 1996, p. 54). Therefore, the researcher’s perspective is inextricably bound up within the findings of an interpretive inquiry (Weaver & Olson, 2006). The interpretive paradigm views knowledge building as an inherently social act (the hermeneutic circle) and, as a result, methods within this paradigm tend to be qualitative (Bunniss & Kelly, 2010).

Hermeneutic Phenomenology is one amongst a range of interpretative methodologies. Other interpretative methodologies that could have been adopted in this study include narrative analysis, grounded theory, ethnography and case studies. The focus of narrative analysis is on exploring the life of a single individual (Creswell, 2003) and, as such, was considered limited in comparison to hermeneutic phenomenology which instead focuses on a single phenomenon across multiple individuals. The aim of grounded theory is to generate or discover a theory (Glaser & Strauss, 1967) – an aim not shared by the study at hand. Instead this study was undertaken with a sense that, when it came to the phenomenon of psychological distress, a single unifying theory is unlikely if not impossible. Ethnography is another popular interpretative methodology but its ‘focus on [an] entire cultural group’ (Creswell, 2003, p. 68), rather than on those with shared experience of a particular phenomenon *within* a particular cultural group, made it a less than ideal methodological choice for this particular study. Case studies offer an in-depth description and analysis of a case or multiple cases (Yin, 1984) and while hermeneutic phenomenology is also concerned with depth, its aim is to reach a deeper and fuller understanding of a phenomenon rather than an individual. All things

considered, hermeneutic phenomenology, with its focus on ‘gaining a deeper understanding of the nature or meaning of experiences’ (van Manen, 1990, p. 9) was deemed the most effective and appropriate means of addressing this study’s aims. The research approach, and the paradigm within which it is located, in turn shape the methods by which the understanding van Manen describes above, may be developed. The methods by which participants were recruited and selected, and by which data were generated and analysed, form the focus of the next number of pages.

4.3 Sampling

According to Steeves (2000) sampling ‘implies that a researcher is choosing informants because those informants might have something to say about an experience they share with others’ (p.45). As a result, qualitative researchers typically, although not exclusively, employ non-probability sampling techniques (Higginbottom, 2004). Field et al. (2006) describe non-probability sampling as ‘a catch-all term’ (p.567) referring to a number of sampling strategies (e.g. convenience sampling, purposive sampling, opportunistic sampling, quota sampling, judgemental sampling, and snowball sampling). Non-probability sampling techniques, in contrast to probability sampling (the word probability deriving from the Latin *probabilitas*, a measure of authority or authoritativeness), do not aim to generate a sample representative of the entire population. Herein lies what many consider the major weakness of non-probability sampling.

Basically, non-probability samples are not samples at all but could be regarded as complete populations from which no statistical generalisations to larger populations can be made.

(Abdellah & Levine, 1979, p. 332)

However, as the aim of qualitative research is to generate rich, contextually laden, explanatory data, it has little concern with generalisations or generating population-based estimates (Guest, Namey, & Mitchell, 2013). Indeed the relevance of generalisability to qualitative research has been disputed (Lincoln & Guba, 1985) with transferability deemed a more appropriate measure of *probabilitas* (DiCenso et al., 2003; Guba & Lincoln, 1985; Sandelowski,

1986). Research subjects in qualitative studies are selected, not because they increase the study's *p*-value, but because they provide insight into the phenomenon under study. Purposive sampling was the non-probability sampling strategy adopted for this study.

4.3.1 Purposive sampling

Purposive, or judgemental, sampling is the most commonly employed non-probabilistic sampling strategy (Guest et al., 2013). It is based on the premise that study participants should be chosen based on the purpose of their involvement in the study. The strength and potency of purposive sampling, argues Quinn Patton (2002), 'lie in selecting information-rich cases for study in-depth...those [cases] from which one can learn a great deal about issues of central importance to the purpose of the inquiry' (p.230).

As the purpose of this study was to explore the lived experience of psychological distress, direct experience of a mental health problem was an essential criterion for participation. The type or severity of mental health problem was not pertinent, nor was 'expert' (e.g. psychiatrist or other mental health professional) validation or diagnosis. Hermeneutic phenomenology aims to objectively examine subjective experience, and as psychological distress is a highly subjective experience, the present study considers it futile to attempt to objectively categorise (i.e. via diagnoses, psychiatric classifications) this experience. However, by virtue of the majority of participants being recruited through a university disability service (see section 4.3.3), which itself required 'evidence of a disability' (Trinity College Dublin, 2016), many of the students did have such diagnoses and were deemed by a mental health professional to be 'disabled' by their mental health problem.

van Manen (1990) encourages phenomenological researchers to consider the experiential situation which they hope to enter. Defining an experiential situation, according to van Manen (1990) is essential if the researcher is to avoid being 'lost in the sheer expanse and depth of one's question' (p.167). As the research question guiding this study was undoubtedly expansive, the experiential situation was refined to third level (HETAC levels 7-10) students who experience or have experienced psychological distress. As such there were

just two defining criteria for participation in this study – participants needed to be third level students and they needed to have lived experience of psychological distress.

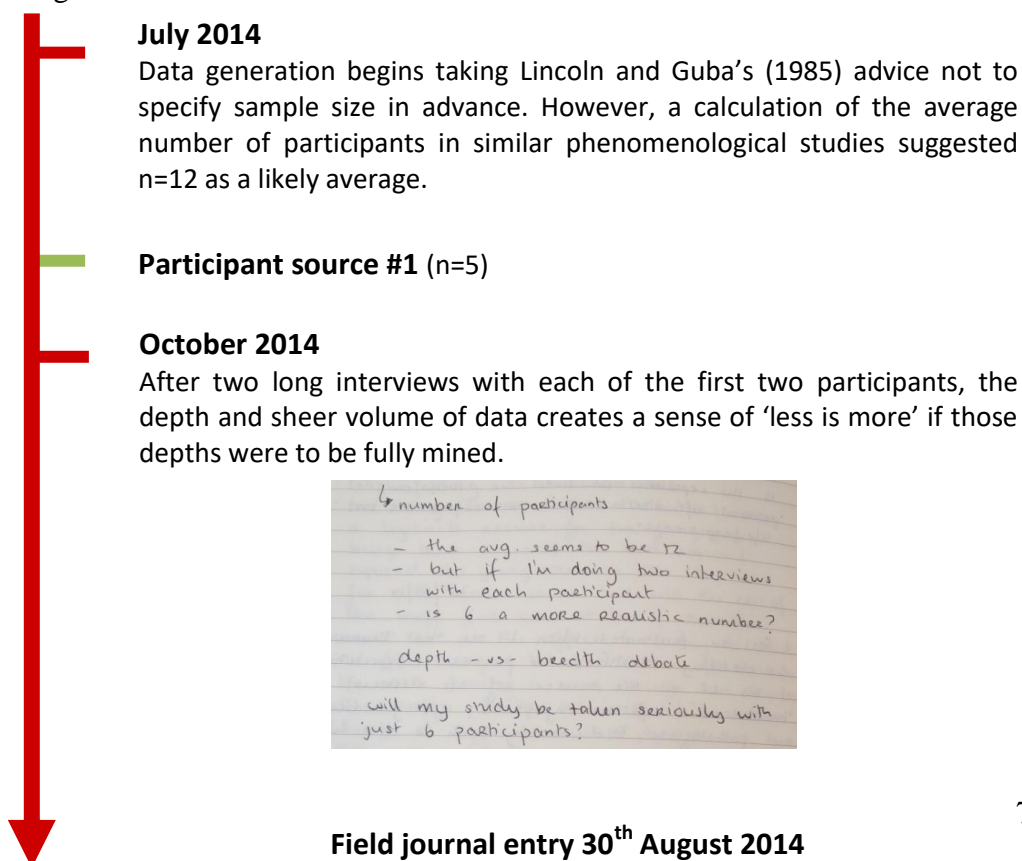
4.3.2 Sample - Size

Sample size was one of the most critical issues throughout this study. When Harry Wolcott was asked ‘how many qualitative interviews is enough?’ by a team of researchers from the British National Centre for Research Methods, he replied ‘the answer, as with all things qualitative, is “it depends”’ (p.3). Phenomenological studies, however, tend to involve smaller sample sizes as these are more cost and time efficient (Hicks, 1990) and allow for greater focus on depth rather than breadth (Quinn Patton, 2002). Speaking about sample size, Quinn Patton (2002) suggests,

No rule of thumb exists to tell a researcher precisely how to focus a study. The extent to which a research or evaluation study is broad or narrow depends on purpose, the resources available, the time available, and the interests of those involved. In brief, these are not choices between good and bad but choices among alternatives, all of which have merit.

(Quinn Patton, 2002, p. 228)

The choices made in this study with regard to sample size are outlined in Figure 2.





November 2014

The first source of participants has been depleted at n=5 and additional student participants are sought.

Participant source #2 (n=4)

January 2015

By this time six students have been interviewed and there is a sense that the study would benefit from a more diverse range of perspectives on the phenomenon. The initial figure of n=12 is seen as an ideal estimate. A third source is drawn from in order to recruit an additional 2-3 students.

Participant source #3 (n=18)

29th January 2015

An email is sent out to students registered with the TCD Disability Service inviting them to participate in the study. Those interested were asked to write to the lead researcher – a step that involved them constructing a new email to an otherwise unknown individual.

The email was sent at 5.30pm. By 6.30pm, eight students had responded and by the next morning 16 students had written requesting to take part in the study. In total 21 students wrote offering to share their experiences (a significantly greater number than the 2-3 respondents anticipated by the Director of the Disability Service).

30th January 2015

An urgent meeting is called with MS to decide how best to respond to the volume of students who wished to participate. The following three options were outlined and discussed:

Scenario 1	<ul style="list-style-type: none">– Cap the number of participants at 12– Interview each student 2+ times– Write to the additional 18 students and decline their offer to participate.
Scenario 2	<ul style="list-style-type: none">– Cap the number of participants at 12– Interview each student 2+ times– Invite the additional students to participate in a focus group.
Scenario 3	<ul style="list-style-type: none">– Interview all eligible students (n=27)– Conduct one long interview with each student – extending into 2 when (a) the interview exceeds 90minutes, (b) the student appears tired, (c) the student requests to go back over a certain aspect of their first discussion, and/or, (d) the researcher is unsure or unclear and requests a second interview to clarify certain events/experiences.

30th January 2015 (contd.)

Scenario 1 was the 'as is' scenario – maintaining the original plan of a smaller number of participants and a focus on depth rather than breadth. However, it meant that the 18 students who had courageously taken the leap of faith in writing to a complete stranger asking to share their experience of mental health difficulties would have to be turned down and denied the opportunity to tell their story. It was also noted from the interviews already carried out that, while a second interview allows for development of a strong relationship with each participant, it did not add significantly to the data generated. Participants seemed most interested in engaging in a respectful and empathic conversation which offered them the opportunity to share their experience and story, largely uninterrupted, from beginning to end.

Scenario 2: MS proposed inviting the additional students to participate in a focus group. This group would be led by the themes raised in the one-to-one interviews and would provide an excellent forum in which to further explore these themes and issues. However EF was concerned that (a) a focus group was not an appropriate data generation method for hermeneutic phenomenology (with its focus on understanding each individual's experience of a phenomenon) and (b) focus groups raised a number of ethical issues – particularly around anonymity and confidentiality.

Scenario 3 accepts all students who were available and eligible to participate (3 of the students who replied were either abroad on Erasmus or not available to meet due to other commitments). Instead of focusing on a select number of students (the limitations of which have already been outlined in scenario 1) this scenario allowed for more students perspectives and experiences to be included in the data set.

Following considerable exploration of each scenario and its impact on the overall research project, particularly in light of its hermeneutic

Figure 2 Sample size audit trail

As outlined in Figure 2 the sample size evolved considerably as the study unfolded. The dawning reality of the sheer depth of the data generated after just four interviews with two students led to a sense that 'less is more' but after six it became apparent that this number was limited in terms of diversity. The majority of these first group of students were female and their accounts heavily shaped by the source from which they were recruited (see section 4.3.3). It was felt that the inclusion of an additional cohort of students, from a different source, would add significantly to the richness and diversity of the data. As will be discussed in the following section, one significant factor underpinned the selection of sources from which students could be invited to participate.

This factor was the direct availability of support to the student if participating in the study brought up old or difficult feelings or issues for them. This and other measures to ensure the study was carried out ethically and responsibly are discussed in section 4.7.

As seen in the latter half of Figure 2, the invitation to participate sent to students registered with the Trinity College Dublin Disability Service (source #3) far exceeded the 2-3 respondents anticipated by the Director of the service (based on previous research calls to participate). This was thought to reveal a lot, not only about the need for spaces where students can share their stories with a sense of them being used for ‘good’, but also about the desire amongst the student body to have their stories heard. The sheer volume of respondents presented the researcher with a moral dilemma – ‘hear’ the stories of all and risk the quality being compromised by the quantity; or inform the students that their stories cannot be heard as they exceed the prescribed sample size. It also presented a number of practical dilemmas as a larger sample size would require more time (as it happened, an additional year) and expense. However, the desire to provide a space for the stories of those brave enough to volunteer them to be heard, outweighed the alternatives, and scenario 3 (as outlined in Figure 2) was deemed of greater ‘merit’, as Quinn Patton puts it, than the others. However this was not without its consequences and the sheer volume of the data presented the researcher with an enormous analysis workload as well as a nagging worry that the depths to which the analysis could plunge was limited by the expanse of the dataset. It was felt, however, that conscious awareness of this concern, coupled with natural conscientiousness and a sense of respect and responsibility towards the student participants, meant that each story was afforded as much diligence as if it were the only one in the dataset and not one of 27. The one limiting factor of such a large number of participants, and consequently a large number of narratives, was that the time that could be allocated to engaging in a to-and-fro relation to each was somewhat restricted. Overall it was felt that there was no ‘good or bad’ (Quinn Patton, 2002, p. 228) option, but that the sample size option taken was the best option available at that time.

4.3.3 Sample - Access

Invitations to participate in this study were extended to students through three sources. The first was a youth mental health charity with which the researcher is heavily involved. Headstrong, the National Centre for Youth Mental Health, aims to change how Ireland thinks about youth mental health through its Jigsaw services, research and youth and community engagement. The third of these three ‘legs’ to the Headstrong stool sees young people, as youth advisors, at the heart of the organisation. Each Jigsaw service has a Youth Advisory Panel (YAP) and a representative of each combines with a range of other key youth representatives on the National YAP. This National YAP is facilitated and supported by a youth engagement co-ordinator – an individual who acted as the chief point of contact for this study. In order to send an email to members of the YAP inviting them to participate in this study, ethical clearance had to be obtained from the organisation. This involved completing an ethics application (that of the UCD School of Psychology) which was assessed and approved by the organisation’s ethics committee. Although Headstrong focuses on young people in the 12-25 age group, not all of the youth advisors (a) had personal experience of psychological distress, and/or (b) were engaged in third level education (HETAC levels 7-10). This meant that a small number were eligible to participate but the majority of those who were, replied to invitation email and generously shared their time and their story. In total, five participants came from this source.

As the interviews and analysis progressed, a certain homogeneity emerged amongst those students invited via the first source. These were young people with a passion and ability to advocate on the issue of youth mental health and, while it was a privilege to bear witness to this articulacy, it was felt that a more diverse set of stories might present varying perspectives. Also, it was felt at this time that five or six was a rather limited number of participants and that a wider range of experiences would create a greater understanding of the lived experience of students with mental health problems overall. As it happened, the desire and ability to articulate their experiences of psychological distress did not vary much amongst the students accessed through the three sources. It appears that the space and freedom offered by the approach itself made for the rendering of powerful accounts, regardless of any prior advocacy experience.

As will be discussed in section 4.7, the study's strong ethical foundation meant that participants could only be sought in spaces where the researcher could be sure of immediate and efficient support in the event that the student was affected by the issues brought up over the course of their interview(s). This limited the number of available sources as, in addition to the availability of support, the researcher required ethical approval from each individual source. As a result, the researcher's own college, Trinity College Dublin (TCD) provided a strongly viable option as it met both these criteria – all registered students are entitled to access a range of support services and the researcher had already obtained ethical approval to commence the study itself. In addition, the researcher was actively involved in a student peer support programme and it was through this that she first approached fellow peer supporters, inviting those with their own experience of mental health problems to participate. This source yielded four student participants.

At this stage the sample size was at nine students and it was decided to seek the support of the Director of the college Disability Service in recruiting an additional two or three. The Director was happy to support the request to send an email to students registered with the disability service but felt that, based on previous experience, this approach was unlikely to yield a significant number of respondents. As described in section 4.3.2, this turned out not to be the case and a total of 21 respondents emerged from this source, with 18 in a position to participate.

4.3.4 Sample – Overview

A total of 27 students participated in this study. Their pseudonyms, ages, course and level of study, and the number of interviews they engaged in, are outlined in Table 2.

Participants ranged in age from 19 to 43 with an average age of 24. The majority of students (n=25) attended the same university with six studying at postgraduate level and 21 studying for an undergraduate degree.

Pseudonym	Age	Sex	UG/PG	Field of Study*	Interviews
Adrianna	22	F	UG	AHSS	2
Alicia	22	F	UG	AHSS	1
Annie	21	F	UG	AHSS	2
Ashley	22	F	UG	AHSS	1
Claire	20	F	UG	STEM	1
Ella	21	F	UG	AHSS	1
Faye	20	F	UG	Health Sciences	1
Fiona	19	F	UG	AHSS	1
Greg	29	M	PG	STEM	1
J.D.	20	M	UG	AHSS	1
James	26	M	PG	STEM	1
John	29	M	UG	AHSS	1
Joseph	43	M	UG	AHSS	1
Kate	27	F	PG	AHSS	1
Kinsley	21	M	UG	AHSS	1
Lauren	21	F	UG	AHSS	1
Leon	41	M	UG	AHSS	1
Louise	30	F	UG	Health Sciences	2
Mai	22	F	UG	Health Sciences	1
Marie	23	F	UG	STEM	2
Mary	26	F	PG	AHSS	2
Millie	19	F	UG	AHSS	1
Niamh	21	F	PG	AHSS	1
Robert	25	M	UG	AHSS	1
Sarah	26	F	PG	AHSS	2
Sophie	20	F	UG	AHSS	2
Thomas	19	M	UG	AHSS	2

Table 2 Participants - Overview

Legend:

UG – Undergraduate

PG – Postgraduate

AHSS – Arts Humanities and Social Sciences

STEM – Science, Technology, Engineering and Mathematics

* - Students were grouped broadly under one of the three major departments adopted by most major Irish universities. This was so as to provide insight into the student's area of study without providing overly specific detail that might reveal their identity.

4.4 Data generation

The genuine will to know calls for the spirit of generosity rather than for that of economy, for reverence rather than for subjugation, for the lens rather than for the hammer.

(Spiegelberg, 1984, p. 680)

Data, stemming from the Latin 'datum' meaning something 'given' or 'granted', reflects the manner in which a hermeneutic phenomenological researcher is 'given' an insight into another's experience. However, as van Manen (1990) points out, experiential accounts are never identical to the lived experiences, rather transformations of those experiences:

So the upshot is that we need to find access to life's living dimensions while realising that the meanings we bring to the surface from the depths of life's oceans have already lost the natural quiver of their undisturbed existence.

(van Manen, 1990, p. 54)

The point of hermeneutic phenomenological data generation is to 'borrow' other people's experiences in order to form an understanding of the deeper meaning of an aspect of human experience. The data of other people's experiences allows us to become more informed, shaped and enriched, so as to enable us to render a fuller understanding of the phenomena in question.

Hermeneutic phenomenological data may be generated using a number of techniques. These include conversational interviewing, eliciting written responses, participation observation and oral or written biographies (van Manen, 1990). However, the most commonly employed data generation technique in hermeneutic phenomenological research is conversational interviewing. Conversational interviewing is an effective means of exploring and gathering experiential narrative material with the aim of developing a richer and deeper understanding of a human phenomenon (van Manen, 1990). The conversational nature of hermeneutic phenomenological interviewing allows for what Bernstein (1991, p. 4) calls the 'to-and-fro play of dialogue' with the ultimate aim of a 'fusion of horizons' (Gadamer, 1960) between researcher and participant.

4.4.1 Conversational Interviews

A total of 35 conversational interviews were carried out with 27 students. These ranged in duration from 40 (for a second interview) to 90 minutes with an average of just over an hour.

An email was sent through a key stakeholder from each of the three sources outlined in 4.3.3 inviting students to participate. This email outlined the purpose of the study; with its emphasis on understanding what it's actually like to live with mental health difficulties, and its aim to better understand the lived experience of students with mental health problems. The criteria for participation are also described in this email

Interested students responded, more often than not, by sharing a little about themselves and why they would like to participate. A response from the researcher thanked them for generously volunteering their story and then provided them with an information sheet (Appendix 1) and a copy of the consent form so that they have a clear sense of what will be involved should they decide to continue and participate. At this stage, if the student was happy to proceed, a date and time for the first interview was arranged.

First Interview

In the majority of cases the researcher met the student at a public meeting point and from there they walked to the room where the interview was to take place. This offered the researcher a brief opportunity to chat casually to the student and set them at a little more ease.

Once settled in the quiet interview room the researcher would reiterate the aims of the study – emphasising that it was very much about understanding the student's experience, that there were no right or wrong answers, and that what was important (to the researcher) was whatever was important to the student themselves. The student was then talked through the consent form (Appendix 2), which they will have already received a copy of before interview, and reminded of their rights as participants. The student was then offered the opportunity to ask any questions before they completed and signed the consent form and the digital voice recorders (two were used in case one failed) were turned on. Each interview commenced with the same general statement "sometimes it can be a little difficult to get going but I wonder if you could tell me a little about yourself and your experience?"

From here the student would typically begin by describing themselves, what they are studying and a little about their family/living situation. However, often within the first 5 minutes, the student would begin to settle in, open up and share their story – the story of their experience of



First Interview (contd.)

Interviews typically lasted between 60 and 90 minutes with the researcher drawing interviews that went over 90 minutes to a close with an assurance of continuing the conversation at a second interview.

The interview would often draw to a natural close itself – marked by a sense of an ending to the story the student was telling that day. The researcher at this point would bring the student back – re-orientating them into the present by asking about their plans for the rest of the day or chatting casually about upcoming assignments or plans for mid-term break. Most importantly the researcher would check-in with the student and ask them how they are after sharing what was often a deeply painful story. She would assess how they were doing in the immediate term and tell them that she would check-in with them later that day by email to see how they are doing.

Immediately after the interview the researcher would make notes in the field journal. These would often be added to later in the day, and sometimes in the days following the interview, as new thoughts, ideas and reflections came to mind.

A follow-up email was sent to every student the evening after their interview. Each was personalised, expressing the appreciation and enormous respect felt towards the participant. It was outlined that, sometimes after going back over such deeply personal issues, the student may feel vulnerable and, if they were at all concerned, the student was encouraged to get in touch with the researcher and additional support could be sought if necessary. For students who only did one interview, they were invited to stay in touch and were reminded that they would be updated about the research at various points throughout its lifecourse.

For students taking part in a second interview, steps 3-5 were repeated a second time

Figure 3 Data generation audit trail

Interviews were carried out in one of two locations – a quiet office in the Headstrong headquarters or a small room on the upper floors of the Trinity College Arts Block. Both locations were ‘safe’ for participants, in that they were familiar environments, as well as ‘safe’ for the researcher, in that support was available on-site at all times should it be needed.

The conversational interviews themselves were just that – conversational. The experience, as researcher, of walking into a room to meet a stranger without an interview schedule or any sense of how things were going to unfold, was intimidating to say the least. It offered a sense of how reassuring a clipboard with a series of guiding questions could be and how, particularly during the first few interviews, a lack of clear structure meant that every interview was a journey into the great unknown. However, the lack of structure proved to be one of this approach’s greatest offerings in that it created space for the student to take the researcher through their experiences, thoughts and feelings without these being curtailed or restricted by the pre-ordained conventions of an interview schedule or hypothesis-driven agenda. The researcher simply sparked the conversation with the question outlined in Figure 3, and interjected only when (a) she didn’t quite understand something and needed clarification, (b) when trains of thought or conversation slowed and appeared to come to a halt and needed to be restarted and, (c) from time to time, to gently steer the focus back to what *it was actually like* (lived experience) and rather than getting overly caught up in the ‘and then this happened’. Prior to almost every interview the researcher experienced a gentle worry that, without the handrail of a series of pre-prepared questions, the conversation would fall flat. However, time and again she was astonished at how much students wanted to share, and how much they thrived upon the opportunity to tell their story in their own words, in their own way, and in their own time. The richness and complexity captured in the data presented in chapter five bears testimony to this.

The check-in emails sent to each student after every interview, had a two-fold intent - to thank them for giving so much during the interview and to check that it hadn’t taken too much out of them or brought any difficult feelings or memories back to the surface. However, it also offered them an opportunity to feedback, not only how they were doing, but how they found the experience overall. The following feedback, offered by Niamh, reflected the students’ appreciation not only of the approach and its value in informing responses to mental health issues, but the opportunity to be empathically and respectfully listened to.

I haven't really ever opened up or talked in depth about those experiences since therapy a few years ago. It was incredibly emotional for me I guess but a huge satisfaction came from it especially today I feel like a weight off my shoulders. It's an honour to talk to someone so incredibly empathetic and a great listener and I hope it will help your research and it will future allow other professionals in the mental health care services that peoples experiences have such a huge richness and so much can come from it. I admire the approach you are taken and the time and effort it takes.

(Niamh, in response to check-in email)

A total of 36 hours of audio was recorded over the course of the 35 conversational interviews and yielded, when transcribed, 997 pages of written data.

4.5 Data analysis

Perhaps the greatest challenge in adopting a philosophical approach such as hermeneutic phenomenology, is translating its often complex philosophical concepts into methodological techniques. Indeed, as Roberts and Taylor (1998) have noted, 'many of the so-called phenomenological methods leave prospective researchers wondering just what to do' (p.109). In attempting to overcome this challenge, data generated over the course of this study were analysed using a combination of the principles of the hermeneutic circle and the methodological framework for thematic analysis offered by Braun and Clarke (2006).

4.5.1 The hermeneutic circle as method of interpretation

The concept of the hermeneutic circle can be viewed from both ontological and methodological perspectives. Heidegger and Gadamer both viewed the circularity of interpretation, not so much as a methodological principle, but as a ubiquitous and inescapable feature of all human efforts to understand (Schwandt, 2007). As such there is no method, experience or meaning that is independent of the hermeneutic circle. Moreover, all efforts to interpret or understand are always located within some background (e.g. socio-historical tradition, value system or practice) that cannot be ignored. Prior to generating and analysing the data, time was devoted to explicating this background (see chapter three).

The hermeneutic circle is essentially based on the idea that understanding the meaning of a text as a whole involves making sense of the parts, and grasping the meaning of the parts depends on having some sense of the whole (Schwandt, 2007). As such, interpretive understanding goes forward in stages with continual movement between the parts and the whole allowing understanding to be enlarged and deepened.

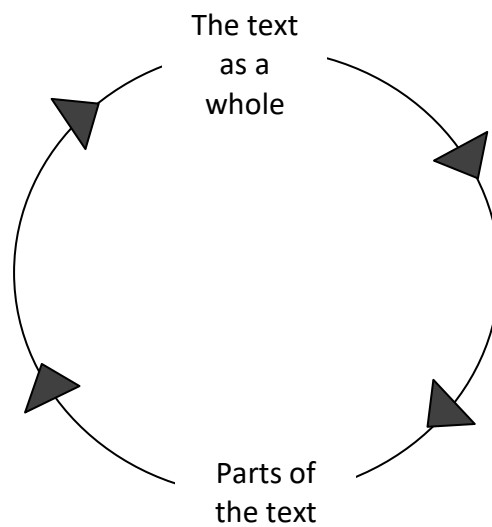


Figure 4 The hermeneutic circle as method of interpretation

The hermeneutic circle, by its very circular nature, suggests that the meaning of a text is not something that can be grasped once and for all. Meaning exists in a complex interplay between parts and whole. Braun and Clarke's (2006) six-step process of data analysis provided a flexible framework for analysing the 'parts' as well as the 'whole' of the text (Figure 5). It is a framework that enjoys 'theoretical freedom' (Braun & Clarke, 2006, p.5) in that it is applicable across a range of epistemological and theoretical approaches without impeding on the particular values of an approach such as hermeneutic phenomenology. As Braun and Clarke (2006) themselves acknowledge, 'one of the benefits of thematic analysis is its flexibility' (p.4). As such, it is a methodological framework that can be adapted to align more closely with the approach taken. Figure 6 outlines the relationship between the data analysis procedure

employed in this study, Braun and Clarke's (2006) method of thematic analysis and the hermeneutic circle itself.

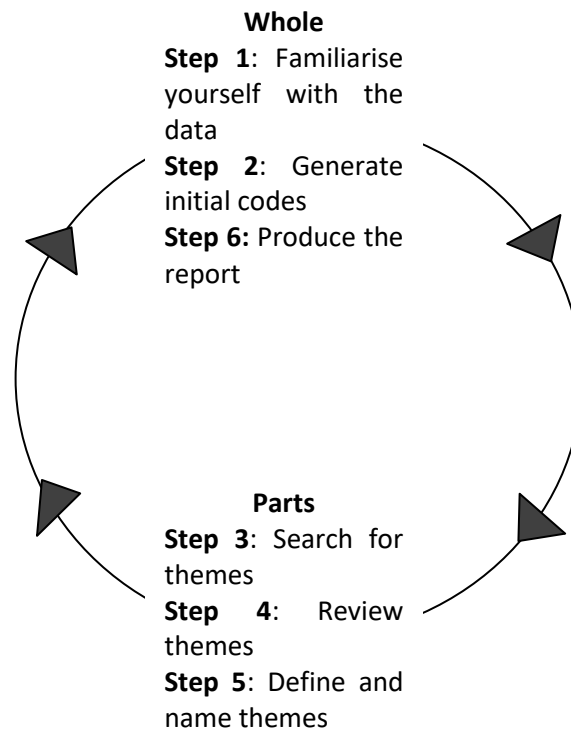


Figure 5 Braun and Clarke's (2006) six step method of thematic analysis as aligned with the hermeneutic circle.

Before the data were analysed, each audio recording needed to be transcribed from oral to written form. After transcribing the initial set of interviews, it was decided that employing the services of a professional transcription agency was more cost and time efficient in light of the volume of data. Each transcript produced was carefully checked, however, in order to ensure that the written transcript was a verbatim account of the audio recording. As will be seen in Figure 7, a stage in the data analysis process was set aside for this task alone. This offered an opportunity, not only to access accuracy, but to add linguistic annotations and descriptions of any gestures the students made.

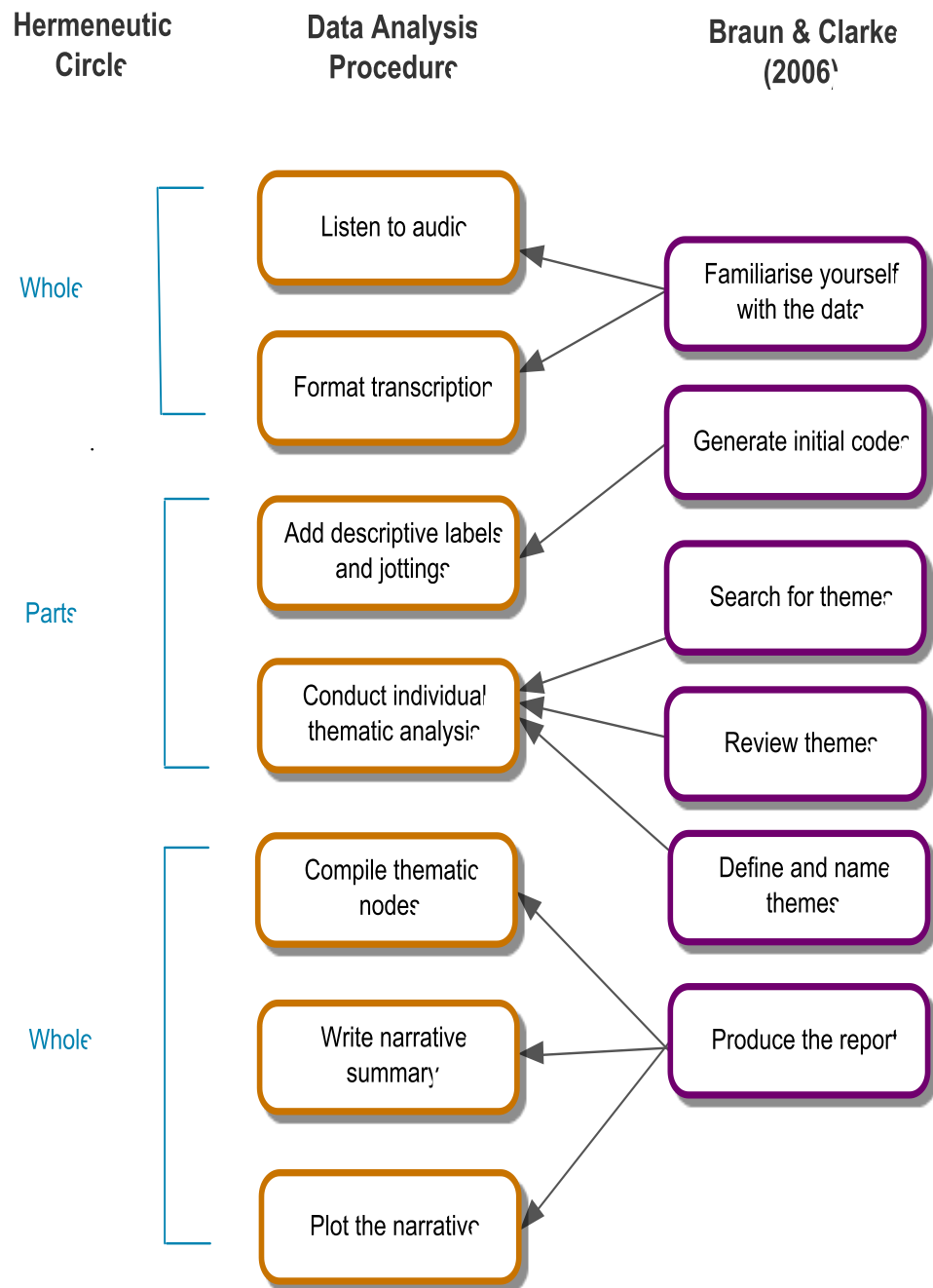


Figure 6 Relationship between individual data analysis procedure, hermeneutic circle and Braun and Clarke's (2006) method of thematic analysis.

1. Listen to the Interview

Before engaging with the written dataset the researcher listened to the entire interview from beginning to end in order to re-familiarise herself with the student and their story as they told it. This step not only offered the researcher an opportunity to refresh her memory, but also to reconnect with the felt sense that was generated over the course of the interview(s) without the distraction of the written word.

2. Format Transcript

Every transcribed interview was carefully checked for accuracy by reading through the transcript while listening to the audio recording a second time. This step allowed for the correction of any inaccuracies as well as offered a second 'hearing' of the interview.

3. Add Descriptive Labels and Jottings

The audio was listened to a third and final time but this time the researcher would add descriptive labels and jottings in a margin constructed along the side of the transcription. This was the point at which content and themes began to be noted and a sense of what the dataset reveals overall began to form. As seen in the segment below, taken from an interview with Kinsley (p.20), the labels at this stage were mainly comprised of striking elements of the students' quotes. This ensured that the labelling process remained as true to the students' own words as possible.

<i>What happened is still very much with me, you know.</i>	"still very much with me"
<i>In what way?</i>	"didn't think about mental health at all" before psychotic episode
<i>Well, I mean, one is that for, like, my first three years in college I didn't think about mental health at all, you know, I was just, you know, I didn't give it a single thought and now after what happened to me like mental health is such a huge issue with me, you know, now. Just I mean like this kind of new relationship I have with my mind after the episode, you know, like now I know where it can go if things go wrong so I have this completely new relationship. It's not something that you establish and then that's it, you have to</i>	Now MH is "such a huge issue" for him Episode resulted in him having a "new relationship" with his mind Knows what can happen if "things go wrong" Feels MH is something he will always be very aware of – will always have to work to maintain positive relationship with his mind & MH
<i>continue kind of keeping with it, you know</i>	



4. Conduct Individual Thematic Analysis

This step enveloped three of Braun and Clarke's methodological steps (as seen in Figure 6). It also marks the step where the data began to be 'transformed' (Wolcott, 1994). This transformation involved actively uncovering themes or, as van Manen (1990) describes them, 'knots in the webs of our experiences, around which certain lived experiences are spun and thus lived through as meaningful wholes' (p.90). A theme, according to Braun and Clarke (2006), 'captures something important about the data in relation to the research question, and represents some level of *patterned* response or meaning within the data set' (p.82).

Continuing the thread of Kinsley's dataset, two themes, or patterns, emerged from the segment above:

- "completely new relationship" with his mental health post psychotic episode
- Constantly having to work to maintain positive relationship – while knowing "where it can go if things go wrong".

This micro level of analysis continued and, once completed, was followed by a 'stepping back' and taking stock of all of the themes generated. This step offered an opportunity to review the themes, or parts, in relation to the 'whole' dataset to see if they meaningfully capture the entire dataset or an aspect thereof.

5. Compile Thematic Nodes

While Braun and Clarke (2012) encourage researchers using their approach to refine and define their themes at this stage, this research adopted a slightly alternative approach. Instead of concretising themes, it was acknowledged that, as the hermeneutic circle is a dynamic and essentially continuous process, solidifying themes at this stage would suggest an absolute end to the circle of understanding. Instead, the researcher created a separate document for each student which listed each theme and its subthemes, generated by phases 1-4, and accompanied these with all the sections of the transcript relating to that theme/subtheme. This means that each theme and subtheme could be revisited at points throughout the research process and prevented the themes being locked into the particular form of understanding that existed at one point in the process. While ultimately, by its very nature, the PhD dissertation will reflect understanding at a single point in time, namely the point at which it is written in preparation for assessment, compiling rather than concretising thematic nodes at the analysis stage allowed greater scope and time for the circular movement between the parts of a single dataset, and its whole; the parts of a single dataset in relation to parts of other datasets, and; the whole of a single dataset in relation to the 'whole' dataset.

6. Write Narrative Summary

In developing this phase, Braun and Clarke (2012) were primarily focusing on the construction of reports, journal articles or other research outputs. However, in this study, phase six represented the opportunity to truly step back and review the 'whole'. It involved writing a 'narrative summary' of each student's story that was both temporal and thematic i.e. it told their story, as they described it unfolding, and ensured that the major themes identified in earlier phases were represented in this chronological telling.

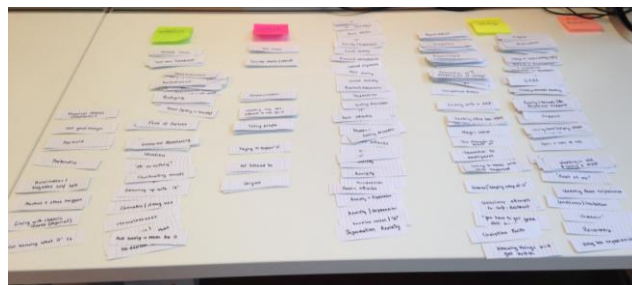
7. Plot the Narrative

During the data generation process, and particularly in the early stages of data analysis, a structure began to emerge from the students' narratives. It became clear that the students themselves, when given freedom and space to tell their story in their own words, did so in a particular way. Their stories followed a 'plot'. This plot will be discussed in further detail in the next, findings, chapter.

While the plotting of the initial stories began as an exercise in curiosity, it became clear that this structure was revealing something very important about the way in which the students were making sense of their experiences. It revealed the narrative meaning that the students had ascribed to their experiences and, as the same structure emerged in dataset after dataset, the plotting of narrative became not only an integral part of the data analysis process but a unique way of viewing each dataset, both in terms of its 'parts' and its 'whole'.

8. Group Thematic Nodes

Once the seven steps above had been completed for each of the 27 students, the thematic nodes generated in steps four and five were compiled and organised. This involved writing each of the 331 thematic nodes generated across the dataset on individual strips of card with the student's pseudonym on the back. Each piece of card was then laid out and placed under the stage of the narrative plot to which it most related.



Initial attempt at organising thematic nodes

8. Group Thematic Nodes (contd.)

Within each of the phases, closely relating themes, were grouped. For example, “‘picked on” by teachers’ (Mai), ‘Bullying’ (Marie, Ella, Niamh, J.D., Sophie) and ‘Dyslexia’ (J.D., Sarah), were all themes relating to issues that students described affecting their early school experiences and so were grouped under the heading of ‘Difficulties in School’.



Final grouping of thematic nodes

These headings then directly formed headings in the Findings chapter, with each of the thematic nodes, and the students’ quotes relating to these nodes (step 5), being drawn upon in the writing of this chapter.

Figure 7 Data analysis audit trail

4.6 Trustworthiness

Up until the late 20th century, social science researchers had developed a certain degree of consensus about what counted as knowledge and, more importantly, what kind of knowledge claims could be validated. However, the ‘narrative turn’, which occurred towards the end of the century, posed a challenge to conventional forms of evidence. Researchers steering the narrative turn, which Polkinghorne (2007) collectively refers to as ‘reformists’ (p.472), argued that personal descriptions of life experiences offered knowledge about important, but often neglected, aspects of the human realm. The pre-existing group, which Polkinghorne (2007) refers to as ‘conventionalists’ (p.472), struggled to accept this new movement. Their dismissal of the claims generated by this form of research was largely justified by the failure of the claims to withstand conventional measures of validity.

Typically, the issue of validity is approached by applying one’s own community’s protocols about what, in its view, is acceptable evidence and appropriate analysis to the other community’s research. In these cases the usual conclusion is that the other community’s research is lacking in support for its knowledge claims.

(Polkinghorne, 2007, p.474)

In response, researchers, such as Lincoln and Guba (1985), took conventional criteria for establishing the ‘trustworthiness’ (p.289) of claims and developed parallel criteria for more qualitative research approaches. These criteria of credibility, transferability, dependability and confirmability will structure the discussion around this study’s efforts to uphold standards of rigour and trustworthiness. Table 3 provides a visual overview of conventional measures of validity, Lincoln and Guba’s (1985) parallel criteria for qualitative research, and the measures taken to uphold and demonstrate efforts to ensure that the data, interpretations and claims espoused in this study are, in so far as it is possible, trustworthy.

	Scientific paradigm criteria	Lincoln & Guba (1985)	Measures taken
Truth values	Internal validity	Credibility	<ul style="list-style-type: none"> ✓ ‘Phenomenological nod’ ✓ Critical friend ✓ Field journal ✓ Narrative summaries
Applicability	External validity	Transferability	<ul style="list-style-type: none"> ✓ Sample transcript and analysed outputs from this transcript ✓ Critical friend ✓ Overview of approach taken (chapter two)
Consistency	Reliability	Dependability	<ul style="list-style-type: none"> ✓ Explication of researcher’s bias (chapter three) ✓ Outline of methodology (chapter four) ✓ Audit trail
Neutrality	Objectivity	Confirmability	<ul style="list-style-type: none"> ✓ Direct quotations ✓ Critical friend report ✓ Sample transcript and analysed outputs from this transcript

Table 3 Criteria for establishing trustworthiness (Lincoln & Guba, 1985) and measures taken to ensure trustworthiness in this study

4.6.1 Credibility

The term ‘credibility’ is used to represent the truth value of the research. Lincoln and Guba (1985) claim that a study is credible when it presents such faithful descriptions that when co-researchers or readers are confronted with the interview transcriptions they recognise the thematic conclusions. The Dutch phenomenologist Buytendijk referred to the ‘phenomenological nod’ as a way of indicating that a credible phenomenological description is something we can nod to, recognising it as an experience that we have had or could have had (van Manen, 1990).

In order to ensure that all conclusions arrived at in the current research are firmly grounded in the data, a random selection (n=4) of interviews – their recordings, transcripts, thematic analyses, narrative summaries and plots – were read and assessed by a ‘critical friend’. With a background in philosophical criticality, the critical friend was well poised to assess the credibility and truth value of the data analysis. The critical friend’s full report may be seen in appendix 3.

According to Koch (1994), credibility in hermeneutic phenomenology is enhanced when researchers describe and interpret their experience as researchers. She believes self-awareness to be essential and recommends researchers keep a journal ‘in which the content and process of interactions are noted, including reactions to various events’ (Koch, 1994, p. 92). A detailed field journal was maintained throughout the data generation, analysis and ‘write up’ phases of this research project. Comprising of two full ‘moleskine’ notebooks, the field journal(s) offered a space to record details around the data generation process, researcher’s reflections on her experience of engaging in the ‘to-and-fro’ of each conversational interview, and any instances where her own ‘prejudice’ may have bubbled to the surface. It also offered a space for the researcher to consider the identification of themes in the analysis process and the many factors that may have resulted in her ‘seeing’ some themes and not others.

4.6.2 Transferability

The applicability of conventional social science research is assessed by how well threats to external validity have been managed. These threats include anything that may interfere with a study's ability to produce claims about cause and effect relationships that are generalisable to populations. Reformist approaches, in contrast, believe generalisability itself to be somewhat of an illusion and focus, not on cause-and-effect relationships, but on understanding human experiences. Guba and Lincoln (1985) suggest that the applicability of such research is better established by its transferability or 'fittingness' into similar contexts.

A study meets the criterion of fittingness when its findings can "fit" into contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experiences. In addition the findings of the study, whether in the form of description, explanation, or theory, "fit" the data from which they are derived.

(Sandelowski, 1986, p.32)

Contextual information is essential if a reader is to assess whether findings "fit" into particular contexts. Although each student's story is entirely unique, the reader is provided with a detailed narrative summary which provides contextual information, not only on the student and their story, but on the process by which the story was generated and analysed. Moreover a full transcript is provided so that a reader may be able to read a verbatim account of an interview and determine if the interpretations of this data, presented in the narrative summary and in the findings relating to that particular student, "fit" with the data from which they are drawn. The critical friend had an opportunity to do this with four full transcripts and his appraisal of transferability may be seen in his report in appendix 3.

4.6.3 Dependability and confirmability

There is no neutrality. There is only greater or less awareness of
one's biases

(Rose, 1985, p. 77)

The consistency and neutrality of an inquiry, sometimes spoken of in terms of ‘reliability’ and ‘objectivity’, refer to the degree to which various readers or researchers may arrive at comparable, but not contradictory, conclusions given the same data (dependability), as well as the degree to which the conclusions may be confirmed by the data (confirmability).

Lincoln and Guba (1985) suggest that both dependability and confirmability are best assessed based on the study’s ‘auditability’.

Essentially an auditor called in to authenticate the accounts of a business or industry is expected to perform two tasks. First, he or she examines the *process* by which the accounts were kept, to satisfy stakeholders that they are not the victims of what is sometimes called “creative accounting” [...]. The second task of the auditor is to examine the *product* – the records - from the point of view of their accuracy.

(Lincoln & Guba, 1986, p.318)

Just as a fiscal auditor should have access to details of the process, the inquiry auditor, or reader, should have access to the details of the process by which the product – the data, findings, interpretations and claims – was developed. These details are presented in chapter 2, which outlines the approach itself and the researcher’s own ‘prejudice’, as well as in this methodology chapter which provides an audit trail detailing the sampling strategy and data generation and analysis processes.

The reader is also offered an opportunity to examine the accuracy of the ‘product’ in a number of ways. These include (a) the use of direct quotations, complete with reference to the page of transcript from which they were taken, (b) the critical friend report which provides an outsider assessment of the dependability and confirmability of four, randomly selected, transcripts and their outputs, and (c) access to one complete transcript, its initial analysis, the thematic conclusions drawn and the manner in which the student’s story was ‘plotted’ onto the narrative structure than emerged in the study.

In being able to assess the *process* of the inquiry, the reader is able to attest to its dependability (Table 3). Equally, in examining the *product*, the reader is able to confirm the degree to which the product is supported by the data. As such, auditability offers a means of assessing both the dependability and

confirmability of the study (Lincoln & Guba, 1985). Research cannot be considered trustworthy, that is, credible, transferable, dependable, and confirmable, unless it is, in the first instance, ethical.

4.7 Ethical considerations

Hermeneutic phenomenological research methods, such as conversational interviewing, typically require the researcher to enter the participant's world and access their lived experience (Polit & Hungler, 1999). As such, it may be classified as 'sensitive' research due to the potential for intrusion into the private sphere (Walker, 2007). Consequently, ethical considerations are of great importance in research adopting a hermeneutic phenomenological approach, particularly the present study which sought to access the lived experience of psychological distress. Gaining ethical approval is at the heart of all research, particularly sensitive research. Accordingly, this study necessitated, and was successfully awarded, ethical approval from both the School of Education TCD and Headstrong ethics committees.

According to Green and Thorogood (2010), all medical and social research ethical guidelines are underpinned by the key principles of informed consent and confidentiality.

4.7.1 Informed consent

Informed consent is the principle that participants should not be coerced or pressured into research 'against their will', but that their participation should be based on voluntarism and with full understanding of the implications of participation (Green & Thorogood, 2010). Informed consent has been the cornerstone of ethical guidelines since the Nuremberg Code – a code established as a result of the atrocities carried out by medical professionals during World War II (Homan, 1991).

Students who volunteered to participate in this study were informed about the aims of this research, what participation would entail and their rights as participants in a number of ways. First was the initial email invitation sent to students via the three sources outlined in section 4.3.3. Those who replied to

this initial email were then given more detailed information in the form of an information sheet (Appendix 1). They were also provided with a copy of the consent form and given time to read this in advance of the initial interview. The interview itself began with a verbal reiteration of the study's aims and the students' rights, as well as an opportunity to ask any questions, before the student completed and signed the informed consent form (Appendix 2).

4.7.2 Confidentiality

The Declaration of Helsinki (World Medical Association, 2008) which outlines the ethical principles of medical research, added confidentiality and privacy to the Nuremberg Code (Green & Thorogood, 2010). Confidentiality means not disclosing information gained from research in other settings, such as everyday informal conversation. It also relates to the protection of the identity of participants and sites in published accounts of the research.

Participant confidentiality was a significant factor in this study – one that was taken very seriously. The only instance in which confidentiality would have been breached was in the event that participants were deemed to be at immediate risk of harming themselves or others. This was in line with standard ethical practice in mental health research (Psychological Society of Ireland, 2011) and participants were made fully aware of this limit to confidentiality verbally, in the information sheet and in the consent form which they were asked to sign before the first interview. Thankfully this did not emerge as an issue at any stage throughout the study but if it had a protocol was in place at all times to ensure the researcher could access additional supports for the students if necessary.

Anonymity was an important aspect of confidentiality. Students were asked to choose their own pseudonym – a name that they liked and felt represented them without making them in any way identifiable. Other distinguishing features such as names, places, courses of study or events that would be considered usual or likely to make the student identifiable were altered to protect the student's identity.

In addition to these two cornerstones of ethical research, Beauchamp and Childers (2001) outline a number of moral principles upon which ethical research practice is based. These are:

Respect for autonomy: respecting an individual's right to make decisions and enabling them to make reasoned informed choices.

Respect for autonomy means respecting the participants' freedom to decide what to do. This particularly relates to the students' right to withdraw at any time without having to offer a reason. As already outlined, students were informed about their rights as participants in a number of ways – the participant information sheet (Appendix 1), verbally at their first interview and again in the consent form where they were required to tick boxes to confirm that they understood what was being asked of them and their rights as participants (including the right to withdraw at any time with giving a reason) (Appendix 2). Moreover, respect was one of the strongest values underpinning this research and respect for the student, and the stories they shared, extended far beyond the data generation process to every aspect of the analysis, write up and dissemination phases.

Beneficence: seeking to achieve the best balance between risk and benefit that achieves the greatest benefits for the individual.

This study sought to capture the 'unique insight and expertise' (National Service Users Executive, 2013) of those with lived experience of psychological distress so as to better understand the experience. At the outset, it wasn't clear if the participant would see any personal benefit in participating in the study. In addition, there was concern that participation may result in the student revisiting painful experience which may be distressing for them. However, as the data generation process unfolded it became clear that participating in this research offered students a rare opportunity to be listened to; to be truly heard for what *they* have to say without being interrupted or corrected; and for their perspectives and insights to be held as valuable sources of knowledge. In addition, students spoke about how much they wished to share their experiences in the hope that it may someday help another in a similar situation.

It appears that these two, largely unforeseen, aspects of participation meant that sharing their stories as part of the research was a worthwhile and even ‘cathartic’ (Kinsley – follow up email) experience for the students.

I would feel so happy if I could help even one person out there to avoid the mistakes I made growing up ... I was unlucky but through modern research I’m hoping that other people do not have to suffer like I did (Joseph, p.28).

Justice: addressing issues fairly for individuals in the same or similar situation.

This study, as outlined in chapter two, sees the phenomenon of psychological distress, to borrow Marcel’s (1950) sentiment, not as a problem in need of a solution but a mystery in need of evocative comprehension. It does not seek justice or to unravel a problem, rather to achieve a direct contact with the world of living with psychological distress. In this sense, the present study sought to ‘do justice’ *to* participants lived experiences rather than result in justice *for* participants and those in a similar situation.

Non-maleficence: Avoiding causing harm

The protection of those who participated in this study was of utmost concern. This concern extended beyond the important ethical aspects associated with the data generation process, to the protection of the students accounts and the integrity with which these stories were treated during analysis, presentation and dissemination.

Van Manen (1990, p. 162) outlines a number of ethical issues of which hermeneutic phenomenological researchers in particular, need to be aware:

- (a) Hermeneutic phenomenological research may have certain effects on participants. They may feel discomfort, anxiety, false hope, guilt, shame, self-doubt but also hope, increased awareness, moral stimulation, insight and/or a sense of liberation.
- (b) Hermeneutic phenomenological research may have certain effects on the institutions or systems on or in which the research is conducted. For example, insights into psychological distress generated by the current

study may challenge current understandings of mental health or illness and the responses and support provided to those who experience such distress (as seen in Nilsson, Naden and Lindstrom's (2008) study on the loneliness of community living for adults with severe mental illness)

- (c) Hermeneutic phenomenological research may have lingering effects on participants. For example, intense conversational interviews may lead to new levels of self-awareness, possible changes in life-style, and shifting priorities and viewpoints. But, if done badly, these methods may instead lead to feelings of anger, disgust, defeat, intolerance, insensitivity, etc.
- (d) Hermeneutic phenomenological research often has a transformative effect on the researcher themselves. It is often itself a form of deep learning, leading to a transformation of consciousness, heightened perceptiveness and increased thoughtfulness and insight.

These issues result in a number of additional steps to ensure non-maleficence to both participants and researchers in hermeneutic phenomenological research. For example, all participants needed to, at least, have access to professional support with which they could connect should there be any immediate or lingering effects as a result of participation. As already outlined in section 4.3.2, if the student was not already in contact with some form of mental health support, the researcher was in a position to support them in accessing this support if they wished. This was discussed at the end of every interview as well as in follow up emails sent to participants later that evening. Students were also encouraged to raise any concerns with the researcher and/or the research supervisors. This was clearly outlined in the information provided, along with the contact details of the researcher and research supervisors.

A number of steps were taken to support the researcher throughout the study. First, the researcher kept a regular reflexive diary which created a space for reflection, not only on the research process itself, but on the personal impact of engaging in this process. The presence of research supervisors also offered an essential form of support and encouragement. In addition, the researcher herself began to attend counselling during the data generation and analysis process. During these stages the researcher was immersed, often for hours

every day, in audio and written accounts of some of the most painful of human experiences. Counselling offered a safe and supportive environment in which she could discuss the impact, both positive and negative, being immersed in such material was inevitably having on her own 'horizon'.

4.8 Conclusion

This chapter outlined the 'how' of this study. It described how participants were recruited, how data were generated and analysed, and how the researcher went about ensuring the research was as ethical and trustworthy as possible. The next, findings, chapter is concerned with the 'what' – what the study revealed about the nature of the lived experience of third level students with mental health problems and the meaning they ascribe to these experiences.

5. Presentation of Findings

5.1 Introduction

The aim of this chapter is to present the findings that emerged from the analysis of data generated via the conversational interviews carried out with 27 third level students (as outlined in chapter four – methodology). These conversational interviews were guided by an openness to the phenomenon so as to (a) gain greater insight into the nature of the lived experience of third level students with mental health problems and (b) try to understand how these students make sense of, or ascribe meaning to, these experiences.

The chapter itself begins by describing the narrative structure, or plot, that emerged from students accounts of their lived experiences of psychological distress. This plot then acts as a structure for the remainder of the chapter, with the data being re-presented in four major sections according to the four stages of the students' narrative plot.

5.2 The narrative plot

Humans are storytelling creatures who, individually and socially, lead storied lives (Connelly & Clandinin, 1990). Storytelling, or narrative, is also the primary means by which human experiences are made meaningful. Narrative meaning, according to Polkinghorne (1988), is created through the organisation of experiences into temporally meaningful episodes. Because this process of organising experiences is a cognitive one, it is not readily accessible or assessable. However, as Polkinghorne (1988) points out, the output of this process, 'the individual stories and histories that emerge in the creation of human narratives are available for direct observation' (p.1). As such, it is by examining the ways in which the teller structures and orders their experiences through the stories they tell that offers us insight into how they make sense of, or ascribe meaning to, these experiences. Meaning, and how it is made, is explored in much greater detail in the next chapter 'discussion', with the remainder of this section focusing on the structure that students who

participated in this study drew on in ordering, or making sense of, their experiences.

Very early on in the data analysis process, a pattern began to emerge in the way the students were structuring their stories. Perhaps one of the greatest advantages of a data generation process that includes just one opening question (can you tell me about yourself and your experience?) is that it creates a ‘space’ and a freedom for the student to tell their story unobstructed by rubrics or interview schedules. Once the student had a chance to become comfortable with the narrative space being offered them, a comfortableness that came surprisingly quickly for most, they opened up and shared their experiences with an unexpected degree of fluency. As discussed in chapter four, one of the most common pieces of feedback from students after their interview(s) was that it offered them the space to tell *their* story in *their* own words and in *their* own way. It was this space, combined with a sense that their story was being acknowledged and respected, as well as the reality that their story could be a force for good and for change, that meant the most to the participants. Another benefit of this ‘space’, from a methodological standpoint, was that it offered relatively unadulterated insight into the ways in which the students structure their experiences into meaningful episodes.

The pattern that emerged in the way that students structured their experiences was underpinned by four discrete, but fluid, phases: ‘pre’ narrative, crisis/interruption, narrative wreckage, and ‘post’ narrative (Figure 8).

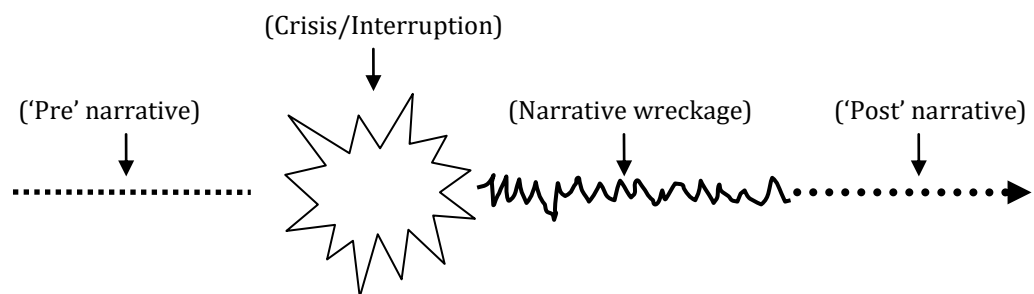


Figure 8 Visual representation of the narrative plot

The **'pre' narrative** phase encompasses both the narrative that preceded the moment where 'it', a student's own particular form of psychological distress, became a firm feature of their conscious awareness, as well as the narrative that, as Frank (2013) suggests, 'the past was supposed to lead up to' (p.55). This stage explores the factors that the students themselves identified retrospectively as being important in the development of their mental health problem. These features include experiences of childhood trauma and abuse, bullying and other school-related issues, perfectionism and, for many, a perplexing reality that there was no 'reason' for 'it'.

Regardless of whether there was an identifiable 'reason' for 'it' ('it' being the term used, in the absence of an agreed or universal alternative, to describe the psychological distress experienced by the students), each student seem to reach a point, almost inevitably, where they could no longer ignore or contain the distress alone. For many students the 'crisis point', a term used by Mary (p.12), came as the, often explosive, result of escalating internal and/or external tensions. For others it was somebody close to them who noticed that they were struggling and interrupted the narrative they had been constructing around the experience. For a small number, **crisis/interruption** was the point at which they just couldn't do it anymore and they considered or attempted to take their own lives.

Unlike physical illness, the duration of a psychological crisis, or at least those described by the students in this study, can vary from anything from days to, in a small number of cases, years with students caught in a macabre dance with crisis until something finally changes (Figure 10). The **narrative wreckage** stage describes 'what happens then'. It encompasses the ways in which the students sought help, how, from whom and what happened; as well as they ways in which they tried to build meaning from the 'wreckage' of the narrative they had for so long, told about themselves.

The fourth stage in the narrative plot is the **'post' narrative** stage. This stage and the boundary between it and its predecessor, narrative wreckage, is intensely subjective and blurred. A small proportion of the students who shared

their story as part of this research identified 'it' as being something in the past or, more commonly, subtly and noninvasively incorporated into their present. The remainder of this chapter will be devoted to exploring in greater detail both the landscape, to borrow the topographical metaphor, and narrative features of each of the four phases of the narrative plot. The landscape of each phase and what it can reveal about the way in which students make sense of their experiences, will be discussed; as will each feature, or thematic node, and what it can reveal about the nature of the lived experience of the students in this study. The four stages will be explored in chronological order, beginning with the 'pre' narrative phase.



Figure 9 Narrative plot and presentation of findings overview

5.3	'Pre' Narrative	5.4	Crisis/interruption	5.5	Narrative wreckage	5.6	'Post' narrative
.1	Introduction	1	Introduction	.1	Introduction		
.2	Trauma/ abuse	A Landscape	A Landscape	.2	Narrative wreckage landscape		
.3	Difficulties in school	.2	Landscape	.3	Narrative wreckage features		
.4	Perfectionism	.3	Articulating experiences	A Intervention	A Intervention		
.5	Existential thinking	.4	Help-seeking	.4	Psychiatry		
.6	Drugs and/or alcohol	B Features	B Features	.5	Hospitalisation		
.7	'It was clear from a very early age'	.5	Self-harm	.6	Diagnosis		
.8	No reason for 'it'	.6	Suicide	.7	Medication		
.9	Conclusion	C The Lived experience of...	C The Lived experience of...	.8	General Practitioner		
		.7	Depression	.9	Talking Therapies		
		.8	Depression and anxiety	B Higher Education	B Higher Education		
		.9	Anxiety and panic	.10	Transition to Higher Education		
		.10	Psychosis	.11	DARE		
		.11	Bipolar disorder	.12	University Disability Support Services		
		.12	Eating disorders	.13	Navigating HE with a MH problem		
		.13	Borderline personality disorder	.14	Studying a mental health related course with a mental health problem		
		.14	Conclusion	C Living with 'it'	C Living with 'it'		
				.15	Supportive others		
				.16	Telling people		
				.17	Living with/managing 'it'		
				.18	Making sense of 'it'		
				.19	Upside of 'it'		
				.20	Challenges/roadblocks		
				.21	Helping others		
				.22	Conclusion		

5.3 ‘Pre’ narrative

5.3.1 Introduction

This ‘pre’ narrative section represents the features of the students’ narratives which they identified as being important in the development of their mental health problem. It is the story before, and leading up to, when ‘it’ became an undisguisable presence in their lives. In contrast to the more standard medical history taken by health professionals, this research was afforded the luxury of not having to ‘curtail storytelling’ (Waitzkin, 1991, p. 28) with predefined systems of assessment or classification. Instead it offered a rare opportunity to sit with, and listen to, the students as they themselves identified what they felt contributed to their distress.

Each student’s story was unique. Each represented a complex weave of factors; warp and weft woven in innumerable ways to produce a unique tapestry of experience. Notwithstanding the uniqueness of the weave, many of the individual threads featured time and again in the students stories. What follows is a more detailed exploration of seven of these more oft-witnessed ‘threads’ or thematic features: childhood trauma; school-related difficulties such as bullying, dyslexia and the pressure of state examinations; deep seated perfectionistic tendencies coupled with an association between achievement and self-worth; a natural tendency towards contemplating the nature of existence itself; drug and alcohol use/abuse; a sense that ‘it’ was always part of them, and; an inability to find a ‘reason’ for ‘it’.

5.3.2 Childhood trauma

Six students made particular reference to traumatic events in their childhood which they felt contributed to their struggles later on. The term and what is said to constitute trauma, is often a source of debate (e.g. McNally, 2009; Rosen & Lilienfeld, 2008), however for the purposes of this research childhood trauma refers to ‘a deeply distressing or disturbing experience’ (Grey & Clohessy, 2014, p. 169) which occurred before the student reached the age of 18.

The word 'chaos' featured in both Adrianna and John's narratives. John described how he 'grew up in a quite chaotic family' (p.3). He says he 'could consider myself the underclass of society in that my parents didn't work and I grew up basically on social welfare' (p.3).

'Education was an inconvenience' (p.3) in John's home and the only expectation of him in life was to 'wait until you are 18, until you get social welfare' (p.3). Moreover, John described how his mother 'had undiagnosed schizophrenia' (p.4). It was only when his father died, when John was 18 years old, that his mother was 'diagnosed and taken into fulltime care by the State' (p.4). John says it 'was horrendous living with that and not knowing what was wrong with her' (p.4):

As kids we didn't know what was wrong with her. She used to constantly talk to herself and talk to other people in the kitchen or in the sitting room where there was no one there. She used to turn her back to us and scream real loudly and scream at us to leave the room because she was having a conversation with people and bang the doors to put us out of the kitchen or sitting room because she was busy talking to someone even though there was no one there (John, p.30).

He also describes his mother as having trouble with 'alcoholism' (p.4) and says his father was also 'a heavy drinker' (p.4). John's maternal grandmother moved in with the family when he was a little boy: 'It was a three bedroom semidetached house so it was over-crowded' (p.4). John's grandmother 'had her mental health issues as well which led to her sexually abusing myself and one of my older brothers when we were kids' (p.4).

I think deprivation or that abuse - they are too nice of words to describe what we went through (John, p.31).

John says that now, as an adult, he feels 'angry looking back at it all' (p.33). He is angry that the family GP 'didn't spot anything' and that his teachers, 'took me in and told me that my shirt is dirty and my hands are dirty' yet didn't ask why. He is angry 'that no one had ever questioned' (p.31) and 'that my life went off track before I ever got on track' (p.33).

I still carry a lot from that, from my upbringing...going through that impacts your mind... I think it kind of influences or messes with your development (John, p.32).

Adrianna also describes her childhood as ‘pretty chaotic’ (p.3). She and her mother ‘moved around a lot’ (p.3), sometimes with her father and sometimes ‘away from my father’ (p.10). By the time she arrived in Ireland as a teenager, Adrianna had already lived in countless homes on four separate continents. She found it ‘really hard to put [her childhood] on a timescale’ and said it was difficult for ‘me to tell you about myself’ (p.3) as her memories were quite disjointed and scattered at different locations across the globe. Because she moved around so much, Adrianna describes her childhood as ‘very kind of isolated’ (p.5): ‘I’d go to a new place, I wouldn’t know anyone so I’d be at home, you know, and then if I did make friends, I’d always know that I’d probably end up moving so they wouldn’t be really close friends, you know, so I was on my own a lot of the time’ (p.4).

In addition to the countless moves, Adrianna described her father as ‘verbally abusive’ (p.9) and said that her mother ‘has been depressed for years’ (p.9). As a child Adrianna says she ‘listened to her [mother’s] problems and I didn’t talk about mine’ (p.9).

At this point I can’t really say I feel at home anywhere because I never had that kind of stable upbringing (Adrianna, p.5).

Mai described how, as a child, ‘what really got me down was just thinking my parents didn’t like me’ (p.4). She says she ‘was always in a childminders’ growing up and ‘would have seen my parents if even an hour a day’ (p.3). When her younger brother was born she feels ‘all the attention would be put on him’ while ‘I was just, you know, not even their kid’ (p.26).

My dad used to hit me a lot and then to say sorry he would give me chocolate so I sort of always overate and then got bullied in school for being fat (Mai, p.6).

Mai relayed how hard it is not to have family love and support: 'I don't have my family because they are the ones that are causing all the problems in the first place really' (p.25).

Leon too talked about 'the childhood things' (p.7). He described how 'there would have been violence in the home' (p.7) growing up. While he tries, as an adult, to empathise with his father and his stressful job in An Garda Síochána, Leon feels 'the abuse I suffered as a child' (p.7) contributed to his later struggle with schizophrenia.

Like Leon, Joseph also feels that 'the root cause' of his anxiety was his 'father's carry on' (p. 31) when Joseph was a young boy. He says that his father is 'fine now' (p.31) but that when he was younger he 'was an alcoholic' and would often 'come in really drunk' (p.2) after a night in the pub. He described how he remembers as 'a kid sitting at the top of the stairs' (p.31) listening to his parents arguing below.

I remember the arguments and the fighting and the shouting when I was a kid and it's not very pleasant. [...] There was a lot of fights; fight after fight after fight (Joseph, p.32).

Louise also described how 'there would have been quite a lot of problems with regards drink' (p.6) in her home growing up. She spoke about how 'it would all kick off over the weekend' after her father would spend 'Friday, Saturday and Sunday' (p.6) drinking at home. While she didn't go into the details of what would happen when things would 'kick off' at home, Louise described the fear and dread that followed her from week to week.

I would be getting up for school on the Monday and I would be taking what happened over the weekend kind of with me going into that and I knew it would happen again and again and again, week by week by week (Louise, p.6).

At 16, as soon as she was old enough, Louise got a part time job after school and at weekends 'to get me out of that [home] scenario' (p.6).

Instead of having to go home in the evenings after work... there were often times where I would stay in a bed and breakfast, hotel, whatever, it did not bother me, just once I didn't have to go back there (Louise, p.8).

For the majority of young people in Ireland, home and school are the two places that occupy the greater proportion of their time. In addition to experiencing difficulties at home, many students described experiencing difficulties in school.

5.3.3 Difficulties in school

Negative school experiences formed a large thematic feature of the 'pre' narrative landscape. Students spoke about the impact of being bullied; about how they would act out in order to cope; about the impact having dyslexia had on their ability to learn and confidently engage in school, and; about the pressure they felt in the run up to state examinations such as the Leaving Certificate.

Niamh described the bullying she experienced in school as 'horrific, it really was' (p.14).

It [bullying] just was horrific. It was probably one of the most destroying things for a young person to go through (Niamh, p.13).

When she was in second class in primary school Niamh described how her teacher 'tormented' and 'humiliated' her 'in front of the class' (p.15). She recounted one incident in particular where the teacher brought in weighing scales for a maths lesson on measurements and weights. She asked every student to stand on the scale to compare their weights, 'eye-balling' (p.14) Niamh throughout. Niamh said she was a 'pudgy' (p.14) child and knew, even at that stage, that she would be 'way, way heavier than everybody else' (p.15). Yet the teacher persisted, taunting her, asking if she was 'too tired to get up' on the scale because she was 'just too heavy' (p.15). Eventually she physically forced Niamh onto the scale, commenting, as she read Niamh's weight aloud, that she knew she would weigh 'way more' than she should have. Niamh described how that teacher was a 'horrible woman' (p.16) who made her feel as

if she was ‘never going to be good enough’ and ‘never going to make anything’ of her life (p.16).

The bullying continued for Niamh as she transitioned into secondary school. The friends she made in first year ‘all of a sudden turned’ (p.17) on her a few weeks into term. They would verbally taunt her as well as physically beat her and push her down flights of stairs. Niamh described how devastating this was: ‘It gets to the point where you just get so angry with yourself and you’re kind of, why is it me? You know?’ (p.18). Niamh feels this was the turning point, the point where she ‘got sick’ (p.17). She described how she felt ‘I just can’t be me anymore’ (p.18) and how controlling her weight offered her a way of gaining ‘control over something that was out of control’ (p.19).

I was very aware that there wasn’t a lot of things I could control in my life in terms of people bullying me or those factors, but something I knew I could control was trying to lose weight (Niamh, p.18).

J.D., like Niamh, spoke about being bullied by an authority figure while in school. In J.D.’s case ‘an SNA...was actually the one bullying me’ (p.4). He described how ‘she just said horrible things to me and I’d come home every day and I’d cry because of this woman’ (p.5).

The problem is no one believed me (J.D., p.5).

Mai also described how her teachers would ‘pick on’(p.2) her in school. She said that ‘what bothered me the most’ was that ‘they didn’t pick up on’ what was going on at home for Mai and instead ‘they just gave out to you or picked on you or called you stupid’ (p.2).

They would say like ‘You are lazy’, ‘You don’t do anything’, ‘Drop down to ordinary level if you will even be able for it’, that type of stuff (Mai, p.2).

Louise had almost the opposite problem to Mai in that her teachers tried to find out what was happening in her home life – a home life Louise couldn’t speak about. In order to deflect their attention Louise would act out, ‘get into trouble’ (p.10) or just not go to school in order to avoid her teachers.

I wasn't even bothered, it didn't bother me that I was getting into trouble at that stage it was like cat and mouse, me and them, you know (Louise, p.10).

Louise even changed schools to get 'a clean break' (p.10).

It was because the other school was just so small and so many people had an input into me and they were all wrong, there was none of them, I never talked to them and they never actually really knew what was going on. So yeah, I wanted just a new start, new teachers, new students, everything. So I changed school and I got that (Louise, p.9).

However, fifteen years later, Louise now wonders how her life might have been different if she had opened up to the teachers in her first school rather than pushed them away.

Ella says she was always 'quite a sensitive child' which 'did kind of leave me open to being bullied I think' (p.3). She described how, when she went to secondary school, she 'very much wanted people to like me and I just screwed it up completely because I just didn't know how to socialise with people my own age' (p.3). Ella was 'academically very high achieving' (p.3) in school and, as an only child, feels that growing up surrounded by adults made her more mature than her peers. She struggled to fit in and, when she was bullied, 'put on a very hard, tough, exterior which then just turned me into a slightly scary [person]' (p.3).

I was a very angry little creature for a long time (Ella, p.4).

Sophie also described how she 'found it difficult to integrate' (p.2) with her classmates in primary school. Academically, Sophie was 'a little bit, well, quite a lot ahead of my peers' (p.2) and says she 'just felt different from them' (p.2). While Sophie didn't talk about being bullied in school she described the experience of 'being isolated' (p.3). She takes care to point out that she 'made efforts to isolate' (p.3) herself after she experienced initial 'rejection' (p.4) but that by 'the age of fourteen/fifteen...I would have tried to integrate myself back in, you know, talking to people, because I was lonely' (p.4). However, Sophie struggled to 'integrate' with her peers and discovered 'I'm not functioning well

socially' (p.4). She says that this, combined with the pressure she felt to prove her academic ability in the run up to her Junior Cert exams, 'has been the cause of all my problems' (p.4): 'I really retreated into myself and I was just very anxious all the time' (p.4)

Marie also described how she 'was in a group of people that I didn't fit in that well with through primary school' (p.8). She says these girls 'were just kind of different to me' (p.8) and 'treated [me] quite badly; I was bullied' (p.12).

It just wears you down (Marie, p.16).

Three of the students who took part in this study spoke about how their dyslexia impacted their experience of school. For Sarah, it wasn't so much the dyslexia itself but her teachers altered expectations of her because of her dyslexia. She gave the example of how her secondary school careers advisor recommended she be placed in a lower, 'pass' (p.2), class as she felt her dyslexia would likely affect her ability to learn.

I think I spent all of my school years trying to prove that woman wrong and I did prove her wrong and I am still proving her wrong you know (Sarah, p.2).

J.D. says his dyslexia 'definitely had an effect' (p.3) on his mental health growing up.

I think it really knocked my confidence. I think when you see all the other kids being able to read and you're not able to read properly even when you're seven or eight (J.D., p.2).

Unlike J.D., who got help with his dyslexia, so much so that he is 'not considered dyslexic anymore' (J.D. p.3), John's dyslexia wasn't diagnosed until he was in his twenties. He says that in school he 'always knew there was something wrong with me [but] I couldn't put words on it' (p.18). He described how he 'wasn't able to process information' (p.18) like the other students and how this could be really 'difficult at times' (p.18).

My dyslexia, when it's troubling me, bothers me too because sometimes I'm not able to keep up with conversations. [...] Not being able to keep

up with what is being communicated can be hard in life, hard in my day to day activities (John, p.26).

A number of students referred to the ‘pressure’ (Millie, p.3) of state examinations, particularly the Leaving Certificate. Millie feels that her psychosis manifested itself in sixth year because there was ‘a lot going on’ particularly ‘with the leaving cert – it was a lot to handle’ (p.3).

It was definitely a huge pressure...having that pressure during fifth and sixth year really did kind of break me a bit (Millie, p.5).

She says that in her sixth year ‘the mental illness kind of took over’ (p.16) which made studying more difficult: ‘having the leaving cert on top of that, the most stressful year of anyone’s life, it was like ten times the stress for me’ (p.16).

Lauren described how things began to fall apart for her from ‘fifth year onwards, I guess because there’s always that, ‘Oh my God, I’m going to fail the Leaving Cert’ (p.7).

But I think come sixth year I just completely lost the plot...I don’t know why it bothered me so much but it all kind of escalated very quickly (Lauren, p.8).

For many of the students, their anxieties around state exams were intimately related to perfectionism and a desire to do well.

5.3.4 Perfectionism

Featuring in 17 of the 27 students’ narratives, perfectionism emerged as one of the strongest and most pervasive features not only of the ‘pre’ narrative phase, but the students’ experiences overall.

The motivation for perfection, as described by the students in this study, appeared to come from four, often inter-related, sources: an internal desire/drive for perfection; a desire to meet the perceived/actual expectations of others; a desire to prove themselves or to prove others wrong, and the fear their

work, and/or they, were not 'good enough'. Each of these four driving factors will be discussed in turn.

A number of the students described how they would have, as Ashley put it, 'very high standards' (p.5) for themselves. Annie described how 'growing up I was always the type who wanted good grades and things like that' (p.4). She remembers winning her first Irish dancing trophy at the age of six and how she realised 'I could actually do this and from then on it became something I *wanted* to do well in' (p.4). Annie says that her parents never pushed her to do well at dancing or school; 'It was very much myself, I was very competitive...it was a personal thing for myself, *I wanted to do well*' (p.4).

Fiona also described how her parents 'are always like 'all you can do is your best' but for me I am like 'no, I need to do better'' (p.13). She says she is 'very hard on myself, like, I push myself really hard' (p.13).

Ashley's father 'could never understand' (p.6) why she pushed herself so hard to achieve in dancing and in school: 'he just didn't think it was normal for a child to put themselves under the pressure I did' (p.6). Like Annie, Ashley discovered that by working hard she did well in dancing competitions. Before third year in secondary school Ashley says school 'wasn't a big deal' (p.5) but when she achieved very high marks in her Junior Certificate 'I realised I was kind of good at school so then that worry transferred from the dancing to my school [work]' (p.6).

James spoke about his 'all or nothing' attitude to life: 'everything has to be the last thing in the world. You have to win every tackle, you have to win everything, you're a complete perfectionist' (p.6). However, he identified that while this attitude has brought him considerable success in life, it also means 'there's no kind of satisfaction at times' (p.6).

[I] just genuinely thought [that] anyone who's not striving for perfection is wasting this, that or the other and then realising they're much happier than you later on in life you kind of start figuring out this is a terrible way to lead your mind or lead your life (James, p.7).

All four students identified how their internal drive to succeed was a double edged sword. On the one hand they are all hugely successful young people but on the other the pressure they place themselves under could become ‘so overwhelming’ (Fiona, p.14) at times. Annie described how in her Leaving Certificate year she was training for the world championships in dancing, working a part time job ‘to fund my dance classes’ (p.5) and, at the same time, working hard in school to achieve the points she needed to get into university. Eventually it all became too much: ‘I couldn’t really handle it I suppose’ (p.5).

Fiona has also struggled to keep up with the standards she sets herself. She described how at the end of the term prior to our interview she had to submit a number of big assignments on the same day. She ‘wanted to do really well in everything’ (p.13) and in the process ‘just worked way too hard...I did just burn out’ (p.23).

It was just way too much for me and I was exhausted because I was working way too hard. And then I couldn’t do anything because I was so tired (Fiona, p.24).

Ashley also identified how the pressure she puts herself under can be ‘quite extreme’ (p.4).

I like it to be, I don’t know, just very, very high standards of perfectionism in all my college work to the point where it’s kind of maybe frightening (Ashley, p.5).

In school she placed herself under such pressure to achieve that when she went into her first Leaving Certificate exam she ‘had the most extreme panic attack’ (p.6). She says that the exams went ‘essentially downhill from there on’ (p.6) and, in the end, Ashley had to repeat the year in school and sit the Leaving Cert a second time.

While Annie, Fiona, Ashley and James described having high standards and expectations of themselves, a number of students spoke about feeling some degree of expectation from others. Adrianna said ‘there was an expectation, it was probably never really kind of said and shouted at me, but there was an expectation that I’d always do really good at school’ (p.6). She feels that this

expectation has 'become so engrained that you don't even consider that you're doing it for someone [else]' (p.6).

You kind of think this is what you have to do, this is what you are, this is your goal. It's not even because I'm not going to go and show my mom that I got an A, I'm kind of like, OK, I have to get an A because if I don't get an A it's not good. I don't know, it's a bit messed up in that way (Adrianna, p.6).

Like Adrianna, Lauren says 'I have this really bad perfectionism complex and it's such an issue, it's a ridiculous issue' (p.6). She said that high expectations were 'in our house' as she was growing up and she is 'sure we're all a little bit like that' [perfectionistic] (p.7).

I remember one year I got a D in maths and I got As and Bs in everything else and I was like 'Oh, they're [her parents] going to kill me, they're going to kill me' (p.7).

From a very young age Lauren had set her sights on becoming a paediatrician. She says that even now, she 'would still be really interested' (p.4) in going back to do medicine but during her leaving cert year Lauren became aware that she 'wasn't doing well' (p.4) in some key subjects and was going to struggle to meet the entry requirements for medicine. Ultimately she decided to 'change the plan' (p.5).

I was worried that people would be disappointed because obviously it is a - you know like medicine's up here [gestures] ...I mean our family; there'd be a lot of really intelligent people. So I don't know, like it would have been nice to be 'up there' but its fine (Lauren, p.5).

Thomas too felt the pressure of expectation as he entered his Leaving Cert year.

It was just this expectation...I felt like I was going to let everyone down because when you got to 6th Year it was just constant... Like from the first week it was like 'okay heads down'. And that just, it killed me (Thomas, p.10).

He described feeling a weight of expectation associated with being a high achieving student in a school where few students go on to third level.

All through secondary school there this constant look of...and from the teachers as well, and from everyone, it was just this perspective 'Oh [Thomas] is going to do great in life' '[Thomas] is gonna go on to do this... [Thomas] is gonna go on to do that...' (Thomas, p.9).

By the second week of sixth year, Thomas was leaving classes 'in tears' (p.10). He wasn't sleeping, had lost his appetite and stopped going out and getting involved in his normal activities. Within two months of starting sixth year he had been diagnosed with 'severe depression' (p.33) and prescribed a series of psychiatric medications.

Three students described how their drive to achieve perfection comes as a result of a deep desire to prove others wrong. In Sarah's case, the person she wanted to prove wrong was her secondary school guidance counsellor. The guidance counsellor suggested Sarah be placed in a lower class as she felt that her dyslexia would prevent Sarah from keeping up in school.

I think I spent all of my school years trying to prove that woman wrong and I did prove her wrong and I'm still proving her wrong you know (Sarah, p.2).

Sarah says 'I think there must be a link there [between] that whole thing of proving people wrong and being a perfectionist' (p.4).

I am always trying to prove others and myself wrong, you know (Sarah, p.4).

For Niamh it was her grandmother, who made it clear that she had low expectations of her from a young age, that she wanted to prove wrong.

[She would say] 'Oh, you're never going to be good enough, you're not going to make anything of your life, you're going to stay the way you are'...I just wanted to prove her wrong (Niamh, p.16).

Claire described how she 'wanted to prove that I could do it' (p.15). When she was in school Claire struggled with depression and anxiety to the point that in sixth year she attended a total of 33 days 'and the days I was in, I left early' (p.6). In spite of this Claire says 'I wanted to do well in my leaving cert and I

wanted to prove myself and I wanted to do the best that I could' (p.13). She says that even today she still tries to 'overcompensate' and constantly worries that she is 'a bit behind people' (p.13).

I need to prove that I can do well if I try and it's not that I'm just lucky to be where I am (Claire, p.14).

The fourth, and perhaps the strongest, force that appeared to motivate students' drive for perfection was fear – fear that their work, and/or they, were not good enough.

Greg described how he doesn't 'feel particularly anxious as long as I can, I suppose, compare to other people nearby and convince myself that I am doing better than them' (p.8). He spoke about how as an undergraduate he 'wanted to be liked' by his lecturers; 'I really wanted to be seen to be understanding and doing well' (p.9). However while this desire to be liked and to do well placed him at the top of his class it also led to him experiencing deep anxiety, particularly when it came to submitting assignments:

I was crippled by anxiety that they would, you know, think that I was a kind of a bit of a, that I was a failure or they were disappointed that I could have done better in it (Greg, p.9).

Greg described immobilising procrastination: 'I suppose I have had difficulty with just getting rid of [assignments] at the deadline and instead going 'oh no, it's not ready it's not done'' (p.10). By the time he reached his final year Greg struggled to submit anything on time for fear that the 'assignments were going to fail' (p.10). Assignments and extensions continued to pile up for Greg until eventually he 'withdrew from college to repeat' (p.11).

Adrianna too described how she 'wanted to do really well and wanting it [her work] to be perfect because I wanted to show that I was hard working and that I really understood it' (p.38).

I think every mistake I made was kind of like 'Oh my God, they think I'm an idiot'. I was terrified of that. I was terrified of being treated like I'm stupid or undeserving of being here, you know (Adrianna, p.38).

Like Greg, Adrianna struggled with procrastination: 'I mean I survived the first year on extensions. In fact, I think I had extensions for almost every assignment' (p.36). She described how she would complete assignments, 'freak out over them and I wouldn't submit them' (p.36) because, in her eyes, they weren't good enough.

Both Robert and Marie described how they would rather not submit an assignment at all than submit something they feared wasn't good enough.

I kind of feel if it's not going to be perfect what's the point in doing it? (Robert, p.13).

I didn't want to do something that wouldn't be good enough...I was so afraid of not doing it right that I couldn't do it at all (Marie, p.5).

Marie spoke about how 'I tie a lot of my self-worth into how I'm doing academically' (p.29). She acknowledges that this 'isn't great' (p.29):

Well, it's just a fragile thing to base it upon. You know, it's easy to do badly on an assignment, to not get the results you want. It happens. Like say in second year I got a 2:2 and everybody around me was getting firsts ...I took that very badly. [...] I remember, like carving 2:2 into my leg because, you know, it wasn't good enough (Marie, p.29).

Louise too spoke about how her fear that an assignment was 'not good enough' (p.64) would prevent her from submitting it on time. She gave one example in particular where the thought of it not being good enough caused her to panic: 'I just panicked...in my head I was like 'I'm gone, I'm done, I'm not going to be able to do this course' (p.64).

The pressure 'to do well' (p.8) was also a feature of Mai's experience: 'oh my God I have to do well' (p.8). She says this pressure only came about after 'I got my first good grade' (p.7) in her PLC course and realised she had an opportunity to go to college. Since then she says:

I have to do well and 90% wasn't good enough, I wanted 99% and if I got 99% why wasn't it 100% (Mai, p.8)?

Like the others before her Mai talked about how her fear that she ‘won’t get a 1:1’ (p.9) has resulted in her procrastinating or, in her own words, ‘burying my head in the sand’ (p.10). She admits that ‘instead of actually doing a bit of study every day’ (p.10), she’d often ‘go back to bed, try not to think of it, try and fall asleep until the next day’ (p.10).

Joseph also describes himself as a ‘perfectionist – it’s terrible, it’s terrible’ (p.23). He says that in the job he had prior to returning to fulltime education he was ‘very neat’ and everything was ‘top quality...I’d always do a really, really good job’ (p.24). While he feels this is a ‘skill I brought to college’ (p.24) he also feels that it hasn’t served him as well in academia as it did in his manual job and instead causes him to feel ‘stressed’ (p.23).

I would stay up till four o’clock in the morning and if I spotted one thing in my essay with syntax or a comma missing or something where the clause was wrong or something like that I would [ripping sound] four o’clock in the morning and I’d fix it (Joseph, p.23).

5.3.5 Existential thinking

Adopting a hermeneutic phenomenological approach allowed for emergence of more subtle thematic features. Subtle though they may seem, themes such as a tendency to reflect on, and contemplate, the very meaning of existence, as seen in the narratives of seven students in particular, had a powerful influence on the student’s mental health.

James spoke about how he had noticed ‘way too deep thinking patterns...from as young as I can remember’ (p.5). He described how ‘even at six I remember just asking way too many questions; like asking ‘what’s forever and ever?’ and ‘what does that mean?’...like all these way too, like for a six year old, intense questions’ (p.25).

I remember [in] secondary school, I would be sitting in French class...and I would be out the window, just zoning out the window, but I’m not looking at the trees, not looking at the grass, all the reminders of life and I would be just blank and mind going a thousand miles an hour thinking about infinity, eternity, just stupid things that you can’t figure out but could think about them 24/7, like what’s the point in all this? Why am I sitting here? There’s absolutely no point in school, no point in life

in the first place, so why would there be point in being here? (James, p.8).

James feels that not everybody thinks as deeply about life as he does ('I never had a spell in my life where I think I was thinking the same way as everyone else' (p.4)) and links this tendency to think existentially with difficulties he has had with his mental health. He spoke about how, as an eight year old, he was 'kicked out of communion practice' (p.25) for 'asking too many questions' (p.25).

I wasn't being rude, I was just going that doesn't make sense, what's this? What's happening here? Why did this guy do this? Like what's the story? [...] Just a general non understanding from life continued on from there, and then within a year or two of that kind of just [...] yeah, I might kill myself someday (James, p.26).

Even in later years, when he was 'studying hard' (p.10) for his leaving cert, 'you'd be still, like, you don't even know whether in your head you want to survive the year never mind do something with your life' (p.10).

I suppose the struggle for everyone is what is the meaning of life, what is life all about, what's this, what's that and that's all very mind driven. If you put all of that aside and just ignore it, just briefly like, you can kind of figure out wow, it feels amazing sometimes just to be. Like you get reminders of it sometimes, so if you're in, it's a sunny day and you jump into that sea and it's your first time swimming in the sea in six months and you're like oh, my God, this is amazing, there's no drug involved, no nothing... you're getting a dopamine rush from just being present and being wow! (James, p.37).

James realised that thinking existentially was fuelling the highs and lows of his bipolar disorder, particularly the lows, and realised he 'needed a mind management plan' (p.30). He began to read books about meditation and bodywork and learned how 'to touch base' and 'get back into myself' rather than get sucked away by thoughts 'about infinity, eternity' (p.8) and the point of existence.

I've noticed, I was like you haven't had a suicidal thought since you started putting this into practice because you don't let your mind run away like that (James, p.31).

Sarah also described ‘questioning why am I here? What am I doing?’ (p.5). She says her thinking is ‘very philosophical but it’s not benefiting me thinking like that because I haven’t worked out what I’m supposed to do or why I am here’ (p.5). Sarah feels she always has had a tendency to think deeply about life but since she has begun to struggle with her mental health these bigger questions have become more pressing for her. Her parents and doctors have advised Sarah not ‘to think like that’ (p.5) but still struggles to avoid questions like ‘what have I done to deserve this’ (p.6), ‘who am I supposed to be’ (p.10) as well as the sense that ‘I want something more’ (p.6).

Kate says that growing up she ‘questioned a lot like the meaning of life and why people are here and why people do what they do’ (p.8). She remembers playing with her dolls as a little girl and experiencing an overwhelming sense of not knowing which she reconciled by thinking ‘just wait until you become an adult because then you will understand’ (p.27). However Kate found ‘there was a huge disappointment in growing up and [realising] that’s not the case’ (p.27). Like James and Sarah, these questions became even more pressing for Kate when she began to struggle with her mental health.

I wanted to get better but I also wanted to die, and was kind of questioning people “Tell me why I should live, what is it that motivates you to live” because I couldn’t understand it and by that stage I couldn’t remember any more what it was like to not have an eating disorder. I didn’t remember anything other than this and this was horrible. It just seemed hopeless to me (Kate, p.23).

Sophie says ‘I probably think about the bigger things too much, like, more than I would say is normal’ (p.34). She described how the summer prior to her interviews she had been ‘reading loads and loads of stuff about consciousness and quantum theories and just trying to make sense of everything’ (p.33). However, rather than help her make sense of things, her reading became ‘very obsessive and to a point nearly manic...one evening I became convinced that what I was experiencing wasn’t real’ (p.33).

I remember when I went to the psychiatrist she was like ‘Are you worried at all about college?’ And I was like ‘Well to be honest I am more concerned with like - I don’t even know if I am real. So it seems a bit stupid to [be worrying about college]’ (Sophie, p.33).

John spoke about how ‘when I was a teenager I questioned the world I lived in, you know, what was the point, you know?’ (p.30). Millie too described existential curiosity and contemplation. She says ‘I always felt there was something kind of different about myself’ (p.3). She says that even as a young girl she could ‘sit for hours by myself’ contemplating ‘the ambiguity of life’ (p.4).

I think I always looked at things differently; I'm a very, kind of, deep person (Millie, p.3).

5.3.6 Drugs and/or alcohol

Drugs and/or alcohol featured in the narrative accounts of five students. Two students, Leon and Kinsley, directly attribute the onset of their psychotic episodes to the use of marijuana.

I smoked a lot of cannabis and I am becoming more and more of the opinion that that's what caused my schizophrenia and my mental illness (Leon, p.2).

Leon described how his ‘first psychosis’ (p.3) occurred when he was 18 following a summer of heavy cannabis use: ‘I really did smoke a lot of it’ (p.4). He also relied heavily on cannabis in the years following his first hospital admission: ‘I was just numbing the pain and I was going nowhere’ (p.2). He eventually gave up drugs many years later but wonders if he would ‘have been sick for so long if I hadn’t smoked cannabis’ (p.2).

Kinsley described how the summer he experienced a psychotic episode ‘I found myself with no schedule and a bit of money’ and ‘essentially what I did was spent the money on marijuana and so I got into this routine of smoking every day’ (p.4).

He says his marijuana use ‘was all escapism really’ (p.4) – a way of escaping the pain of a ‘rough break-up’ he’d had ‘around the end of May’ (p.4). He says that ‘essentially I was like three to four weeks of using marijuana every day’

which eventually reached ‘a rather thunderous climax’ when, in August, Kinsley was ‘struck by one hell of a psychotic episode’ (p.5).

All the doctors and stuff I have talked to about it have said it has all the signs of a drug induced psychosis just because of the huge drug use I had at the start of the summer and the fact that it kind of flared up and died down relatively quickly. It was a matter of weeks as opposed to months (Kinsley, p.8).

Unlike Leon and Kinsley who feel their mental health issues were the direct result of their drug use, John, Ashley and Joseph described using alcohol as a way of coping with their distress. John said that alcohol was his ‘outlet’ from the abuse he was experiencing at home growing up.

Alcohol made me feel really good. It got me away from the deprivation in the home place, from the chaos, from the coldness, the dampness, the poverty, the neglect, the abuse, the emotional abuse, the verbal abuse (John, p.9).

By the time he was 16 John was drinking regularly and heavily. John described ‘days in bed getting sick, shaking all over, paranoid about what I did or what I didn’t do’ (p.9) while under the influence of alcohol and then drinking again to escape these feelings: ‘I kind of got into a viscous circle like that over the years’ (p.10).

It wasn’t until he reached his 20’s that John met a friend who encouraged him to attend AA meetings:

I started going to AA and I really felt that I couldn’t control my mind because of my alcohol intake or my alcoholism. I knew I had a problem with drink, I definitely knew I had a problem with it or I knew I was an alcoholic...when I drank there was always problems with it. When I didn’t drink I didn’t have those problems (John, p.11).

Ashley described alcohol as ‘a fall back thing’ (p.14): ‘I always used it as an escape and I knew I drank worse than what other people did’ (p.16). While she appreciates that alcohol ‘makes things worse and worse’ (p.16) she says it’s ‘not something I’m completely on top of yet’ (p.15).

I can't really comprehend how I used to drink the volume of alcohol that I drank...I always used to just find so much happiness with drinking everything back and taking my box of cigarettes and sitting away from everyone on my own. And that was what I wanted to do all the time (Ashley, p.18).

Joseph too described 'drinking alcohol to try, as every teenager does, to try to cope and maybe I drank it too excessively' (p.5). He says that 'at the time I thought it was a good solution' (p.9). Eventually, in his twenties, 'the realisation started to kick in that alcohol was contributing to my anxiety problems and it wasn't the sole cause of my anxiety problems but it was exacerbating it, you know' (p.10).

I feel if I had given up alcohol when I was 17, I could have saved myself a lot of torture which was self inflicted, because alcohol exacerbates anxiety (Joseph, p.28).

5.3.7 'It was clear from a very early age'

Two of the students spoke about how 'it was clear from a very early age' (Ashley, p.1). Ashley and James, who both later received a diagnosis of bipolar disorder, described how 'it' was something that they grew up with, that it was part of them.

I have diary entries from about fourteen where I definitely know I was different and I don't think the same way as other people and what I think is right or normal, so I think I knew from quite early (Ashley, p.7).

I suppose it manifested itself as well from about eleven or twelve, my last couple of years in primary school, I went from being a more quiet reserved kid to maybe being possibly one of the louder kids (James, p.7).

5.3.8 No reason for it

The pre-narrative stage encompasses factors that students themselves identified as contributing to the onset of their particular form of psychological distress. However, several students struggled to identify any factor in particular that led to the development of the problems they experience(d). For many, not having a reason for 'it' made it more difficult for the student, as well as those around them, to make sense of, or in some cases justify, their experience.

Alicia described how her anxiety came ‘out of the blue’ (p.2) when she was 14: ‘[there was] literally nothing you could pinpoint wrong with my life’ (p.2). Not having a reason, or ‘trigger’ (p.12) for her anxiety and panic attacks became the ‘main problem’ (p.12) for Alicia:

My panic attacks and anxiety seemed to come out of nowhere...just no triggers that I can think of. Even at this point...I just am wracking my brains for a trigger and I think that really frustrated the therapist I had at the time that there was no triggers. She was kind of insisting well you must, you know, there must be something. You’re thinking, like, ‘I don’t know, you’re the doctor!’ (Alicia, p.12).

Kate too experienced her therapist’s frustration at the apparent lack of a reason for her eating disorder.

I haven’t a clue why I have an eating disorder. [...] I had one therapist who refused to believe that I wasn’t abused. She said ‘until you can admit it, you are never going to get better’. She would give me books about not remembering being abused and I was like ‘But I wasn’t fucking abused!’ (Kate, p.23).

Annie spoke about how not having a reason for her depression almost meant she wasn’t entitled to ‘be upset’ at all.

I don’t think there was ever really a cause for it. That kinda makes you feel like you don’t have a right to be upset, you know? Because you don’t have a massive reason behind it (Annie, p.2).

Both J.D. and Fiona echoed Annie’s sentiment and felt that not having a reason for it made it harder for others to understand why they were struggling.

That’s one of the big problems with people understanding it. Because people don’t understand. [They say] ‘oh you must feel crap for a reason’, but the whole thing about depression is you don’t and that really sucks. That was probably one of the worst parts, trying to explain that. In the end you don’t explain it. Because it’s just too hard and people don’t understand (J.D., p.11).

People would say ‘why are you unhappy’? And I don’t have a reason. I don’t understand it myself. It is just the way it is (Fiona, p.4).

For Sarah, not having a concrete reason for her distress adds to the distress itself.

One thing which annoys me is that I can't put my finger on why I feel this way. I don't come from a broken home, my family have been so supportive of me my entire life. I sometimes wonder what I have done to deserve this? (Sarah, p.6).

5.3.9 Conclusion

Not having a reason for it, along with childhood trauma, difficulties in school, perfectionism, existential thinking, drug or alcohol use/abuse and the view that it was always a part of them, emerged as the seven strongest thematic features of the 'pre' narrative landscape. For many students this landscape contained a number of these thematic features whereas others struggled to identify 'things' that led to the onset of the mental health difficulty. Ultimately, however, each narrative reached what Mary described as a 'breaking point' (p.4), a point where the student was forced to acknowledge that something was wrong. A point where they realised they needed help.

5.4 Crisis/Interruption

5.4.1 Introduction

Crisis/interruption represents the point at which 'it', each student's particular type of psychological distress, makes its presence known. How it does this, what it's like and what happens next form the basis of this section. The section itself is divided into three separate but interdependent parts – all relating to the student's experience of crisis/interruption. Part A explores the 'landscape' of the phase. It recounts each student's journey to crisis or interruption and the patterns that emerged in the ways that this journey unfolded for the students as a whole. It also captures the challenge of articulating unfamiliar and often frightening experiences as well as conveying these experiences to others in order to ask for and/or receive help and support.

Part B explores the two main thematic features of the crisis/interruption landscape, self-harm and suicidal ideation/attempts, while part C attempts to get as close as possible to students lived experience of psychological distress.

Part A: Crisis/interruption landscape

5.4.2 Crisis/interruption landscape

Crisis/interruption represents the point at which, to borrow Kate's words, 'everything fell apart' (Kate, p.6). For some, this point manifested as a crisis, an eruption or escalation of distress to 'breaking point' (Ella, p.9). For others the realisation that what they had been experiencing had a name, was a 'thing' and, most importantly, wasn't their fault, interrupted the narrative they had been constructing around their lives. For all, however, this point was the point at which they were forced to acknowledge that something was wrong and they needed help.

While each student's crisis/interruption unfolded uniquely, a number of striking patterns began to emerge which revealed much, not only about how distress 'builds' (Millie, p.7), but also about how 'it' becomes a recognisable entity in the students' lives. Four patterns in particular emerged charting students' initial experience of crisis/interruption. The first represents a gradual and subtle onset of distress building to an often dramatic 'crisis point' (Mary, p.14). The second pattern describes how awareness of what 'it' was, interrupted the narrative the students had been creating around the experience. The third pattern mirrors the first in that it is marked by a rather explosive crisis but, unlike the first pattern, this crisis occurs 'out of the blue' (Alicia, p.2). The fourth and final pattern sees students whose childhood was laden with adversity, reach a point, often arbitrarily, where they just cannot carry the load anymore. Each of these four patterns will be explored in further detail presently.

Crisis, in particular, was a reoccurring feature of many of the students' narratives – a point they would visit time and again during their development – however the patterns represented below reflect the students' initial crisis/interruption. Rather than neglect subsequent crises described by the

students, the next, narrative wreckage, phase acknowledges that, for many, the road out of crisis is far from straight.

The first crisis/interruption pattern revealed how 'it' slowly crept into the students' lives; its onset and progression almost unidentifiable, 'like ageing', as J.D. says, 'you don't even notice yourself getting worse' (p.12). These students described 'it's' silent progression until 'all of a sudden' (Claire, p.9) something happens which draws the distress out into open consciousness. Ella described how it took her reaching 'breaking point' (p.9) at 15 for her to realise that something was wrong: 'I figured it out finally then' (p.10). Mary too spoke about 'breaking point'. She struggles to pinpoint 'when it started to become a problem' (p.2) but says that, in her first year as a postgraduate student, 'it just got to breaking point' (p.4).

At that point I really realised that I actually could not do it (Mary, p.5).

Mary says she doesn't think she 'would have come to that realisation had I not reached crisis point' (p.14). She feels that it was necessary that it reached this point as she doubts she 'would have ever accepted that this is a problem' (p.14) otherwise. Fiona shared a very similar sentiment.

Sometimes it takes something really big to realise that you really do need help (Fiona, p.15).

While Ella and Mary spoke about reaching 'breaking point', Ashley described it as 'the all-time low' (p.12). This moment for Ashley, a moment in which she 'harmed myself quite significantly while under the influence' (p.17) of alcohol, represented a conscious acknowledgement that she needed to 'reach out' (p.2) and seek support.

Like Ashley, Sarah's crisis point was a moment in which she realised that she was unsafe; that she 'just didn't want to live anymore' (p.11). For Sarah, and indeed many of the students in this study, reaching crisis point acted as a catalyst for seeking professional help. It represented, for Claire, the moment when 'it', which had been 'slowly growing' (p.9) over many years, 'all of a sudden...tipped over and became a proper issue that I needed to deal with'

(p.9). Millie described how she tried to ‘cope with it by myself’ (p.7) but ‘became completely overwhelmed’ when her distress ‘turned into voices in my head’ (p.7) and she ‘eventually’ (p.7) conceded to telling her mother.

Kate described her crisis point as the moment ‘everything fell apart’ (p.6), whereas for Lauren, it was the point where she ‘just completely lost the plot’ (p.8): ‘it all kind of escalated very quickly...it was obvious that I wasn’t right’ (Lauren, p.9).

Annie’s story breaks the pattern slightly in that she *was* aware that ‘things were not really right’ (p.1) as early as third year in school yet chose to ‘ignore it’ (p.3). Her mother’s experience of depression had taught Annie ‘the telltale signs’ (p.8) and when she started to notice these same signs, ‘like no interest, no motivation, feeling sad for no reason’ (p.8), in herself she ‘knew what was going on at that stage’ (p.8).

So I did ignore it and I think that probably worsened the situation (Annie, p.3).

By the time she reached 6th year Annie says she ‘couldn’t really ignore things as much’ (p.5) and by Christmas of that year Annie reached a point where she ‘just couldn’t do it anymore’ (p.2). Annie’s crisis occurred at ‘the point where [she couldn’t] pretend anymore’ (p.9).

While this first pattern reflects a moment of ‘crisis’, a sharp ‘breaking point’ (Ella, p.9) in the students’ narratives, the second emerging pattern recounts how the realisation of what ‘it’ is acted as an interruption to the narrative students had been constructing for themselves, and others, about their experiences.

Greg described how he had ‘been suffering without really knowing’ (p.1) throughout his adolescence and early years at university. This suffering escalated throughout his time in university until, in his final year, he was worried that he ‘was going to fail’ (p.12) his exams and decided to express this concern to one of his lecturers. Greg says his lecturer ‘obviously recognised

from talking to me' that he was struggling with anxiety and suggested he seek professional help.

Marie says that although looking back now she can see that depression has been 'a big part' (p.2) of her life since her early teens she 'didn't really understand' (p.2) what 'it' was until her friend asked her to go along with her to a counselling talk organised for in-coming students at her university. She said it was while listening to that talk that she 'realised that something was up' (p.3). Prior to that Marie says 'I just thought that this was just me, this was just how I am' (p.3) and feels very strongly that had she had more information when she first began to struggle as a teenager she may have been able to interrupt this perspective, as well as the progression of her depression, at an earlier stage.

I just kind of wish there was more information. I mean in school in our religion class they used to get people in to talk to us, like Jehovah's Witnesses...but there was nothing on mental health (Marie, p.19).

J.D., like Marie, says he 'didn't think anything was wrong' (p.11): 'I just thought it was me, that it was my fault. I'm feeling crap because I'm a bad person' (p.11). It was only when a friend expressed concern to J.D.'s parents, and he was referred to a child and adolescent psychiatrist, that J.D. understood that what he was feeling was not, in fact, his fault.

The problem is it's so slow creeping up on you. People think that it's like the flu, you're fine one day, you're sick the next. It's not - the awful thing that happens is it takes months (J.D., p.12).

For Mai the problem wasn't that she didn't know something was wrong, rather she 'didn't know what that name was' (p.5). She says that 'looking back' she 'was depressed and anxious' but didn't know how to name these experiences until she 'was taught about them' (p.5) as part of her mental health nursing course. It was only when Mai knew how to describe 'it' that she 'properly got help for it' (p.2). However Mai feels 'really upset' when she thinks about 'how things could have been easier if I knew ages ago' (p.5).

James described how he was ‘convinced’ (p.19) that his fluctuating moods and suicidal thoughts happened simply ‘because it’s you’ (p.19); because he was in some way less able to manage them. He says that looking back he experienced ‘depressive periods...from as young as I can remember’ (p.4) and struggled with intense lows, even attempting suicide, until one night he finally ‘figured out’ (p.26) what ‘it’ was. It was while watching a documentary about Stephen Fry that James was first introduced to the term bipolar disorder and he says ‘it clicked with me all of a sudden. [By] the end of the documentary I just came out with the feeling of ‘wow, that’s 100% what I have’’ (p.39). When he hit his next ‘bad patch’ (p.28), James knew what ‘it’ was and decided ‘I’m going to do something medically about this’ (p.28). Figuring out what ‘it’ was interrupted the narrative that James had constructed over many years to make sense of his, often intense and debilitating, experiences.

All students in this second group described how something or someone interrupted their understandings of ‘it’. For Greg it was a college lecturer, for Marie it was a chance attendance at a counselling talk, for J.D. it was his friend’s insight, for Mai ‘it’ happened to be on her college curriculum and for James it was catching a documentary on television one night which accurately described and named his experience that helped him see ‘it’ for what it was.

The third pattern that emerged in how ‘it’ manifested, either as a crisis or an interruption to the existing narrative, is a variant on the first. Instead of the distress slowly ‘creeping’ (J.D. p. 12) into their lives, a number of students described how they ‘slipped’ (Kinsley, p.5), often rather rapidly and unexpectedly, into crisis.

Alicia says her panic and anxiety arose ‘suddenly out of the blue’ (p.2) when she was in second year in school. Joseph described a similar experience and says he’ll ‘never forget’ his first major panic attack at 17 which happened without any prior warning: ‘I really thought I was going to die’ (p.3). Neither Joseph nor Alicia could ‘pinpoint’ (Alicia, p.2) what led to them experiencing that first panic attack, a point that seemed to add to the distress for them both. Thomas, on the other hand, traces the onset of his depression to the week he ‘went into 6th year’ (p.9). He says that by the end of that first week he felt he

was 'was going to...well break down nearly' (p.9) and within a short space of time he 'wasn't doing well' (p.10). By November of that year Thomas had been diagnosed with 'severe depression' (p.33).

Kinsley described how his crisis arose and reached 'a thunderous climax' (p.4) when, after 'three to four weeks of using marijuana every day' (p.5), he experienced 'one hell of a psychotic episode' (p.5) while staying with his uncle abroad on holiday. Leon was also on holidays when he 'got sick' (p.3). After 'a summer of a lot of smoking powerful cannabis' he 'ended up' in a foreign airport 'going through all sorts of delusions and bordering on hallucinations' (p.3): 'I thought I was Jesus Christ you see' (p.3).

In contrast to this third group whose mental health problem seems to have almost erupted within a short space of time, the fourth and final pattern that emerged reflects how, for a number of students, distress seems to have been subtly woven into the very fabric of their lives. These students accounts are lined with perseverance yet they too described a point where it all became too much. Adrianna describes her childhood as 'pretty chaotic' (p.3) and says that by the time she was 11 years old things weren't 'really great' (p.9). She described her adolescent self as 'one ball of unidentified problem' (p.9) and says that in transition year, 'it just got too much' (p.11). Adrianna says she reached a point where she 'just couldn't do it anymore' (p.10): 'by that time I'd already tried to kill myself...I couldn't even keep it in' (p.10).

Louise too described an early life of adversity yet a life where 'looking in from the outside...it was like its all rosy' (p.8). She described how she would 'pretend' in order 'to make everything seem all right' (p.4) but by the time she reached her early twenties it had all become too much: 'I remember thinking I need to do something because if I don't go and talk to someone, I am going to kill myself' (p.30). John recounted a similar experience. He says his 'life went off track before I ever got on track' (p.33) and described early years marred by 'poverty' 'deprivation' and 'abuse' (p.31). At the age of 22 John described coming face to face with 'the hopelessness of life' (p.12) and trying to end it by killing himself.

Each individual's experience of crisis/interruption is infinitely more nuanced and complex than any pattern can encapsulate. However, the patterns themselves represent commonalities in the journey the students took, not only to crisis/interruption, but to getting help and support. Some students struggled for many years before their distress became severe enough to warrant help while others suffered 'without really knowing' (Greg, p.1) until someone or something interrupted the narrative they had been constructing and helped them see that such suffering was not 'normal' and, most importantly, was not their fault. For some students, their crisis erupted almost without warning while for others it was a constant companion throughout an adversity-ridden childhood that, at a certain point, became too much for the student to handle.

However it unfolded, crisis/interruption was the point at which 'it' becomes acknowledged and admissive as 'a problem' that required some form of support or intervention. The first, and often most challenging, step to seeking support is trying to figure out what 'it' is and find the words to communicate its presence to others.

5.4.3 Articulating experiences

Crisis/interruption marks a 'turning point' (Niamh, p.29) for students. It is a point at which they cannot deny that 'something' has changed and that they need help. However reaching that realisation was often not enough – they also needed to convert lived experiences that were often confusing and frighteningly unfamiliar, into words that could be understood by others.

Sarah described how she 'couldn't really articulate – I still can't – what goes on for me, like, in my head' (p.9). She struggles to 'put words on' (Sarah, p.5) what is happening, something that is echoed in Mai's experience: 'I didn't know what that name [depression] was' (Mai, p.5).

Millie also described how she didn't 'know the words' (p.7) and struggled to 'find' (p.7) the right ones: 'it was all kind of just one big jumble in the head that I was just trying to figure out but I couldn't' (p.7). She says that 'when I was going through it I couldn't actually grasp what was going on' (p.7).

I didn't even really know how to explain it, because it wasn't like, oh I feel sick or something (Millie, p.7).

Ella, like Mai, says she 'didn't understand what it was, I didn't understand what was going wrong' (p.9). Marie too described how she 'didn't know what was wrong with me because depression seemed like a big label' (p.2). Because she 'didn't understand it' (p.2) and didn't feel it was as bad as the word depression seemed to her as a teenager, Marie says she 'hid a lot of it' (p.2): 'I know it sounds weird not to realise that something was wrong, but I didn't for a long time' (p.2).

Fiona described a similar experience. She says she 'didn't know even how to tell anyone I was upset or anything' (p.5): 'I didn't like know how to cope with it and I didn't know how to tell anyone' (p.5).

It is really hard when you are going through it to, like, tell someone... [it's] just this 'thing' and you don't even know what it is (Fiona, p.6).

Joseph says he 'had no clue' (p.6) what was happening to him and in spite of having 'lots of different tests' (p.1) it was many years before he was able to name the terrifying experiences he was having as panic attacks. Even now he struggles to find the words 'to explain' (p.6) to others what the experience is like.

It's really hard to define it and to explain what it is to somebody who has not had a panic attack, you know. Like by me explaining it, I really don't do it justice (Joseph, p.6).

Ashley spoke about how she 'could never really explain' (p.7) what she was experiencing. She found this particularly frustrating as, although she knew she needed help, she struggled to express herself when she finally got to see a professional who could help her: 'you go in and you desperately want someone to help so bad that you can't communicate what's going on so they can't understand and then they can't get there' (p.7).

While some students described how they struggled to find the words to describe their distress to others, for Kate her eating disorder itself 'is a form of

communication' (p.19). For this reason she feels that attempts to force feed her were 'not getting to the problem at all' (p.30).

To stuff somebody with food is almost like gagging them as in shutting up the mouth, and that is what you are doing, you are cutting off a very essential, perhaps the only way they have of communicating, so it's not going to result in their recovery (Kate, p.30).

5.4.3.1 Not being heard

Two students described how they struggled to speak about what they were experiencing, not because they couldn't find the words, but because they felt that they wouldn't be heard or believed.

Louise described how when she was in secondary school 'one or two' (p.7) of her teachers became aware that something was wrong. They even went so far as to call Louise's mother to express their concern but her mother would deny that anything was wrong and express frustration with Louise that her teachers were contacting her. As a result, asking for help seemed 'pointless' (p.7) to Louise.

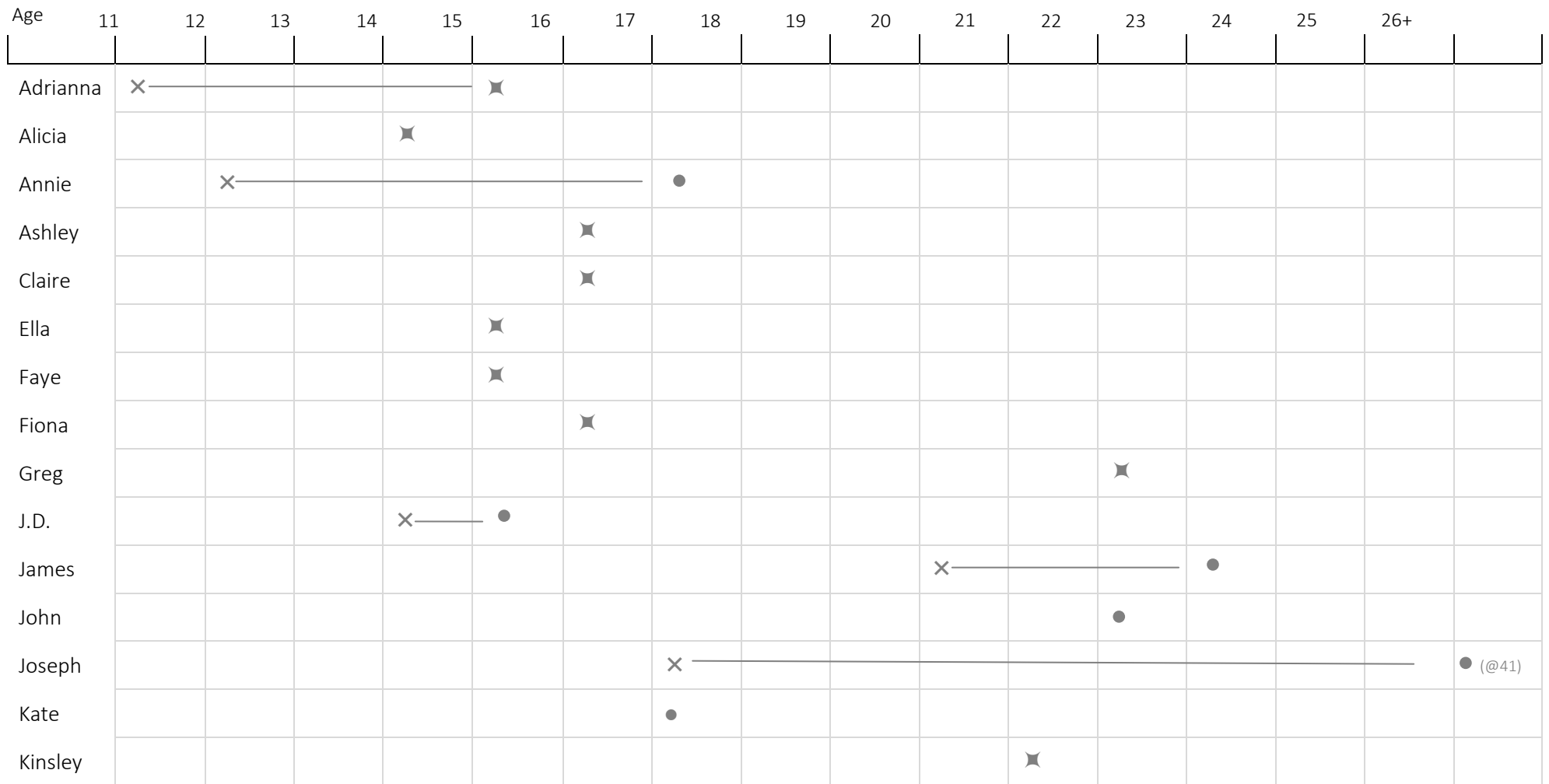
I was saying what's the point? If they are in contact with my mother, and my mother is swearing black is white that nothing is wrong; they are not going to believe me saying that there is something wrong (Louise, p.8).

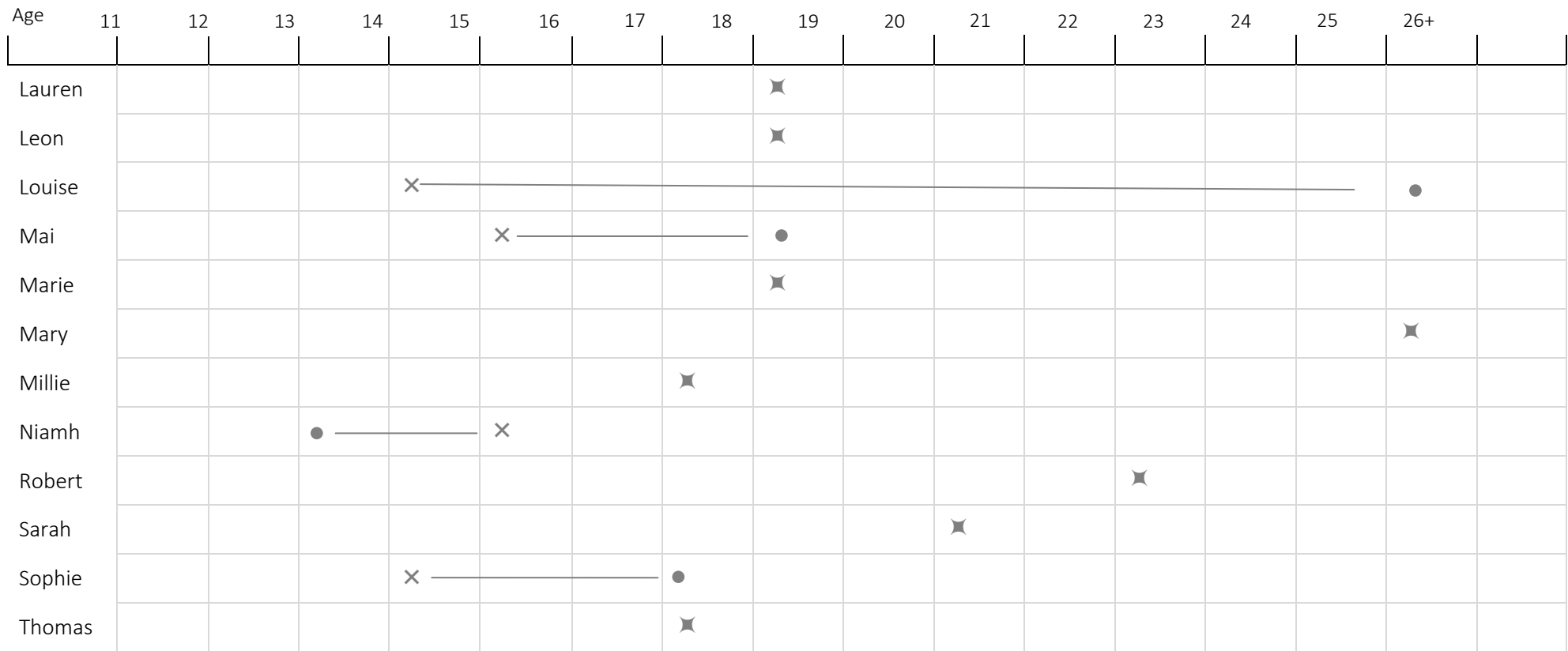
Adrianna spoke how at 'about eleven or twelve', when she realised 'I need to see someone' (p.9), her mother's response was 'No you don't, you don't need to see someone, you don't need to talk to anyone. You know, just get over it, you don't have problems, you're eleven' (p.9). This had a significant impact on Adrianna and she says from then she just 'kept it quiet' (p.9). Even when things 'really took a spin' (p.10) a number of years later, Adrianna 'kept it quiet of course' (p.10).

Articulating confusing and often distressing experiences proved enormously challenging for many students and impeded their capacity to ask for help. The next section explores just how the participants managed to communicate what was happening to them to others or, as was the case for a number of students, those around them were able to see that they were struggling and opened that conversation up for them.

5.4.4 Help-seeking

This section explores *how* students first went about seeking help, who they turned to and the initial response they received. It charts their help seeking journeys from the students who turned to their parents for help; to parents who realised their child needed support even when they couldn't see it themselves; to the 'others', namely teachers and college lecturers/tutors, in students' lives who helped them see 'it' for what it was. What this section does not explore is whether students found the help they received 'helpful'. This, and their experience of 'help' in general, will be explored in further detail in section 5.5 'narrative wreckage'. Figure 10 charts the duration from when each of the 27 students first became aware of 'it', regardless of whether this awareness was arrived at independently or not, and when they sought and/or received professional support.





Legend:

x Student consciously aware something was wrong ● Student sought help ✦ Both at once/within same year

Figure 10 Time from student becoming aware of 'it' and seeking/receiving professional support

5.4.4.1 Telling parents

For many students their first point of contact, once they came to the realisation that something was wrong and found a way of verbalising their experiences, was their parents. Alicia says her 'parents were so supportive' (p.3) when she opened up to them at 15 about the anxiety and panic she was experiencing: 'they understood it so straightaway we got on it and went to the GP who referred me on to the psychiatrist' (p.17). She feels that the fact that her mother has her own experience of depression 'was really helpful actually' (p.10) in that she knew what to do and knew how to reassure Alicia that it was going to be OK.

It terrifies me the thought of people who have to go through it without like strong family support. I don't know how they do it, you know, it's terrifying to think about it (Alicia, p.10).

While Alicia saw her mother's experience of depression as making it easier for her to ask for help, Annie feels that, initially at least, her mother's experience prevented her from admitting she was struggling. However, as will be seen in section 5.5.15, her mother's experience later became an important asset in Annie's moving on. But when she first began to struggle Annie says she put a lot of energy into 'keeping up appearances...partly for my mum's protection' (p.8): 'I kind of felt guilty that if I was to be sick too that would add to hers and it wasn't fair on her' (p.8). However, Annie reached a point where she couldn't keep up the appearance any longer and finally told her mother that she was struggling.

When I was explaining it to her I got very upset. I was saying 'It is, I've just gotten to the point where I can't pretend anymore' (Annie, p.9).

Annie's mother would say that up until that point 'she never spotted anything' (p.8) but Annie regrets not asking for help sooner.

Looking back at my 16 year old self I would say 'just tell somebody, you're not feeling great' but at the time it was something that was not going to happen (Annie, p.8).

Fiona described how, one morning before school, she 'just burst into tears' (p.5) in front of her mother. She says she 'didn't know how to cope with it and I didn't know how to tell anyone' (p.5).

That was the only way I could think of telling her because I didn't know like how to sit her down and be like you know "I need to tell you something" or... Because I just didn't understand it at the time (Fiona, p.5).

Fiona says her mother was 'completely shocked' at first: 'she didn't know what to do...it was such an outburst, she was just so shocked' (p.6). However 'the first thing' Fiona's mother did was 'try to help me and [we] went to the doctor the same day' (p.6).

It is really hard when you are going through it to tell someone (Fiona, p.6).

Millie too described how she 'tried to explain it' to her mother 'but I couldn't really explain, I just started crying and breaking down crying' (p.9). She described how her distress 'just kind of built' and she became 'completely overwhelmed' yet 'for ages I didn't really say anything' (p.7). She says that 'after about six or seven months of trying to be strong enough to kind of cope with it by myself' Millie's 'sadness...turned into voices in my head' and she 'eventually' (p.7) decided to tell her mother. Like Fiona she says she 'couldn't get the words out' (p.9) but that when she did manage to explain she said her mother was 'really understanding, she's brilliant' (p.9).

Claire also struggled to find a way of telling her mother about the depression and 'anxiety attacks' (p.8) she was experiencing. She says 'they both kind of tipped over and became a proper issue' (p.8) when she was in transition year and she knew she needed help.

I wrote a letter to my mum to tell her how I was feeling, how I was feeling really down and I wanted to do something about it (Claire, p.8).

Like Claire, Adrianna knew she needed to do something about the distress she was experiencing and she knew that, as she was still very young, she would

need her mother's help to get that help. Sophie too turned to her parents for support when she began to struggle with anxiety during her teens. She describes 'a very close relationship with them' which has meant that she has 'always felt that I could talk to them about anything' (p.9).

A close relationship presents as a uniting feature for all seven girls who turned to their parents, particularly their mothers, when they knew something was wrong. While for these seven, they were the ones who asked for help, for other students it was their parents who made them realise that they needed help.

5.4.4.2 Parents telling them

Five students described how their parents could see 'it' affecting their well-being and helped them seek support. For Ella her parents were the first to say 'you can't do this' (p.10). She says she 'didn't really know how to understand what was going on myself' and it was only when her anxiety 'came to a breaking point' while on holidays with her parents at 15 that they told her she needed help that she 'figured it finally then' (p.10).

Niamh described how, rather than seeing her eating as a problem in itself, she viewed restricting what she ate, over-exercising and losing weight as a solution to the problems she was experiencing in her life: 'something I knew I *could* control was trying to lose weight' (p.18). However, Niamh soon began 'losing a lot of weight' and her mother 'was bringing me to doctors and kind of saying what's wrong with her, why's she losing so much weight, like, it's ridiculous' (p.22). Even when she was diagnosed with anorexia nervosa and became seriously ill, Niamh still struggled to see that there was anything wrong: 'it took me about four months [being tube fed in hospital in the UK] to realise I actually was sick' (p.27).

J.D., like Ella and Niamh, says he 'didn't think it was anything' (p.11).

I just thought it was me, that it was my fault. I'm feeling crap because I'm a bad person (J.D., p.11).

He says 'the problem is it's so slow creeping up on you.... that you don't even notice yourself getting worse' (p.11).

It's kind of like people aging. If you're with them every day you can't see it, but if you don't see them for two years then you notice it (J.D. p.11).

However, a friend of J.D.'s noticed his increasingly low mood and said it to his parents. J.D. himself had become 'disconnected' (p.14) from his parents in the months before his friend spoke to them and says that 'they didn't really know what was going on' (p.14). He says that at 'the time I wouldn't talk to my parents; I wouldn't do that at all' (p.14) and while he was 'pretty angry' (p.15) with his friend at the time for telling his parents he says 'it's only now I realise he was actually right and know I might not be here if he hadn't have' (p.26).

Like Ella, Niamh and J.D., both Faye and Ashley's parents were the ones to suggest that they 'needed to reach out' (Ashley, p.2) and get some support during their teenage years.

5.4.4.3 Parents acting on their behalf

Two students, both of whom described experiencing a 'psychotic episode' (Kinsley, p.5), didn't so much seek help as help was urgently sought for them. In both cases it was their parents who acted on their behalf – admitting them to hospital where they could receive help and be kept safe from harm. Kinsley's mother 'essentially took custody' (p.7) of him and brought him safely home from holidays. He says 'the next day' he 'was taken' (p.7) to hospital to which he was immediately admitted. Kinsley described how he 'never really questioned' (p.24) why his mother had met him at the airport and why he was being admitted to hospital. He says he remembers 'absolutely nothing' (p.24) about being admitted but later his parents told him he was 'saying all this absolutely horrible stuff' (p.24): 'it's very terrifying to think that I was talking to people in this way' (p.24). Leon too says that a psychotic episode 'is not only bizarre it's dangerous as well' (p.17) and although he spoke about how frightening it was to be 'taken off' to hospital by 'Gardaí' he feels 'you might do something to harm yourself or the general public, you know, so you have to be brought in' (p.17).

5.4.4.4 Teachers

Sometimes it wasn't the parents but the student's school teacher who noticed something was wrong and suggested the student seek professional help. This was particularly the case for Kate, Thomas and Lauren.

Kate described how her parents 'didn't know I had an eating disorder, they hadn't a clue' (p.16). It was her teacher who first approached Kate when she was in fifth year in school 'and said that she was really worried, she had noticed what was going on with me' (p.16). While at first Kate tried to reassure her that 'No everything is fine' (p.16), Kate says she 'liked her, she was my favourite [teacher]' (p.16) .

So after a little while I started to open up to her and tell her...it was the first time somebody sat down and was like 'You know you are anorexic' (Kate, p.16).

It was Kate's teacher, with the support of the school principal, who first contacted Kate's parents and explained their concerns for Kate's well-being.

Thomas associates his struggle with depression to the pressure of the Leaving Certificate: 'I just started feeling like I was going to...well break down nearly. Just the thought of exams...' (p.9). His teachers could see that Thomas was struggling and it was his class tutor who first 'recommended I go to see a G.P.' (p.10). Lauren also described how it was her teachers who first noticed something was wrong when she was in transition year: 'teachers were pulling me out of class and stuff and they were going, "What's wrong with you?"' (p.4). It was when Lauren's teacher 'rang my mum' (p.7) that her parents brought her to counselling.

While for Kate, Thomas and Lauren it was their secondary school teacher who helped them identify that they would benefit from professional support for other students this help came later and was offered by a college lecturer or tutor.

5.4.4.5 College lecturer/tutor

Greg, Joseph and Mai described how it was academic issues that first brought them into contact with a lecturer or tutor who was then able to help them

uncover the mental health issues underlying their academic concerns. Greg feels that he had probably ‘been suffering [from anxiety and depression] without really knowing’ (p.1) throughout his adolescence and early years at university. Things came to a head in Greg’s final year, during which time he was ‘extremely emotional’ and ‘fairly depressed’ (p.12) and feared he was going to fail his exams. He approached one of his lecturers for academic advice but from talking to him the lecturer ‘obviously recognised’ that Greg ‘was in trouble’ (p.13) and explored with him the possibility of taking time off college as well as seeking professional help.

Mai too described struggling from a young age but says it wasn’t until she came to university that she ‘properly got help for it’ (p.2). It was when she met with her tutor the Christmas of her second year in relation to an exam she had done poorly in that the tutor recommended she attend the university counselling service. Like Mai, it was while meeting with a lecturer to discuss an essay result that Joseph opened up and ‘told her I’m struggling’ (p.21): ‘she picked up her phone and she rang the counselling [service] right there while I was sitting in front of her and she booked me an appointment’ (p.21). For Greg, Mai and Joseph academic issues opened up a conversation which revealed underlying personal and mental health issues and it was their tutor or lecturer who acted as their bridge to accessing the supports readily available for them at university. Other students were able to by-pass this bridge and access the supports directly through self-referral.

5.4.4.6 Self-referral

Students who realised they needed support seemed to go to one of two initial points of contact: their GP or their university counselling service. James says that once he’d ‘figured out’ (p.26) that what he was experiencing had a name, bipolar disorder, the next time he went through a ‘bad patch’ (p.28) he decided ‘I’m going to do something medically about this’ (p.28) and went to his university’s GP clinic.

Although she had been struggling with anxiety for many years it was only when Mary ‘accepted that this is a problem’ (p.14) that she went to see her family GP. Louise described a similar experience. She had struggled

throughout her adolescence but it was only when she reached crisis point that she thought ‘I need to do something because if I don’t go and talk to someone, I am going to kill myself’ (p.30). The person she chose to go talk to was a GP, although in Louise’s case she went to a late-night clinic and spoke to a GP she had never met before. Sarah, like James, chose to attend her university GP. She described how she ‘went in with stomach pains’ (p.12) and when the GP asked her how she was ‘it just all came out, everything, I didn’t know what was wrong on me’ (p.12).

The GP appeared to be the first port of call for many of the students in this study, whether they were brought by their parents, referred by their teacher or college tutor or chose to attend themselves. Two students, however, chose to access support from their university’s counselling service. The first, Robert, describes himself as ‘a regular client’ (p.18) of the counselling service, a service he turned to when he began to slip into ‘deeper and darker pits’ (p.27) as an undergraduate. Marie says she ‘thought that this was just me’ (p.3) and it wasn’t until she ‘reluctantly went along’ (p.2) with a friend to a talk organised for incoming students by the university counselling service that she ‘realised that something was up’ (p.3) and ‘realised that maybe it could be good to go to counselling’ (p.18).

I remember going up to the student counselling service and I was like, my heart pounding, I was climbing the stairs and I went in and I was in tears, I was so upset just making an appointment (Marie, p.18).

This section explored the space between *when* a student realised they needed help and *how* they went about seeking it. What it does not explore is the students’ experience of accessing professional help and whether this help was indeed ‘helpful’. Both these points will be explored in detail in section 5.5 narrative wreckage.

Part B: Crisis/interruption features

Part A of the crisis/interruption stage outlines the landscape of the phase itself. It charts the journey of each student to the point where they become aware of ‘it’ and beyond that point to where they receive help for ‘it’ as well as the

patterns that emerged in how this journey unfolded. Part B of this stage explores the features of students' crisis/interruption experience – namely self-harm and suicidal ideation and/or attempts.

5.4.5 Self-harm

Self-harm, or deliberately injuring oneself (Barnett Veague, 2008), featured in the narratives of seven students. For some students self-injury was part of, or immediately preceded, the point which they identified as being a major crisis/turning point. For others self-harm acted as a means of keeping this point at bay. Self-harm was described as a way of 'coping' (Faye, p.2), a way of releasing or 'dealing with' (Marie, p.34) intense feelings or emotions as well as a way of expressing inexpressible distress.

Faye described 'cutting' (p.2) as 'a coping mechanism' (p.2). She remembers how at 14 she wondered if this was 'a good way for me to cope' (p.2) and described how cutting 'acted as a release' (p.11) for the 'immense pain' (p.11) and 'numbness' (p.11) she was experiencing at the time: 'It took away the numbness and made me feel a particular thing' (p.11). J.D. also spoke about how self-harm was his way of coping with the numbness.

Most people would probably assume when you self-harm it's when you're feeling crap about yourself. It's when you feel nothing, that's when you self-harm (J.D., p.10).

Marie, like Faye, cuts herself as 'a kind of release' (p.35). She feels that 'self harm is quite helpful' (p.34) and while she says that 'rationally it shouldn't be' cutting acts as Marie's ways of 'dealing with' (p.34) intense feelings.

[M] When I feel negative emotions, like it's painful, it's so strong, it's hard to describe but it's just so much and it's so big and the cutting helps to kind of release [it] and then I'm calm again.

[E] So it kind of builds up inside physically.

[M] Yeah, and it builds and it's just, I want to tear off my skin, it just feels wrong. And so the cutting felt like my only way of dealing with this because I couldn't cry (Marie, p.35).

Marie's self harm has been an escalating issue for her throughout her time at college. Her psychiatrist recently challenged her on the issue, asking her 'what are you getting from it?' (p.39) and whether it was a way of generating 'a surge of support' (p.39) at times of crisis. Marie says that initially she was worried her psychiatrist was suggesting she was 'just looking for attention' (p.39) but, on reflection, feels 'it's fair what she's saying that it is reaching out for support...the support is there I just need to ask for it' (p.39).

At the time of interview Marie was taking her psychiatrist's advice on board and was trying to address her self-harm.

Working against the self-harm has been very difficult. I've never found anything to combat it, so I ignore it and I focus on feeling well generally and then the urges go down. But I don't have any, despite all my skills; I've nothing in my arsenal that's ever worked against self-harm (Marie, p.51).

Lauren says that 'I didn't really cut or anything until I was in hospital' (p.15). Prior to admission she began to scratch her skin with her finger nails, largely in response to the 'panic' (p.15) she was experiencing. The scratching resulted in scars that were 'like burns, they weren't like cuts or anything' (p.15) but Lauren says these scars 'looked really bad, they looked way worse than they were' (p.15). She feels the appearance of her scars contributed to her being admitted to hospital where her self-harm progressed to cutting and starving herself.

I didn't really cut or anything until I was in hospital. But that's more being in hospital because you learn the tricks of the trade and how to hide food and even like safety pins on the inside of your clothes because they take everything (Lauren, p.15).

Like Faye and Marie, Louise started self harming at the age of 15 as a way of releasing intense feelings and emotions. She described how 'when I was feeling upset or angry' these feelings would 'build up inside; build up and up and up' (p.5). She first 'tried' (p.5) cutting as a way to 'get rid of' (p.5) these feelings and was pleased to discover 'yeah, this is good' (p.5). Louise says that that first night she realised that when 'everything builds up to that point that this [cutting] was here to help' (p.5).

Louise continued to cut throughout her teens and into her twenties. She says that ‘as time went on and it all just got bigger and bigger, everything got bigger, I stayed quieter and the self-harming...that was starting to lose its effectiveness’ (p.34). When cutting began to lose its effectiveness, Louise turned to overdosing on prescription medication:

It wasn't actually to take an overdose and die, it was cutting isn't getting me anywhere, this is a notch up and this could help (Louise, p.35).

Although Louise has ‘stopped self harming on my arm area’ (p.56) the scars still present a problem for her in her work as a care assistant and as a student nurse. She has overcome this by wearing ‘a cardigan over the uniform [or] something under the uniform’ (p.56). Louise describes her self-harm as a way of communicating yet throughout her numerous hospital admissions she says ‘I had no one to talk to about it, no one at all’ (p.36). Instead she feels her behaviour was viewed as ‘kind of attention seeking’ (p.36) for which Louise felt the psychiatrist and nursing staff were ‘giving out’ (p.37) to her.

Adrianna says she began self-harming when she ‘was about eleven’ (p.10). Like Louise she described how her self-harm ‘kind of developed’ (p.10) into a cycle of ‘not eating for a few days then bingeing and purging for a few days and self-harming, then taking overdoses’ (p.10).

Self-harm for many of the students appears to represent an attempt to cope with and release intense and distressing emotional states. However, it appears that for Louise and Adrianna, who both moved from cutting to overdosing, the line between self-harm and suicide attempt was no longer ‘so clear cut’ (Louise, p.36).

5.4.6 Suicidal ideation and attempts

Thoughts of suicide, plans and attempts, featured in the narratives of ten of the students who took part in this study. Suicide appeared to offer students a means of escape. For some it was a chance to escape excessive amounts of pain and

‘torture’ (John, p.12), while for others it was a way of escaping the pointlessness of life itself.

Faye remembers how she ‘thought about how I was going to kill myself’ from a young age: ‘From first class I would say; I remember thinking about it before my communion’ (p.2). As she got older she ‘realised that it wasn’t normal’ to ‘think about suicide so much’ and ‘kind of went on to different methods and stopped thinking about it’ (p.2). By different methods Faye was referring to self harm.

Mai, like Faye, traces the origins of her suicidal ideation and attempts back to when she was a little girl. She says she first ‘tried to commit suicide when I was 10’ (p.3) by putting a plastic bag over her head. She ‘tried again’ at 14, this time ‘with an overdose, but that didn’t work’ (p.4). Mai feels that her suicidal urges are a response to a sense that she’s had from a young age that her parents don’t love her and says that, even now, when things are bad at home she sometimes finds herself ‘tying ropes and stuff like that to hang myself’ (p.26).

John too described how thoughts of suicide, for him, were related to difficulties from his childhood. By the time he reached his early 20’s, John described battling with ‘the hopelessness of life’ (p.12).

*Why go through, why struggle through all this? What was the point?
What was the point of all this torture? (John, p. 12).*

Thomas also spoke about how suicide offered a means of escape. He says he ‘tried to kill myself’ during his leaving certificate year because ‘the pressure was getting too much for me’ (p.11): ‘I tried to run out in front of a car...the car stopped and I broke down in the middle of the road’ (p.11).

Niamh too spoke about how suicide seemed like a welcome relief from the distress she experienced as a child and young teenager. She talked about how even as a ‘12 or 13’ (p.20) year old she felt she ‘just wasn’t worthy of anything’ (p.20): ‘I didn’t deserve to be loved’ (p.20).

When I think back on it sometimes I just think that I don't know how I got through it to be honest, I was just at the end of my rope. I just didn't want to be there anymore and I just wished I could go to sleep and I wouldn't wake up (Niamh, p.20).

Niamh says that during those years she 'had thoughts about committing suicide' (p.25) and had 'a plan in my head' but says that when she went to 'actually do it' she found she 'couldn't' (p.25). She says that in her mind she thought 'no, I can't do this, I'll just keep going the way I'm going with the eating disorder' (p.25).

Later, when her anorexia nervosa had progressed to the point where her weight 'wasn't even on the percentile charts' and her medical team 'were really, really worried, saying 'Oh my God, this girl's going to die'' (p.24); Niamh says 'I didn't care. I hate saying it but I didn't, I really didn't care' (p.24) whether she lived or died.

I just didn't believe in myself, I had no self worth for myself, didn't care, why would I care? Nobody would care anyway if I was gone. I was only a burden being here (Niamh, p.27).

Sarah also described how 'when I was in 2nd year in college, I just didn't want to live anymore' (p.11). While she says she was 'very suicidal' and was having 'very bad thoughts' (p.11), these thoughts never progressed to a plan or intent.

What I've come to learn now is that suicidal thoughts are very different to suicidal intent and I think that some people cannot tell the difference and I think that is a big stigma because people don't know that you can have a lot of thoughts and not act on them (Sarah, p.11).

Sarah spoke to her college G.P. about the thoughts she was having and was referred to a psychiatrist, who in turn 'said straight away that he thought I needed to go to hospital' (p.11). While she says 'I suppose the line is very fine' (p.11) between thinking about suicide and acting on the thoughts Sarah is unsure if a hospital admission really was what she needed at that time.

While Sarah wonders if her admission to hospital for suicidal thoughts was premature, for Adrianna it took a suicide attempt for her to get an appointment with a psychiatrist.

[Her G.P.] realised that she couldn't do anything so she gave me a referral to the psychiatrist. But I was on a waiting list for two years... About a month later I was in A&E because I tried to kill myself again and that really speeded up the process of seeing the psychiatrist (Adrianna, p.11).

Adrianna described how she began self-harming at an early age as a way of managing intense feelings of distress. Later, self harm 'kind of developed' (p.10) into 'taking overdoses' (p.10) until eventually she reached the point where 'I was just like I'm just going to kill myself...I couldn't keep it in' (p.10).

Louise too described how she began taking overdoses in order to take self harm 'up a notch' (p.36) and how, in time, the line between taking overdoses in order to hurt herself and taking overdoses in order to kill herself, became less 'clear cut' (p.36). She described what it was like the first time she took an overdose:

I remember sitting there and I could suddenly feel like, well over a little bit of time, I could suddenly feel kind of my head starting to go funny, the place starting to twirl around, my heart felt like it was going to come out of my chest really and that frightened me, the whole heart beating crazy, I was convinced I was going to have a heart attack...then I started seeing all things, it was like hallucinating or something, I started seeing snakes and all coming out of the ceiling and I was like 'Shit, I am actually going to die' (Louise, p.35).

Louise says that that first overdose was more an attempt to take self harm 'up a notch' (p.36) but 'that one overdose started the domino effect for more severe ones' (p.36). In time, Louise was overdosing regularly on 'quite serious amounts' (p.36) of 'anti-depressants', 'sedatives' (p.36) as well as paracetamol and over-the-counter medication.

As time went on it was getting more and more serious and at this stage my intent wasn't kind of so clear cut, it wasn't self-harm, it was kind of, let's see what happens kind of thing (Louise, p.36).

Louise was playing a game of Russian roulette where she says she ‘could decide if I am going to die from this or I am not going to die from this’ (p.36).

In the space of that year I think I was hospitalised 12 times or something like that for overdoses; on the serious end of things (Louise, p.37).

Louise says that overdoses became ‘the only thing that would keep me going...week by week’ (p.38). She would ‘plan these overdoses around the Friday afternoon’ after working during the week in the knowledge that ‘I would have myself out [of hospital] Monday, Tuesday max’ (p.38): ‘That’s what kept me going...and when I would do it and I would feel a million times lighter then after, a million times’ (p.38).

Eventually Louise says things got ‘progressively worse and worse and worse’ (p.38): ‘I was kind of blurring normality from not normality and that I wasn’t capable of keeping myself safe’ (p.38). She said that ‘overdoses and self harm [were] a routine thing, like I was going out to buy a litre of milk’ (p.47). When she turned up for an appointment with her psychiatrist one day, hours after taking an overdose, things came to a head for Louise and her consultant: ‘He was spinning, the room was spinning...it was like he was panicking, and I remember thinking if he doesn’t think he can fix this, how am I meant to?’ (p.45).

Louise went into hospital that day under threat of involuntary admission and it was during that hospital stay that she thought ‘there has to be something else...there has to be something more’ (p.48).

James described how he struggled to see ‘the point in life’ (p.8). He says he started ‘thinking of maybe killing myself [when] I was about nine or ten’ (p.25): ‘when I was younger I always thought that was the way I was going to go’ (p.45). Career and life choices seemed almost futile to James when he was growing up: ‘like you don’t even know whether in your head you want to survive the year never mind do something with your life’ (p.10).

James described how suicide was his 'safety mechanism' (p.25): 'it's like no matter what happens I've got this back up so if everything goes wrong in life I've got this back up' (p.25). He spoke about the time he 'tried to kill myself' (p.21). A bad experience in work occurred during what James described as 'probably the worst period I'd say as an adult' (p.21) and again brought the suicide option to the forefront of his mind.

I attempted to hang myself but the rope broke (James, p.21).

After his suicide attempt 'didn't work' (p.21), James described 'just lying in bed for a week doing nothing like, I wasn't eating, wasn't drinking... I wasn't taking care, I was just done' (p.21).

I wanted to die a thousand times, just it gets to a point where nothing makes sense anymore, nothing holds your interest, there's no element of happiness and the torture is, it's on a level you can't replicate physically (James, p.24).

James feels very strongly that 'guns are a really bad thing to have legal in society' (p.24). While now, for the first time in his life, James feels he can say 'I don't think I'll ever kill myself' (p.45) that was not always the case. He feels that if suicide 'was simpler' (p.24) he, and many others like him, 'would do it' (p.25).

Hanging yourself is fucking difficult like. Overdosing on pills is fucking difficult and if you survive it you're going to have lifelong damage and stuff, and even if you don't, you're going to survive it and people will know because you'll either have passed out or started throwing up violently but there's no hiding it, whereas if you had a gun ...if you've a depressed person who goes to severe levels and you leave a gun with them for long enough, you definitely have a certain percentage of people who'd pick it up because it's so quick (James, p.25).

He feels that hanging ('you have to go and get some rope' (p.25)) and overdosing ('you're thinking who's going to be in the house?' (p.25)) by their less convenient nature offer a delay which James says creates space 'to talk yourself out of' (p.25) completing the act. James described how talking himself out of suicide 'is a difficult thing to do' (p.25) as 'your survival instinct or whatever switches off parts of your brain that let you think [about] it logically' (p.25). Guns, for James, don't offer the time to think logically and 'that's the

issue with fast' (p.25): 'if you think about something for long enough, ten, fifteen, twenty minutes even, you've usually ah no, not today' (p.25). He wonders if he would be still alive today if he had 'grown up in a different country' (p.25); one where 'fast' modes of suicide, such as guns, were readily available.

Kate, like James, described how, when she was in her final year of school, she 'didn't see the point of anything anymore' (p.19): 'By that stage I was starting to think 'no, life is not worth it', and wanting to kill myself' (p.19).

She remembers 'being in a therapy room one day and reading a poem that a client who had recovered had written years ago, and in it she mentioned about wanting to die' (p.19): 'And I kind of, I don't know why or where it came from or what, but I kind of thought, that's what needs to happen' (p.19).

I was looking for something or to be heard in a way that I wasn't being. So yeah, so I saw this thing and I was like 'maybe I should die' and it kind of just progressed from there, then it became the whole world is shit, and I could not see anything, there was just no point to anything (Kate, p.20).

Kate says that 'for about four or five months' after this 'I was taking a lot of overdoses, I was in hospital quite a lot' (p.20): 'I never got admitted though. They once even gave me back a box of tablets that I hadn't finished!' (p.20).

This continued until it 'got to a point' where her doctors told Kate's mother that she 'would be dead within a month' (p.22). The therapy centre she had been attending 'said they couldn't keep me any longer' but eventually agreed to take her back on 'condition' (p.22) that she wouldn't try to kill herself again and would 'do what they say' (p.22): 'So I said 'OK' and that was kind of it' (p.22). However, when she went back to the therapy centre Kate says she 'never really spoke' (p.23) and she continued to struggle to find a reason to live.

I kind of wanted to get better but I also wanted to die, and was kind of questioning people 'Tell me why I should live, what is it that motivates you to live' because I couldn't understand it and by that stage I couldn't remember any more what it was like to not have an eating disorder. I

didn't remember anything other than this and this was horrible. It just seemed hopeless to me (Kate, p.23).

Suicide attempts for Kate, and for many of the other students, reflected an intensity within their experiences that was intolerable and from which they sought to escape. The next part, part C, of this crisis/interruption stage attempts to get as close as possible to the students lived experience of their own particular 'it'.

Part C: The lived experience of...

The individual features seen throughout the four stages of the narrative 'plot' reveal much about the students' lived experience of mental health problems. From the struggle to produce a reason for 'it', as seen in the 'pre' narrative phase, to the experience of feeling deeply suicidal, as seen in this crisis/interruption phase; these features of the students' narratives draw us closer to what it is actually like to live with psychological distress.

This third section, however, attempts to get even closer to the phenomenon. It is concerned, not with what it is like to live with 'it', but what 'it' is like itself. Thus far 'it' has been used to refer to the distress experienced by the students in this study. As seen in section 1.2 on the language of psychological distress, words and language itself are enormously limited in their capacity to convey and portray the depths and uniqueness of human suffering. However, a language has built up around the phenomenon of psychological distress which, like all major discourses, serves to allow human beings organise and communicate particular objects, events and experiences. Diagnostic categorisation, the origins of which are explored in chapter three, offers the most common form of shared language and descriptive labelling in mental health. Many of the students described themselves as 'having' or 'suffering from' depression or anxiety or anorexia or psychosis - all of which are terms that are commonly found between the pages of diagnostic manuals such as the ICD-10 or DSM-V. While this section is all about scratching below the surface of these words to the actual experience and meanings, it acknowledges the usefulness of these diagnostic labels in helping to locate the experience within

a broader context. The labels used in this section reflect the labels the students themselves used during their interviews. They act simply as a means of grouping students' experiences across the dataset; serving as signposts to a richer and deeper experiential terrain.

Part C attempts to draw us closer to students' experience of particular phenomena, for example depression or bi-polar disorder. However, it must be highlighted that what follows merely skims the surface of students' experiences in order to provide a brief insight into what it is like, for example, to experience a psychotic episode. It does not, and cannot, portray the depth and complexity of each student's individual experience. What part C will provide, in turn, is a synopsis of students' lived experience of depression, anxiety, panic, psychosis, bi-polar disorder, eating disorders and borderline personality disorder.

5.4.7 Depression

Depression featured as the most defining concern in the narratives of five students. When asked to describe what depression is actually like, the students drew on a wide variety of words, similes and metaphors. While some began by using terms more readily seen on the pages of a psychological or psychiatric textbook, most appreciated and rose to the challenge of giving a sense of what it is actually like to experience the phenomenon often labelled 'depression'.

A word which appeared time and again in the narratives of these students was 'numb'. J.D. described how he felt 'nothing at all' (p.10) and says 'that numbness, it just kills you. It just drains everything from you' (p.10). Fiona too said that that 'numbness' is 'just so draining' (p.21): 'You don't know what to feel anymore and it's just so tiring' (p.21).

It is like I just don't feel, like nothing is making me happy, like everything is just bad (Fiona, p.22).

Annie said she felt 'numb' (p.16) when her depression was at its deepest: 'I was just feeling nothing at the time' (p.17). She reckons she 'was so upset that I stopped feeling anything' and feels that, by that stage, she had completely

'burnt out' (p.17). John spoke about feeling 'burnt out' (p.19). He described being 'fed up' with life and 'worn out' by the never ending battle with his 'own mental health' (p.19).

Fiona compared depression to being stuck 'in a hole' (p.4).

It feels like nothing can lift you up out of that hole. It is like you are just constantly being pulled down, dragged down and you are just trying to get up the surface all the time. It's really hard (Fiona, p.4).

While Fiona compared the experience of depression to being stuck in a deep hole, unable to get out, Sophie compared it to 'being trapped in a weird grey bubble' (p.11). She recounted how she tried to describe the experience to her father one day by saying 'it's like I'm wearing grey glasses' (p.11) which 'filtered' and 'warped' her perception of the world and meant that she was 'seeing everything in a very negative light' (p.11).

Sophie also described how, when she's struggling, she feels 'very detached' (p.36). This was something Marie spoke about too when she described 'periods of being very detached' (p.3) during which she would go through the motions of getting up and going to school or college without much 'interest' (p.3) in what was going on around her. She described 'finding it hard to engage' (p.34) with the world:

When I get quite bad, I feel like a zombie, I'm going along. I mean I can hear the things around me and I can see but I can't connect enough, like my brain just works too slow to make connections to really know what's going on around me (Marie, p.34).

Engaging with the world proved challenging for many of the students experiencing depression. J.D. described how he 'shut myself off' (p.14) from the world and 'disconnected' from his friends and family when his depression was at its most severe: 'I'd just sit in my room by myself listening to music' (p.14). Annie recounted how, during a particularly difficult spell in college she 'just locked myself into my room' (p.22): 'I hardly ate a bite for a week, didn't talk to anybody, didn't want to see anybody' (p.22). Sophie too says that when times got tough she 'really retreated' into herself and described feeling

‘trapped in this feeling of loneliness and hopelessness and I didn’t see how that could ever be changed’ (p.11).

Retreating into themselves, and away from the world, appears a common response for students struggling with depression. J.D. says he ‘wouldn’t call living with depression living’ (p.16). He says that all he wanted when his depression was ‘real bad’ (p.16) was ‘to stay at home and just dwell, survive’ (p.16). Fiona described how ‘when you are feeling so low you don’t want to do anything’: ‘I don’t want to go to college, I don’t want to go and talk to anyone. I don’t want to do anything’ (p.16). Marie also spoke about how she loses interest in most things when she’s struggling with depression and says that ‘getting up in the mornings’ in particular is ‘very difficult’ (p.3). The struggle to get up and face the world was a common one for students who described experiencing depression. John spoke about ‘the torture of getting out of bed’ (p.25) in the morning while Annie says that when she was struggling she ‘wanted nothing more than to go to bed for the summer’ (p.17).

In addition to all the above, students described the frustration of not being able to concentrate (Sophie; J.D.; Annie); not being able to sleep (Thomas; Annie; Fiona); and not being able to halt the endless thoughts that ‘would be going over and over in your head’ (Annie, p.10). J.D. spoke about how, at his lowest, he ‘was pretty angry at the world’ (p.15) and says he was ‘being a dick’ (p.15) to his friends and his family. He remembers how he was ‘just so unhappy’ that he was ‘not a nice person at all’ (p.15) and feels grateful that, instead of giving up on him, his friends and family ‘realised something was happening’ (p.15). J.D. feels that one of the worst effects of depression is the way in which it shreds his confidence.

That's what depression does, it makes you feel worthless, so you're not going to have any confidence (J.D., p.30).

John also feels that, although his depression ‘has greatly improved’ (p.26), he has ‘a long way to go’ (p.26) before he gains in self-confidence and self-esteem.

Numb, burnt out, detached, disengaged, withdrawn, angry, worthless – all words used by students in describing what the phenomenon commonly referred to as depression is actually like. While for these students their dominant experience was of depression, other students described experiencing both depression and anxiety.

5.4.8 Depression and anxiety

While for some students depression was the more dominant experience, others experienced depression ‘as a result of anxiety’ (Alicia, p.3). Claire says that although depression was her ‘major worry’ (p.8) and her anxiety ‘was secondary’ (p.8), that both were ‘slowly growing together’ (p.8) and were largely inseparable. Greg says that it was only following ‘a sustained period of anxiety’ that he first entered into ‘a pretty bad depressive episode’ (p.1). This association was also something that Joseph emphasised: ‘I get depressed because I have panic attacks, not the other way around. And that’s important’ (p.30).

Like depression, and further emphasising the link between the two, students who struggled with anxiety spoke about experiencing sleep-related difficulties. Greg spoke about how his anxiety and depression have ‘prevented me from sleeping’ (p.3). He says not being able to sleep is ‘a huge problem in itself’ as it is impossible to ‘function’ when ‘you’re not getting more than four hours sleep a night’ (p.3). Mai described how, at her worst, she ‘wasn’t sleeping’ (p.16) while Fiona spoke about how, when she’s ‘very anxious I don’t sleep well, I wake six or seven times a night’ (p.22). Unsurprisingly, not being able to get sufficient sleep means that the students struggle with exhaustion and fatigue which, as Greg highlighted, makes it even more difficult to manage their mental health and generally ‘function’ (p.3). Alicia spoke about how ‘tiring’ (p.20) living with anxiety is and says that sometimes she gets ‘so sick of it’ (p.20). Mai described how ‘hard’ she found it to generate the energy necessary to sustain her through ‘long days’ (p.19) in college while Mary says that ‘tiredness is a *huge* thing’ for her: ‘I just feel so tired’ (p.27). Greg summed up the undulating energy levels described by many students who struggled with depression and anxiety:

It might be a day of extreme anxiety [followed by] a day of extreme exhaustion ...There is two ends. There is the hyper alert end and the exhausted end (Greg, p.4).

For many students depression was a close, and unwelcome, cousin of anxiety. However, as Claire says, the anxiety came first. The following section will look at this phenomenon in more detail.

5.4.9 Anxiety and panic attacks

Featuring in the narratives of 12 students, anxiety emerged as the most frequently described ‘disorder’ amongst those who shared their story as part of this study. Students who spoke about anxiety described intense physiological experiences, high levels of stress and distress as well as real difficulty in being around large groups of people or, sometimes, even leaving the safety of their own bedrooms.

Alicia says that during ‘periods of high anxiety I feel like I have enough energy to pick up a car and throw it’ (p.17). She says it’s like experiencing a ‘constant...adrenaline rush’ (p.17). This state leaves her ‘clammy’ ‘fidgety’ ‘really uneasy’ and her vision ‘slightly veiled’ (p.17). The worst part, according to Alicia, is the fact that she is never sure when this intense state is going to end. She, like many of the other students, described this experience as ‘all consuming’ (p.3): ‘The high anxiety, it’s horrible, it’s just horrible’ (p.17).

Greg describes anxiety as being ‘distressing’ and ‘quite physical’ (p.3). He described ‘the urge is to run or to get away from whatever it is that is bothering me’ (p.3). Joseph described how during periods of high anxiety his body’s ‘fight or flight’ (p.6) response is ‘triggered all the time for nothing’ (p.6). When Ella was asked what it is like to be inside her skin when she is extremely anxious she simply replied ‘like you don’t want to be inside your skin anymore’ (p.8). She said ‘it’s like everything is moving very very fast inside your head but everything else [outside your head] is moving quite slowly’ (p.8). While Ella calls this experience ‘sheer blind panic’ (p.8), Robert says it’s ‘a paralysing fear’ (p.13).

Experiential accounts of anxiety were laced with descriptions of just how physical the experience is. Students spoke about how they ‘just couldn’t breathe’ (Clarie, p.3): ‘you’re trying to breathe and you can’t get a breath’ (Joseph, p.8). Mary described how ‘you feel it in your chest’ (p.27) and says for years she had used inhalers for asthma whereas ‘now I don’t even have asthma, it was all anxiety’ (p.3). Joseph described how having a panic attack ‘tightens your airwaves and it’s like somebody’s kneeling on your throat, you can’t breathe’ (p.29). In addition to difficulty breathing, many students described ‘nausea’ (Alicia, p.2), ‘retching’ (Mai, p.6), feeling ‘all clogged up’ and ‘like throwing up’ (Claire, p.6). Greg described how his anxiety ‘clouds my judgement’ (p.3) and worries that he ‘can’t always be sure that what I’m doing is the most rational thing’ (p.3). Both Mai and Sophie described how their anxiety affected their concentration and how frustrating it was when material they are studying for college doesn’t ‘register’ (Mai, p.9) in their memories.

A number of students spoke about how these often debilitating physical experiences made it ‘really difficult’ for them ‘to leave the house’ (Mary, p.4). Alicia described how her anxiety ‘peaked with me staying inside [and] leaving my house once in seven weeks’ (p.2). Fiona says she ‘missed a lot of school’ (p.7) because she ‘couldn’t cope with being there’ (p.7). She says that ‘being at home was the only safe place’ for her at that time and she developed ‘a fear of leaving the house’ (p.7). Claire too struggled to go to school because of her anxiety and says she only managed to attend for ‘thirty-three days in sixth year’ (p.6). She says that even ‘the days that I was in, I left early because I got social anxiety’ (p.6) and described how ‘a big group’ of people would make her ‘really nervous and uncomfortable and I’d just leave’ (p.7). Greg too spoke about ‘a social anxiety element’ (p.3) to his experience. He described the ‘embarrassment’ when those around him, particularly those who he shared his lab with, would ‘see me in that condition [highly anxious]’ (p.3).

5.4.10 Psychosis

Three students identified themselves as having experienced psychosis. Kinsley says that ‘essentially what happened was’ that after a number of weeks of ‘smoking [marijuana] every day’ (p.4) during his college holidays he was

‘struck by one hell of a psychotic episode’ (p.7). He ‘suddenly stopped sleeping’ and says that his ‘perceptions were completely altered’ (p.5). He described thinking he ‘was at the centre of this continent-wide conspiracy [and] that I was somehow at the centre of this network of people and they were all trying to find me which was terrifying’ (p.5). He also described a ‘messianic feel to it as well as if somehow I was a chosen one or something and that’s why everyone was looking for me’ (p.5). He spoke about ‘mad cap drawings’ he was ‘scrawling all over the place’ and the ‘haunting’ and ‘grotesque’ images that would ‘flash’ into his mind which were ‘totally tormenting’ (p.5) him.

I was either in tears because of these images I was having or I was terrified, like, under the bed because I thought everyone was coming to get me or else I was really happy because I was the chosen one (Kinsley, p.5).

Leon too described how the summer before his first psychotic break he ‘smoked a lot of cannabis’ (p.2). He spoke about ‘going through all sorts of delusions’ (p.5): ‘I thought I was Jesus Christ you see’ (p.5). Leon also thought he ‘had discovered a secret’ about the Greek island he was holidaying on with friends and feared that he was part of a conspiracy as ‘the Greek Tourist Board didn’t want people knowing’ about the secret he had uncovered (p.5).

Millie, like Kinsley and Leon, was diagnosed with psychosis as a teenager. She described how at the age of sixteen she began ‘hearing voices in my head’ (p.7). She ‘was sleeping really, really badly’ (p.9) and over time began ‘experiencing hallucinations at night as well’ (p.8).

That’s when I kind of did get quite scared, when they [the voices] were saying to do things that I didn’t want to do, really kind of hateful things (Millie, p.8).

At the time of interview all three students said that while it had been sometime since they had been in a psychotic state ‘what happened is still very much with’ (Kinsley, p.20) them today.

5.4.11 Bipolar disorder

Bipolar disorder dominated the narratives of two students; James and Ashley. Both students trace the origins of their bipolar disorder back to ‘a very early age’ (Ashley, p.1) but didn’t come to the realisation that what they experienced was ‘anything different to anyone else’ (James, p.12) until later in life. Ashley spoke about the fluctuating moods she has experienced for most of her adolescent and adult life. She described how ‘things would get good and good and good and even absolutely top of the world and then they’d all fall apart’ (p.11).

James also described the ‘horrible highs and lows’ (p.12) during which he would go ‘from being one of the happiest people in the world one day’ to a blistering ‘crash, usually the day after being the happiest person’ (p.12). Both students recounted their struggles with the ‘mundane and everyday’ (Ashley, p.11) and described ‘finding it very difficult to balance’ (James, p.6) their moods and maintain an ‘overall level of consistency’ (Ashley, p.12). Learning what ‘it’ was acted as a real turning point for both James and Ashley.

5.4.12 Eating disorders

Three students, Kate, Niamh and Lauren, spoke about their lived experience of anorexia nervosa and bulimia nervosa. While Kate says there was no ‘reason behind’ (p.5) the onset of her eating disorder, Niamh clearly attributes the development of her anorexia nervosa to the bullying she received at the hands of teachers and her peers.

I was very aware that there wasn’t a lot of things I could control in my life in terms of people bullying me or those factors, but something I knew I could control was trying to lose weight (Niamh, p.18).

Lauren, on the other hand, feels she developed her eating disorder while in hospital: ‘they were like, you have an eating disorder, I was like, well I better start losing weight...I may as well tick the box’ (p.9).

All three girls described how ‘gradual’ (Kate, p.12) their weight loss was and how they became more and more ‘conscious’ (Kate, p.5) and ‘focused’ (Niamh, p.23) on food, cooking, counting calories and exercise. Niamh

described how anorexia ‘gets inside your mind’ (p.20) and says ‘it like this devil’ that tried to convince her that no matter how much weight she lost that she’s ‘fat’ and ‘ugly’ (p.20) and needed to lose more. Lauren described how ‘it does make me feel better when I lose [weight] but I know it doesn’t really help’ (p.22). She describes her eating disorder as the ‘best form of control ever’ (p.13) and says ‘it balances out the rest of your life’ (p.13): ‘obviously it’s not the best coping mechanism’ (p.13).

Kate spoke about how, more than a decade after she first began to struggle with food, it continues to ‘affect most things’ (p.28):

At the moment I get sick every day in college and it’s horrific and it affects everything (Kate, p.28).

Lauren too is still engaged in an ‘internal battle’ (p.18) with her anorexia and says that ‘I guess the eating disorder’s winning just a little bit at the moment, just a little bit’ (p.18). Niamh, however, described reaching a ‘turning point’ (p.29) and is ‘glad that part of my life is over’ (p.46) she hopes to use her experience ‘for the better’ and show other young people that ‘recovery is possible’ (p.48).

5.4.13 Borderline personality disorder

Three students mentioned the diagnosis ‘borderline personality disorder’ (BPD). For all three this was a highly sensitive and controversial diagnosis to receive or to acknowledge. Adrianna feels ‘they [psychiatrists] diagnose you with something along the lines of borderline, because they don’t really know what the hell’s going on’ (p.21). She feels that when medication used to treat other mental health problems doesn’t work ‘they kind of say yeah you’re probably borderline so we can’t really do anything about that’ (p.22). She says she doesn’t know what her diagnosis is (‘I fit everything and they’re telling me it’s everything so it must be everything’ (p.28)) but feels that ‘my whatever collection of disorders’ are all ‘conscious attempts to self-destruct’ (p.29).

Lauren, like Adrianna, feels that BPD is a diagnosis that is applied to 'everyone who has ever gone through anything between the ages of 17 and 22' (p.14).

Borderline personality disorder, that's my favourite. I'm like, 'You literally give that to everyone' (Lauren, p.14).

Louise was 'advised not to disclose' (p.65) her borderline personality disorder diagnosis to her college. She says she doesn't 'agree' with the diagnosis and feels that 'because I have this diagnosis of borderline personality it's like different things that I do' are seen through the lens of the diagnosis which she feels undermines her credibility. All three students were reluctant to talk about themselves as having borderline personality disorder. They spoke about how stigmatised the borderline diagnosis is and how, once it is applied, it is a label that is very difficult to remove.

This, part C, has attempted to provide an overview of students' lived experience of the variety of mental health problems they themselves identified. However, one single chapter or sub-section cannot possibly hope to capture the depth and complexity of the lived experience of twenty seven students who describe a variety of different 'disorders'. What this section has hoped to provide is an overview of the features of the narratives, organised according to the diagnostic categories identified by the students themselves.

5.4.14 Conclusion

As section 5.4 has shown, the crisis/interruption phase represents the point at which 'it', each student's particular type of psychological distress, makes its presence known. Part A explored the crisis/ interruption landscape and the patterns that emerged in how 'it' became an undeniable presence in the students' lives. The first of these patterns represented a gradual and subtle onset of distress building to an often dramatic 'crisis point' (Mary, p.14). The second pattern described how awareness of what 'it' was interrupted the narrative the students had been creating around the experience. The third pattern was very similar to the first in that it was marked by a crisis but, unlike the first, this crisis occurred 'out of the blue' (Alicia, p.2). The fourth and final

pattern reflected how, for a number of students, their lives were spent averting crisis until one day they could no longer manage and things finally fell apart. Part A also explored how difficult the students found it to find the words to describe 'it' to others. In addition it examined the many ways in which students, whether or not they managed to articulate what was happening for them, came to be in contact with help – in all its many forms. This help-seeking section revealed how some students were able to ask for help, others didn't realise they needed help until someone pointed this out to them and, for some students, help was something they sought independently.

Part B explored the two main features of the crisis/ interruption landscape; self-harm and suicidal ideation and/or intent. It revealed how many students use self-harm as a way of 'coping' (Faye, p.2) or 'dealing with' (Marie, p.34) the distress they experience and how for some students this distress meant that, for them, life was not worth living.

Part C concluded this section by providing an overview of the students' lived experiences of depression, anxiety, psychosis, bi-polar disorder, eating disorders and borderline personality disorder.

All students, regardless of the particular form of distress they identified themselves as experiencing, inevitably moved from crisis/interruption into the next narrative phase; narrative wreckage.

5.5 Narrative wreckage

5.5.1 Introduction

The third phase of the narrative plot, narrative wreckage, represents the space right after the moment when 'it' made its presence known. Narrative wreckage is the calm after the storm; when the crisis has passed or the interruption sunk in. This phase captures the 'what happened next?' The section, section 5.5, begins by scanning the landscape of the narrative wreckage phase before focusing in on the features that punctuate this landscape. It is a vast landscape with multiple features, all of which loosely fall under three headings;

intervention, higher education and living with 'it' (as represented in Figure 9). The first of these, intervention, offers insight into the sources of professional support the students, and their families, sought in the aftermath of the wreckage. The second examines the place of higher education in building or rebuilding the students' narratives about themselves and who they are. The third, and final, grouping looks at how students come to terms with 'it'. It explores the many ways in which they manage themselves and their mental health from day to day, how they talk about 'it' with others as well as the ways they've attempted to make sense of 'it' in their own minds.

5.5.2 Narrative wreckage landscape

Narrative wreckage, a term borrowed from sociologist Arthur Frank, is the phase where the students must sit and observe the wreckage of the narratives they have been developing about who they are and the life they lead. The crisis or interruption they have experienced, for many students, shattered the familiar stories they had been telling themselves, and others, about who they are. The narrative wreckage phase sees the student pause amidst the wreckage of the old narrative and begin to rebuild from this wreckage a new narrative that incorporates this new 'thing' in their lives.

The narrative wreckage landscape is perhaps more unique to each individual than even 'pre' narrative or crisis/interruption. Just as each student's journey to wreckage was unique, the new narrative they create from the wreckage, and the resources they draw upon in the creation of this narrative, is even more distinctive to each individual. What this reveals is that there is no one way out of narrative wreckage.

It is a highly personal journey and, as such, nobody can tell another what exact route to take or how the journey will unfold. One can offer guidance, suggest paths taken by others or accompany them at least part of the way, but ultimately it is a journey that nobody can make but the student themselves.

Narrative wreckage, as can be seen in the students' individual stories, is often fraught with frustration, disappointment, helplessness and hopelessness. The phase reveals much about how students come to terms with 'it' and weave it

into the narrative of their being. It reflects how the students made sense of the experience and how they tell its story to themselves and to those around them.

The first step in narrative wreckage, one that takes varying degrees of time to make, involves turning towards 'it'. For, as Ella says, to ignore the mental health issue, or deny 'its' presence, 'is to turn your back on a tiger' (p.23). Narrative wreckage is all about learning to live with a tiger.

Kinsley described what happened when he turned his back on 'it'. He said that once the initial psychotic episode had passed and he had been discharged from hospital, he tried to carry on with life as if nothing had happened. He described how he left hospital 'with this sense that my leg was broken and now it was fixed again' and threw himself back into college life 'just making sure I didn't break it again' (p.15).

The whole thing was just not dealing with it, you know, and just ignoring it and that is just not what you have to do because it catches up (Kinsley, p.29).

'It' caught up with Kinsley a number of weeks into term when he says his distress escalated to the point where he became an 'internal cacophony of stress' (p.11): 'realistically I had left no room for recovery' (p.11). Kinsley decided to take time out of college, a decision that was a hard one for him to make. He described how 'tough' it was 'revealing to friends how I wasn't doing well' (p.14) and how going off books felt almost like stepping out of life for a time while his friends lives continued.

That was hard, you know, because everyone, all my other friends were completely striving, you know, they were all continuing with college and getting jobs and stuff (Kinsley, p.14).

However Kinsley also describes this time as a 'turning point' (p.15) during which he worked on making changes in his life to support his mental health and began working with a psychologist who helped him see that he was 'very much on the path...towards recovery' (p.15): 'That's when I started, because beforehand I wasn't doing anything to actively facilitate the recovery' (p.15).

My first three years in college, I didn't think about mental health at all, you know, I didn't give it a single thought and now after what happened to me like mental health is such a huge issue with me (Kinsley, p.20).

Kinsley described having 'this kind of new relationship...with my mind after the episode' and says that 'now I know where it can go if things go wrong' (p.20). For Kinsley, this relationship is 'not something you establish and then that's it, you have to continue kind of keep with it, you know' (p.20).

In the immediate aftermath of the initial crisis/interruption, a number of students struggled to come to terms with that had happened to them and the sense of profound injustice it left them with. Sarah wondered 'what I have done to deserve this?' (p.6). She finds it 'really hard to cope with' the idea that 'this is just something' she is going to 'have to live with' (p.34). J.D. spoke about how 'angry' he was at the injustice of his situation: 'I was angry at the 'why me?'' (p.15). Like Sarah, J.D. had struggled with 'so much other stuff in my life' (p.15) and felt like his depression was an unfair addition. Fiona says she 'used to always say why did it happen to me' (p.27) but says she has come to accept that 'it is not fair but it is just life' (p.27).

Life isn't fair, life is strange and I don't know why it happened to me and I don't know why I feel like this but I don't think there is any answers really. It just happens (Fiona, p.27).

Having to accept that 'it just happens' hasn't been easy for Fiona nor for many other students in the study. Depression, for Fiona, feels like she's stuck 'in a hole and it's dark and there is no way out and it's just a horrible feeling' (p.22) but she knows nobody else can lift her out of that hole.

You have to make an effort, you are the solution. No one else can pull you up out of that hole...you have to do it yourself. So, there is no point sitting around crying about it because you are not going to get anywhere (Fiona, p.22).

Ashley too spoke about how her psychiatrist had made her realise 'you are the captain of your own ship' (p.9). She describes this realisation as 'a massive turning point...even maybe maturity wise as well' and says that since then she has 'taken a big control over' (p.9) her mental health and wellbeing.

Niamh also says that people often ‘go into therapy [and are like] tell me what’s wrong with me’ (p.48). She feels that they want a mental health professional to ‘fix to problem’ but feels ‘it’s not about fixing the problem, it’s just trying to deal with what’s going on right now’ (p.48). She doesn’t feel mental health problems can be ‘fixed’ as such and feels very strongly that each of us ‘have the answers’ (p.48) within us.

Adrianna, tried to find the answers but, after trying ‘every sort of medication’ (p.12) and spending six months in hospital, during which she ‘didn’t actually get better’ (p.14), says she realised it was up to her to get her ‘shit together pretty quickly’ (p.14). She described the dawning realisation that her current track wasn’t ‘going to get me anywhere’ and that this reality ‘made me really get a grip, like that’s harsh but I had to get a grip’ (p.14).

Sophie also spoke of the harsh reality that she has ‘no choice’ (p.33) but to continue to try to face the world in spite of crippling anxiety and depression. She too says that ‘it is just that this is the way things are and I feel like I have to do it’ (p.33).

There is nothing else to do, there is no way out of it...I can’t just not do anything for the rest of my life, like, there is no choice but to do it (Sophie, p.33).

Annie feels like she has no choice but ‘to come to terms with it’ (p.33). This is something that Ella agreed with and she added that ‘letting yourself feel hard done by isn’t going to get you anywhere with something like this’ (p.25).

Millie described how ‘the mental illness kind of took over where I was trying to go in life and that was difficult (p.16). She found it hard to come to terms with this and how her ‘mind was controlling me’ (p.16) and was determining the course of her day to day life. She felt particularly defeated when she found that she ‘wasn’t able to switch’ her mind back to a healthy, non-psychotic, state ‘and feel better again’ (p.16).

For Greg it was ‘transitioning to identifying yourself as unwell in some way’ (p.15) that proved particularly challenging in his narrative wreckage stage. He

described how he struggled to come to terms with the idea ‘that I may not be mentally healthy, you know, or even may struggle for some time with an issue like this’ (p.15). On the other hand Mary says it was being able to identify that her anxiety was a real, diagnosable, mental health problem and not simply the consequence of her always being ‘a bit of a worrier’ (p.3), that helped her realise ‘I need to take control here’ (p.5). Mary says that naming it, ‘knowing that I have it’ (p.4), allowed her to ‘face it’ and develop ‘strategies that I can do to make myself feel better’ (p.4).

A large part of building a new narrative that incorporates ‘it’ involves looking around you to those who have also experienced it and seeing what narratives they created. However, looking to existing, ready-made, narratives proved to be a double edged sword for many students.

Sarah says she is ‘still figuring out who I am supposed to be’ (p.10). This process is further complicated when those around her, with similar symptoms and diagnoses, chose to end their lives - as a friend of hers did just prior to our interview.

Sometimes you would be thinking ‘am I going down the same road she was going down’? Sometimes I am like this, this and this happened to her and then she died [by suicide] and I am like those things happened to me so am I going to die as well? (Sarah, p.46).

Lauren says that in hospital, she was told that ‘there are three categories’ (p.18) of people with eating disorders. This appears to have presented her with three options or narrative outcomes from which she could choose.

There’s the people who get one [eating disorder] and then recover and then that’s it. There’re people that recover and then relapse, and then there’re people that die. I don’t think I’m going to die but I think I’ll probably be in and out of relapse (Lauren, p.18).

Niamh spoke about how she too was told that ‘there is a certain path that everyone [with anorexia] goes down’ (p.50). She managed, through sheer will, to step off that path and hopes to use her experience ‘for the better’ (p.48) by pursuing a career in mental health and helping other young people see that ‘you have the answers’ (p.48).

The thing that Thomas most struggled to come to terms with when he developed depression was the fear that it, in some way, might derail his dreams of pursuing a career in the future through which he might be able to help others. The fear that he'd 'never be able to help anyone' (p.12) left Thomas with a sense that his life was not worth living.

A lot of it [suicidal thoughts] was I didn't think I'd ever be able to help anyone. I'd never be able to help myself and if I couldn't help myself then how am I going to help anyone else? And then I was like, my life is not worth living if I'm not able to do what I want in it. There's no point in me being here, I'm just a waste of space (Thomas, p.12).

Narrative wreckage is the space where students were forced to turn towards 'it' and survey the wreckage that 'it' had left of the narrative they had created up to that point. For some students, like Kinsley, turning towards 'it' was not something they wanted to do. Many students struggled to come to terms with it and its unjust nature. A number of students spoke about how they 'had no choice' (Sophie, p.33) but to 'face it' (Mary, p.4) and, although it was incredibly hard, they felt that 'feeling hard done by' wasn't going to get them 'anywhere with something like this' (Ella, p.25). The realisation that they were captains of their own ship, to borrow Ashley's phrase, was in some ways liberating for students. However for some this realisation was hard come by, as seen in Adrianna and Sophie's stories. Narrative wreckage was also the space where students were presented with identifying themselves as 'unwell in some way' (Greg, p.15). Identifying with 'it' and with others who have 'it' was for some helpful, but for others it was frightening and drained some of the promise from their future.

The students' narrative wreckage landscapes are dominated by multiple features. This very fact alone reflects the multitude of ways in which students rebuild their narratives and the resources they drew upon to do this.

5.5.3 Narrative wreckage features

Following the format of the previous phases, section 5.5 began with taking in the landscape of the narrative wreckage phase of the narrative plot. It provided an overview of what it was like for students to find themselves in this space and how they came to terms with the presence of a mental health problem in their lives. This section, section 5.5.3, explores the features of the narrative wreckage phase. Divided into three parts, it outlines the resources students used, the people they turned to and places they went, as well as how they attempted to carry on with their lives, bringing ‘it’, their mental health problem, along with them in so far as they could. The first part, part A, looks at the professional interventions or support they sought. Part B looks at what it was like for the students to journey through higher education, a traditional developmental milestone for many Irish young people, with a mental health problem. The third part, part C, examines what it is like to live with ‘it’. It explores how the students manage their mental health in day-to-day life, how they talk about it with others and how they make sense of it in their own minds.

Part A Intervention

All of the students in this study sought professional support or intervention at one point or another. This section explores the various professional interventions the students mentioned utilising following their crisis/interruption experience. It attempts to garner the students’ experience of the intervention and whether the form of help they sought was in fact ‘helpful’ for them. As shown in Figure 9, six main interventions featured in the students accounts: psychiatry, hospitalisation, diagnosis, medication, GP and ‘talk therapy’ – namely counselling, clinical psychology, psychotherapy and psychoanalysis. This section presents each in turn.

Just as every student’s journey through narrative wreckage unfolded uniquely, the types of support that student’s required, and the manner in which this support was sought and delivered, varied from student to student. What is more difficult to capture is the path each student took in their efforts to find ‘help’ that made sense to, and worked for, them. Figure 11 charts Adrianna’s, alphabetically the first student participant on the list, attempts to find support

during her narrative wreckage phase. The efforts and avenues explored by Adrianna contained features that also popped up in the narrative wreckage accounts of other students, but in different ways and to different effects. While this section explores the ‘intervention’ features of the narrative wreckage phase, the paths each individual student took to, or around, these features, are recounted in each student’s narrative summary in the supporting document.

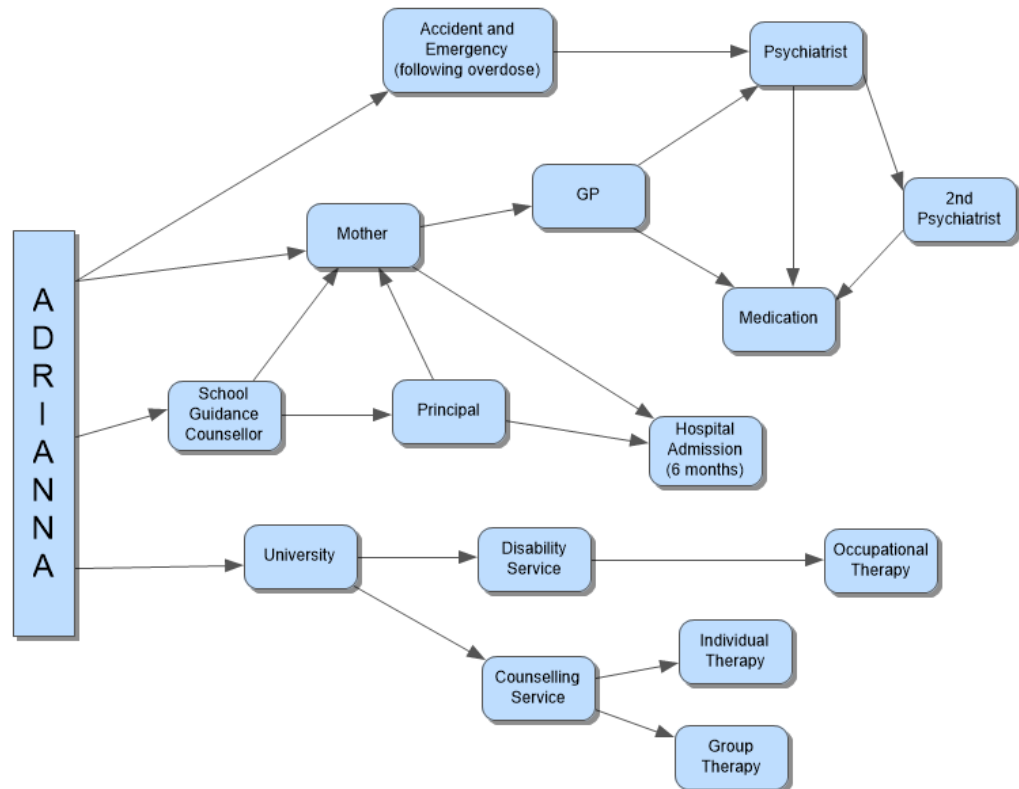


Figure 11 Adrianna: Narrative wreckage help-seeking/support

5.5.4 Psychiatry

Of the 27 students who participated in this study, 21 mentioned seeing a psychiatrist while 13 spoke in more detail about this experience and the role psychiatry played in helping them rebuild their lives. From the experiences of these 13, four main themes emerged. The first reflects the students’ sense that role of the psychiatrist is primarily about medication with little or no space for talk or the more ‘social side of things’ (Thomas, p.36). The second relates to the nature of the relationship between the student and their psychiatrist. For some this was a fraught relationship while others described a more ‘collaborative’ (Ashley, p.21) and productive relationship. The third theme,

building on the second, centres on the students' sense of being listened to and being heard while the fourth and final theme related to the psychiatric system and service itself.

Adrianna's GP put her 'on a waiting list for two years' but ending up 'in A&E because I tried to kill myself' a month after going on the list 'really speeded up the process of seeing the psychiatrist' (p.11). She described how 'at the beginning you're naive in that you think that maybe it will make things better' (p.20) but she was disappointed to find that her psychiatrist 'medicated me and she just kept increasing the dose' (p.12).

She was just feeding me medication...I was like, 'you're not helping because you don't care if I feel fine or not. You're just upping my medication every time I see you' (Adrianna, p.15).

Sophie too spoke about how 'they [psychiatrists] basically just medicate, that's what I found anyway' (p.8). She described how when she 'got to see a psychiatrist' she 'was medicated' and 'found it to be very much on the medical side of things and my actual stuff wasn't being dealt with' (p.8). A focus primarily on the 'medical side of things' (p.36) and not on the more holistic aspect of the student's wellbeing was echoed in Thomas' story. He felt that his psychiatrist's 'interest' in him came solely from 'a medical point of view' (p.36).

When he talked it wouldn't be about the social side of things. It would be more like the chemical imbalance in my brain and he'd be more interested in the medication and stuff like that. He really noticed the medical side of things more than the other side (Thomas, p.36).

The sense that psychiatrists were primarily interested in 'the chemical imbalance in my brain' reverberated in the experiences of a number of students. Millie spoke about how her psychiatrist is 'just purely for medication' (p.12). She says that when she was first diagnosed with psychosis, 'it was just psychiatrists, it was just medication, really quite medical' and feels that that 'wasn't at all what I needed' (p.21): 'Like I know I needed the medication but...you definitely always need someone to talk to too' (p.21). Many students said they quickly learned that they weren't going to find 'someone to talk to'

(Millie, p.21) in their psychiatrist and, like Sophie, felt that they ‘had to very much take it into our own hands’ (p.8) and seek counselling or therapy elsewhere. To use Lauren’s words, they felt that ‘basically his [psychiatrist’s] job is just to sign the dotted line and give me the script’ (Lauren, p.17).

A number of students described their relationship with their psychiatrist as ‘collaborative’ (Ashley, p.21) and positive. Adrianna, after reaching a major impasse with her first psychiatrist, was referred to a second psychiatrist and feels that this is a much more equal and collusive relationship.

At the moment I’m really happy with the psychiatrist I have because she actually involves me in the decision, she doesn’t just feed me medication (Adrianna, p.20).

Marie says her psychiatrist is ‘brilliant’ but equally described her as ‘tough, like she asks tough questions’ (p.38). This, however, works for Marie; ‘I like someone to push me a bit’ (p.38).

She’s good. She’s tough on me but it’s what I need (Marie, p.39).

Ashley described how many of the professionals she had turned to for help in the past were ‘condescending’ (p.9) but feels that her current psychiatrist has ‘worked really hard to try and understand’ (p.21) what is going on for her. Although, like Marie, she described how her psychiatrist can challenge her, particularly to take responsibility for her behaviour and for her own well-being, she feels that she has ‘understanding that no one else had before’ (p.21).

I felt like I wanted to work collaboratively with her, Whereas before I never did want to work with anyone who was telling me ‘you’re fine’...I think that had a massive thing to do with it, and I kind of stopped rebelling a bit (Ashley, p.21).

For Ashley, it was finally being heard after years of sporadic encounters with professionals who didn’t take her or her experience (which was later diagnosed as bipolar disorder) as seriously as she hoped, that ‘really brought me a lot of peace’ (p.21). Other students described the fight to be heard and have their views listened to and taken seriously. Adrianna spoke about how frustrated she

felt when her initial psychiatrist glossed over her concerns about the medication she was ‘feeding’ (p.15) her.

I was like, ‘Do you realise that I can’t concentrate?I sleep all the time, I can’t go to school. Do you realise that this is making it worse because I can’t do school and that’s the only thing I can do at the moment.’ And she was like, ‘Yeah, it’s going to get better, don’t worry’ So I was going crazy at that time because things were getting worse but everyone was bullshitting that they were getting better (Adrianna, p.12).

Like Adrianna, Mai felt that her psychiatrist wasn’t hearing her. Unlike Adrianna however, it was Mai who wanted more medication and her psychiatrist who disagreed with her and refused to consent to her wishes.

We weren’t meeting eye to eye. I knew what would help me, what type of medications would help me but she was like ‘No, you’ll be fine, you know, just do your breathing exercises’ and stuff like what and I was like ‘No, they’re not working for me’ (Mai, p.13).

Mai says she and her first psychiatrist realised they were ‘getting nowhere’ (p.14) and so Mai was referred on to another psychiatric team where initially her requests for benzodiazepines were met. However, in the weeks leading up to her interview Mai’s new team had been trying to reduce and ultimately remove her benzodiazepine prescription.

They don’t respect that that is what really works for me...when you are the one that’s taking them and you know nothing else works, it lets you live your life, you know. But I don’t think they see that. I think they just see it as dangerous (Mai, p.15).

Although coming at the issue from opposite ends, both Adrianna and Mai struggled to have their opinions heard about what medication works, or does not work, for them. For both girls this was a huge source of frustration and annoyance. Mai wonders how different the first two years of her college experience could have been had ‘the psychiatrist just listened to me’ (p.16) and prescribed her the medication she felt benefitted her. She says this has negatively impacted their relationship and that she doesn’t ‘want to talk to the psychiatrist’ because she feels she is treated as if she is ‘just being childish or that type of stuff’ (p.27).

While Adrianna and Mai felt frustrated that they were not being heard, they felt able at least to express their opinions. Thomas, in contrast, spoke about how his psychiatrist was interested in him solely ‘from a medical point of view’ (p.36) and that he would filter or ‘hide some things from him because I think of him as just a medical person’ (p.32). As such, Thomas’ opinions and thoughts were restricted to those relating to his ‘medication and stuff like that’ (p.36).

The system itself, the fourth main theme relating to psychiatry, also served, in some students’ cases, to limit the degree to which they were heard. Alicia described the Child and Adolescent Mental Health Service (CAMHS) she attended as ‘awful’ (p.17). She felt like she was ‘just another number that they had to get through’ (p.18) and says that her ‘doctor was changed about four times’ (p.17) over the short time she was with the service.

[Each time] I was sitting there telling a new doctor my entire stuff again for them to come up with a decision (Alicia, p.17).

Ella too describes the CAMHS service she attended as a teenager as ‘woeful’ (p.10) and also remarked at how ‘you get a fifteen minute consultation with a group of people where a woman smiles at you like you’re an injured puppy’ (p.10). Louise also described how when she started attending her local psychiatric service she was initially assessed by the consultant heading the team but, following that initial assessment, she was ‘seen by some of his registrars and what not’ (p.33). However, as soon as ‘there was an overdose’ she says the consultant ‘started seeing me then’ (p.35).

Mai doesn’t think the registrar she is seeing currently ‘is even interested in doing psychiatry’ (p.18).

[It] is a bit annoying because the consultant would have a registrar and they change every six months so it’s like meeting someone new all the time (Mai, p.21).

She finds it particularly ‘annoying’ that each doctor is ‘going by the notes that [the previous one] wrote so based on [their] opinion they got an opinion’ (p.21).

Then that registrar read all the notes instead of asking me, you know (Mai, p.21).

Sophie also says she hasn't 'had a great experience' (p.8) with her local public mental health service. She described how, upon receipt of a diagnosis, she was 'sort of shoved in the door of the system' (p.8). She felt she was being 'processed' (p.8) rather than treated and felt that 'it [her anxiety and depression] wasn't being dealt with effectively basically' (p.8).

As noted in the introduction to this section, while 21 students spoke about seeing a psychiatrist, it is the experiences of the 13 who spoke at length on the subject that are reflected more here. This, perhaps, reflects a methodology that doesn't 'go after' particular experiences, rather leaves it up to the student to talk about those aspects of their experience which are of particular importance to them. As such, it could be argued that the predominantly (but not wholly) negative accounts above reflect the experiences of those students for whom the psychiatry was a negative force in their lives. Be this as it may, elements of the psychiatric model, notably hospitalisation, diagnosis and medication, emerged as three of the most dominant features of the students narrative wreckage stage.

5.5.5 Hospitalisation

Eight of the 27 students spoke about their experiences of being admitted to a psychiatric hospital. A further two spoke about how they 'were pretty adamant' (Kate, p.18) that they didn't want to go into hospital in spite of strong recommendation. In Adrianna's case the recommendation wasn't so much as strong as an ultimatum. She described how at the time she was sure 'I'm not going to hospital, I don't need to go to hospital' (p.13) and felt that hospital would not help her and offered her 'no specific path I could take to get better' (p.13). However, when her secondary school principal and guidance counsellor told her that they would not take her back to school as they were concerned for her safety and wellbeing, the only way Adrianna and her mother felt they could proceed was to take the school's recommendation to seek admission to hospital. Marie too spoke about how when her psychiatrist first recommended hospital she and her parents thought 'I don't think I need that' (p.21). She says

that looking back now she thinks ‘it’s crazy how bad you’ll let yourself get before you look for help’ (p.21) and feels that if she had broken her leg she wouldn’t have had the same issues in accepting medical help. Marie says that while she was ‘suprised’ that her psychiatrist recommended inpatient admission she is glad ‘we were open minded enough to say, you know, she’s the professional’ (p.40).

Marie described how she ‘was told I’d be going in for five to ten days which I found out is what they tell everyone because if they tell you the truth you wouldn’t go in’ (p.40). It seems that a number of students were told a similar story. Lauren was told ‘Oh, it’ll just be a week of tests’ (p.8):

I was like I can totally do a week of tests, a week off [school], that’s fine, no bother. Then it was like...but lads, that’s three weeks now, you’re telling me fibs’ (Lauren, p. 8).

Lauren spent a total of ten weeks in hospital, Marie spent eight and Sarah, who had been told ‘a night or two’ (p.47) was admitted for six weeks.

They say you should go in for a night or two but you end up being in there for weeks (Sarah, p.47).

Kate described being ‘sent to’ (p.29) the admissions office of a psychiatric hospital by a GP she attended in college. She says ‘I was really just trying to keep him happy’ by going along and ‘couldn’t believe that they were going to admit me’ (p.29).

They wanted to admit me and I was like no fucking way! (Kate, p.29).

She described the assurances the admissions team tried to give her as ‘hilarious’ (p.29).

She said ‘we’ll bring you in and you will eat and we’ll get you at a proper weight to be physically healthy and then after that we will assess you and see if you need to go on medication’. [...] I was like, if that is the way you are going to approach this, it’s ridiculous because it’s not about food...it is not a solution (Kate, p.29).

Louise described how on one occasion she was ‘dead against’ going into hospital; ‘it wasn’t happening’ (p.43). However, her psychiatrist was concerned and threatened to admit her involuntarily – taking care to make abundantly clear the devastating impact an involuntary admission would have on her future plans to become a nurse.

They said things have gone too far and they didn’t have a choice at this stage (Louise, p.45).

Three of the students experienced involuntarily admission, two of whom were admitted in the midst of a psychotic episode. Kinsley described how ‘he never really questioned me being’ in hospital and says that ‘with the medication [I was on] I can’t really remember’ (p.23) much about his five weeks in hospital. He says he ‘can vaguely remember’ talking to the doctor admitting him, ‘just talking about Gods and stuff’, and says ‘it must have been rather frightening for the ones around me as well’ (p.24).

While Kinsley can’t remember much about his admission to, and first few days in, hospital other students described the shock of realising where they were.

I didn’t think it was serious...until I went to the toilet and there was no handles on the doors. Then it kind of hit me (Adrianna, p.14).

Marie says the day she was admitted ‘was a weird day, everything was so surreal’(p.41).

It was as if I was watching through weird distorted glass. I couldn’t really figure out what was going on around me. I couldn’t make decisions (Marie, p.41)

Marie says that looking at the photo they took of her upon admission she was ‘a shell’ (p.41) of herself. She described being ‘terrified’ for the first few days: ‘I didn’t leave my bed; I went to the bathroom and that was it’ (p.42). Louise also spoke about how, the first time she was admitted to hospital, ‘they took everything off me apart from my phone and then I was realising okay this is a psychiatric ward but still not quite getting the concept’ (p.32). Adrianna spoke about how she felt the day she was involuntarily admitted to hospital:

I was so disoriented with everything and I was so tired and just really didn't know my name. When they asked me my address I didn't know my address so I didn't really know what was going on (Adrianna, p.17).

Overall the students described hospital as 'a weird mixture of good and bad' (Marie, p.41). In terms of the 'good' students described how hospital was 'a place where you can get away from everyone and everything and just be there whereas it is very hard to do that at home' (Sarah, p.47). The sense of being able to get away from life for a while reverberated through Adrianna's, Kinsley's and Marie's stories too. Adrianna says 'the only benefit I had was being away from my family' (p.18) while Kinsley appreciated being 'kept out of the public eye for that period' (p.24) of his psychosis. Marie says hospital 'gave me the space' she needed to 'just stop' (p.43) and take care of herself.

'Being safe' (Adrianna, p. 18) was another positive aspect of a hospital admission identified by the participants. For Adrianna, being safe meant 'from myself' (p.18) whereas for Sarah hospital was seen as 'a safe space' (p.47). Being safe for Leon meant being safe from harm while he was in a psychotic state, something that Kinsley also resonated with: 'who knows what I would have got up to had I not been in [hospital]' (Kinsley, p.25).

A third positive aspect of hospitalisation as identified by the students was being able to give up responsibility for a while. Adrianna spoke about the relief of 'not having the responsibility of everything because I couldn't do it' (p.18). This was something Marie touched on too when she said 'before I went into [hospital] I was trying to juggle college and friends and keeping up the mask and everything' (p.43). She spoke about how being able to step away from these responsibilities for a while was 'huge' (p.43).

A number of the students, particularly those who attended a privately funded hospital, spoke about the benefits of engaging in the therapeutic activities available to them while they were there. After an initial period, where 'they just kind of let you sleep' (p.42), Marie described engaging in 'brilliant' (p.42) therapeutic day programmes organised in the hospital. Lauren too spoke about how when she was in the children's ward she 'just coloured and we made bracelets' (p.9). She described being 'devastated' (p.9) when she was

transferred to the adult ward on her 18th birthday and was no longer able to do these activities with patients her age. Adrianna described how, after three months on an acute ward where she ‘couldn’t go outside or have anything’ (p.14), she appreciated being transferred to a more open ward where ‘we had classes and stuff and therapy classes and psychoeducation and art therapy and exercise and whatever’ (p.18). However she also added the clause that ‘you have to go to those or you’d be sent back to the [acute] ward’ (p.18).

Kate, who wasn’t admitted to hospital, highlighted a fifth positive to hospitalisation. She felt hospital could have validated the severity of her experience – for others more so than for her.

I didn’t want to be in hospital but it was the kind of validation as well, that, okay, you are sick if you are in hospital (Kate, p.24).

Ashley also spoke about she has ‘never been in hospital which is good’ but when she sought referral to a psychiatrist her request wasn’t taken seriously by her college GP because ‘she said you’ve never been in hospital’ (p.17).

Do I have to be in hospital for me to make people realise that this isn’t OK? (Ashley, p.17).

A sixth and final aspect of being in hospital, one that most students identified as both ‘good’ and ‘bad’, was ‘being around people who could understand what you’re going through’ (Marie, p.43). Marie summed up the experience of being around people in a similar situation as like ‘joining the best club you never wanted to join’ (p.45). While for some this meant that ‘in hospital I could talk about it and people would say ‘yeah I know how you feel’’ (Marie, p.43) it also offered others an opportunity to learn ‘the tricks of the trade’ (Niamh, p.25). For Niamh the tricks of the trade included hiding food, taping batteries to the insides of her clothes and ‘water loading’ (p.25) before her regular weight checks.

I think I actually self-harmed more when I was in [hospital] because it’s quite triggering, like the girls with their arms just destroyed. One of the girls on our ward smashed a plate and slit her throat (Marie, p.45).

Lauren spoke about how, in hospital, ‘they told me I had developed an eating disorder’: ‘Then because they were like, you have an eating disorder, I was like, well I better start losing weight...I may as well tick the box’ (p.9).

Being around other people who were struggling, or ‘at different levels’ as Marie put it, could be both helpful and unhelpful. In addition to learning certain behaviours, it offered an opportunity for the young people to look around and see what their future may hold. Marie said ‘it’s hard’ when ‘you see some people who have been in there for a long time, and you see people coming back from ECT which, you know, is hard’ (p.44). Kinsley felt ‘annoyed’ at the long-term prospects being offered him and his psychosis by the hospital staff: ‘they always refer to it as my *first* episode, that’s always the terminology they use’ (p.22).

Just as having people they could identify with had a flip side, being able to escape responsibility for a time also had a flip side which for most students had a lasting significance. Giving up responsibility, for many students, also meant giving away their freedoms upon admission. Adrianna spoke about how when she was admitted involuntarily to an acute ward at the age of 18 she ‘obviously couldn’t go outside or have anything’ (p.14). She had to earn these freedoms back by ‘being cooperative’ (p.17).

I realised that by not being co-operative you didn’t get a blue dot instead of a red dot so you couldn’t even go outside for a walk with the doctors, you know, you had to be inside. Or they took away your cigarettes or whatever. [...] So you kind of realise, OK, this is a way of getting out, it’s pretending (Adrianna, p.17).

Adrianna described being ‘migrated’ to an open ward after three months in the acute ward: ‘I was like ‘Oh the freedom!’’ (p.14). However she says that ‘I was pretending to get better but I wasn’t actually getting better’ (p.14).

It takes a while to realise that if you behave well, they might let you out. I mean, six months is a long time...why didn’t I realise this quicker? (Adrianna, p.19).

Louise talked about how ‘I wasn’t allowed out of the ward, I had to stay in pyjamas’ (p.46). In a hospital setting, wearing day clothes signifies greater freedoms and many of the students stories described having day clothes taken away, if only for the initial few days of their stay. Louise, who struggled with self-harm and suicidal ideation, lost greater privileges than many as the staff were concerned that she may try to hurt herself.

I wasn't really allowed to do anything or go anywhere. My phone was took off me, shampoo, all that stuff was took off me and they were afraid in case I swallowed creams or shampoos or anything like that. They had my phone, they had everything basically (Louise, p.48).

This reality appears to have been a cold one for Louise; one which forced her to think ‘there has to be something else than all of this...there has to be something more’ (p.48).

Like Adrianna and Louise, Niamh spoke about the process of having her freedoms and belongings taken away and having to earn them back by eating and gaining weight.

They took away everything. They took away my phone, my friends, they took away visiting hour, I was only allowed to see my family for one hour in the evenings. I was on bed rest, not that I ever did that, but I was on bed rest for 24 hours a day. I wasn't allowed to go down to the playroom. I wasn't allowed talk to anybody (Niamh, p.26).

When these tactics failed to work, and Niamh’s life was in danger, she was transferred to a specialist children’s eating disorder unit in the UK where the behavioural consequences continued.

You would go and sit at mealtimes. They'd offer you food. If you didn't eat food you have to drink Jevity. It was disgusting. If you didn't do that then you were tube fed. [...] Essentially I wouldn't do any of that, I didn't care. Like, I sat there and just let them put a tube into me (Niamh, p.27).

However, in spite of the difficulty of the situation, Niamh feels ‘it was the best thing for me at the time and that’s why I’m still alive really’ (p.36).

I'd be a big advocate that some people have to go into hospital. Like, if I hadn't gone into hospital I would have been dead, I would have been long gone. I know that myself, because at that point I didn't care (Niamh, p.36).

Leon also acknowledged that there are times when you 'have to be brought in' (p.16) because 'you know, you might do something to harm yourself or the general public' (p.16) while in the midst of a psychotic episode. Kinsley said something very similar and says he 'can totally understand why I was in a lock down ward for two weeks' (p.25), particularly as he had been going off alone for long walks without any sense of where he was or what was happening.

Kinsley says he is 'eternally happy' with the hospital: 'I mean they got me out of psychosis' (p.16). He described walking out of hospital 'and I immediately think OK, I'm totally cured. That was a crap seven weeks!' (p.8). However it wasn't long before the reality that 'episodes of mental health aren't sorted out that easily' (p.9) hit home. This was something Marie spoke about too:

I mean it just kind of put me on the right path and what they say to you is you're never going to leave hospital 100% better. We can make you like 50, 60% better and that's really, really true. You're coming out having struggled a lot with a way longer harder struggle ahead of you (Marie, p.46).

Niamh said that when she was well enough to come home she still struggled. She described it as a 'very, very, very slow process' and says 'it took me about three years before I actually said 'right, the scales are going today' (p.37).

People think you come out of hospital and you're grand (Niamh, p.37).

However, some students struggled to see the benefits of their hospital experience. Sarah says 'basically I was left in the hospital with not a lot done for me...like I was in hospital for six weeks, you know' (p.14).

It's really hard to know. I know definitely the last time I went into hospital I came out worse than when I went in. It wasn't beneficial to me at all but I do think the hospital setting is a good place where you can get away from everyone and everything and just be there whereas it is very hard to do that at home. But I don't think hospital is the answer (Sarah, p.47).

Lauren described her ten weeks in hospital as ‘a waste of time’ (p.9). She says that she ‘stopped eating while I was in hospital’ and her consultant came to the conclusion that ‘okay, this isn’t working’ (p.9) and discharged her: ‘I was hysterical, I’ve been here for ten weeks and now you’re just sending me home?’ (p.9). Louise spoke about how her consultant told her ‘the longer we keep you in hospital the worse it’s doing for you’ (p.48). She described how he said her admission was ‘pointless’ (p.48) because ‘whatever chance there is of you kind of surviving and getting back to normality outside, he said, there is nothing normal about this situation’ (p.48). If anything the admission served to make her realise ‘I get out of here and what is there for me like?’ (p.48), which, in turn, resulted in Louise making some major changes in her life.

Regardless of whether the students had a positive or negative experience of hospitalisation, each was afforded a key element of the medical model supporting the hospital system - a diagnosis.

5.5.6 Diagnosis

All 27 of the students who took part in this study talked about and named ‘it’; either as they perceived it or as a professional authority whom they encountered in their lives perceived it. Thirteen of the students spoke at greater length about what it was like to receive a diagnosis, what it meant, and how it altered their experience. One of the strongest experiences voiced by the students was how a diagnosis validated their experience. Ashley described how receiving her diagnosis of bipolar disorder ‘gave my difficulties, that I think were always belittled, some credit’ (p.10).

At the beginning I was really happy because it validated that I wasn’t making this up, like that this was actually a problem (Adrianna, p.28).

Sophie spoke about she had ‘to fight very hard’ (p.6) for a diagnosis and for validation. She described how, upon initial assessment as a teenager, she ‘met some of the criteria’ (p.6) but not enough to receive a formal diagnosis of depression. She said she ‘found it very difficult throughout that time because I felt that everything that I had struggled with wasn’t validated’ (p.6). She felt that her experience ‘justified some kind of medical reason as opposed to ‘you

just can't cope with your life'' (p.7). Sophie described the 'relief' when three years later, at 17, she was diagnosed with depression: 'it was nice to have that feeling of validation and acknowledgement' (p.7).

A second strong positive current running through the diagnosis feature was that of knowing what 'it' was. Mary says 'I definitely think knowing that I have anxiety was extremely liberating' (p.8). She also said that 'knowing that I have anxiety definitely [makes] other people take it a bit more seriously' (p.8). Mary described how, in the past, her family would joke about it and 'be like 'oh [Mary's] worrying again'' (p.8) but that since she found out what 'it' is 'they don't actually joke anymore' (p.8). Knowing what is was also offered Mary words 'to explain it' (p.8) to others.

I feel it's a relief when I can say to someone, 'I'm feeling really anxious at the moment' (Mary, p.36).

Alicia said that she didn't mind receiving a diagnosis as a teenager as 'it was better than just thinking you are actually insane' (p.19). J.D. said that knowing what it was 'named the monster': 'it wasn't as scary anymore because it had a name' (p.16). Ashley is grateful that 'I now know what is going on' (p.9) and that 'there's a reason for it and it's not just my fault' (p.10). Claire spoke about how knowing what it was gave her a sense that there was something that could be done about it.

When I was diagnosed with depression, straight away a big weight felt lifted because it was just, it's not just how I feel, it's like, it's something wrong with me and I can be fixed (Claire, p.11).

John too described his diagnosis as a pathway to treatment and getting better: 'I didn't care what he said to me, you know, I just wanted him to do something for me' (p.20). Sarah says her psychiatrist 'doesn't like putting labels on people': 'which I think is good but at the same time I think it would be good to know [what 'it' is]' (p.13).

It would be good to know what is wrong with me on the one sense but on the other I think it's great that they are not labelling me with loads of different things (Sarah, p.13).

Sarah's feeling is that 'once you have one diagnosis you end up with ten – every time you go in you get a different one' (p.13). A diagnosis, for Sarah, is quickly followed with a corresponding prescription; 'every time you go to the doctor you get a different one and you're on different medications' (p.13). Lauren also described receiving multiple diagnoses: 'they throw them all at you' (p.14). She disagrees with her current diagnosis of borderline personality disorder 'I'm like, you literally give that to everyone' (p.14). Receiving multiple and varied diagnoses was something Adrianna spoke about too.

When one specialist doesn't know what to do and they send you to another and another diagnoses you with something else and another thinks you should be on different medication because you have something completely different you start to get a bit confused. You are like, OK, maybe just everything is wrong with me (Adrianna, p.28).

Louise described how, as she has 'a diagnosis of borderline personality disorder', she 'was advised not to disclose that to college or anything like that' which she thinks 'says a lot' (p.65). She knows that if her diagnosis was known 'I wouldn't be on the [mental health nursing] course, like, I wouldn't' (p.66). Having a stigmatised diagnosis was something that Louise felt she couldn't do anything about. It didn't seem to matter that she doesn't 'agree with it' (p.66). She described how 'because I have this diagnosis of borderline personality it's like different things that I do' are viewed, unfavourably, through the lens of the diagnosis which, again, is not something she has control over.

Overall, the students who spoke about their experience of receiving a diagnosis described a largely positive and beneficial experience. Many feel it has helped them, with some wishing they had been diagnosed sooner.

I should have been diagnosed months before then. I think if I had gotten help earlier I wouldn't have gotten as bad and that means that I would've gotten rid of it sooner (J.D., p.34).

5.5.7 Medication

Medication featured in the narratives of almost all of the students. Some described being offered it as an option, but declining, while most (n=22) spoke

about the experience of being on medication at the time of interview or having being on medication at some time in the past. A number of students spoke about their fears and reservations when the subject of medication was first broached with them. Sophie described being ‘reluctant’ (p.12) while Greg said he was ‘resistant to the idea’ (p.14) of going on meds. Joseph feared becoming ‘dependant’ (p.20) on the medication – a fear that was echoed in Annie and Fiona’s experience. Claire spoke about how she didn’t ‘want it [medication] to change my thoughts’ (p.12) which she now thinks ‘was a bit silly’ (p.12). Mary, Joseph and Ashley described feeling a sense of ‘stigma’ (Joseph, p.21) around taking medication. Ashley said she ‘would be concerned how other people view it’ (p.23) and doesn’t tell many people in her life that she takes medication for her bipolar disorder. Mary says ‘I think there is definitely a stigma on medication’ (p.5) and, when her GP suggested she take medication for her anxiety, her thoughts immediately turned to what her parents would think:

I suppose part of me felt like I would be letting them [parents] down and showing weakness by taking medication (Mary, p.5).

A number of students, when offered medication, felt that in some ways it was taking the easy way out. Both Fiona and James described how, for them, addressing the lifestyle factors was what they needed to do – even when they didn’t necessarily feel like it. Fiona felt ‘if it would just make me better or if I could just be happy again I would take it but I know there is so much more I could do’ (p.18). By ‘so much more’ Fiona was talking about exercise, going to college and being around people – things when she is ‘feeling so low you don’t want to do’ (p.18).

[Sometimes I] think like ‘Oh medication would be good because all I have to do is take a tablet and I will probably feel better’, but... (Fiona, p.18).

James also described how he ‘started to think medication could be a good route’ (p.39) for him but when he tried taking meds he realised that ‘for me it just wasn’t a fit’ (p.39). He described feeling ‘sedated’ and ‘was like ‘I’d rather deal with my head and not feel sedated’’ (p.29).

Sophie says she was ‘sort of talked into’ (p.13) taking medication by her doctor.

I took them because I didn't know what else to do. I was just – I felt that I was really at the end of my tether so I took them’ (Sophie, p.13).

Mary also spoke about how she ‘was in such a state’ (p.4) when she sought help from her GP that she felt she could no longer deal with it herself and was ‘like, ok I’m handing over a little bit of power’ (p.25) to her GP in taking his advice with regard to medication. Claire says it ‘felt like something I had to do’ (p.12) while Greg described how he was left with little alternative when it became clear he ‘wasn’t improving’ (p.15) on his own.

Claire, Marie, Ella and Mai, all students studying for Bachelor of Science degrees, commented on how medication and the biochemical approach ‘was a good approach for me, again a scientific mind’ (Claire, p.12). Marie spoke about how she ‘wasn’t completely averse to the idea, because, I suppose, studying science I wouldn’t be’ (p.20) while Ella spoke about being ‘a big believer in modern science’ (p.17).

I was a big fan of the drugs (Ella, p.18).

Others were less convinced and described how for them it’s easier if they ‘don’t think about it; if I just took it [his medication]’ (Thomas, p.27). Leon reconciles himself to the reality of having ‘to take this medication for the rest of my life’ (p.2) by comparing the injection he gets every couple of weeks for his schizophrenia to the daily injections he would have to take ‘if I was diabetic’ (p.2). Leon described how ‘lucky’ (p.16) he was that his psychiatrist managed to find a medication that worked for him at the first attempt; ‘it’s like picking it out of a hat, there are so many of them’ (p.16). Alicia also felt she ‘was lucky that they [her anti-depressants] clicked right away’ (p.3); ‘lucky’ (p.14) being a word that Greg also used to describe his initial experience of finding a medication that worked for him.

A number of students, weren't so lucky and 'it took a while to find [the] ones to suit' (Millie, p.10) them. Side effects were a big issue for most of the students – if only initially. They described 'sleeping all the time' (Kinsley, p.10; but also Marie, Adrianna, Ashley, Thomas and Millie); feeling sedated (Greg, p.29; James, p.29), 'zoned-out' (Adrianna, p.21) and 'like a zombie' (Sarah, p.16). Adrianna and Claire spoke about not being able to concentrate while Thomas, Mai, Ashley and Sarah described how they 'gained a significant amount of weight' (Ashley, p.22) when they began taking medication – particularly anti-psychotic medication. Thomas spoke about how he is 'always tired' (p.24) and how he is 'snacking in the middle of the night' (p.25). He says he has 'no clue' (p.25) as to why he is doing this, feeling that he is 'just lazy' (p.25), when what he describes appears to correlate with two of the major side effects of the medication (seroquel) he is currently taking. Other common side-effects described by students include nausea (Marie), excessive thirst (Ella), shakes and tremors (Thomas and Marie), poor memory (Kinsley), early morning wakening (Ella) and generally feeling like they weren't themselves (Millie).

I stopped taking my medication for a while just because I didn't like how I was feeling (Millie, p.11).

Millie wasn't the only one who spoke about coming off their meds, either because they perceived the side effects as out-weighting the benefits (James, Lauren) or because they felt they were better and didn't need them any more (Ashley, John). Each of these students discovered that suddenly discontinuing psychiatric medication created a whole range of problems and each described how, in time, they felt that it would be better to go back on them. Many of the students expressed fears about the prospect of having to come off their medication. Ella said the prospect was 'similar to trying to taking a blanky off a seven year old who isn't ready to let go yet' (p.18) and, like Adrianna, Kinsley, Marie and Thomas, says that she'll only 'consider it once my fourth year exams are done because I'm not risking my degree' (Ella, p.19). Most of the students said that they didn't see medication as 'a long term solution' (Mary, p.10) but more of a 'lift [to help you] pull yourself out of the hole' (Marie, p.52).

The way I see medication is like a little band aid. It fixes the problem for now but I don't see myself being on medication for life (Annie, p.35).

In terms of the effectiveness of medication, ten expressed a sense that it was an effective way of managing their mental health (Alicia, Ella, Greg, Joseph, Kinsley, Mary, John, Annie, Mai and Marie); six described taking it but feel unsure if it is 'working or not' (Sarah, p.11) (Thomas, Sophie, Sarah, Claire, Lauren and Louise); two described taking it for a time but feeling that it wasn't the way forward for them (James and Fiona); while the remainder of the students who described their lived experience of taking medication didn't express an opinion either way during the course of their interview(s).

Medication offered Alicia 'a whole new lease of life' (p.3) and for Mary it 'had a really positive effect on my life' (p.6). Joseph described how since taking medication his 'nervousness doesn't manifest into' (p.5) full blown anxiety and panic attacks while Greg attributes being able to complete his final year dissertation to his taking anti-depressants. Thomas, on the other hand, feels that 'medication doesn't work for anything, it doesn't work' (p.24) while Lauren feels 'it's pointless [and] really expensive' (p.17). Sophie 'doesn't feel it had that much of an effect on me' but her parents seem to think it helped: 'They noticed [but] maybe it was because they were looking for it though' (p.12). Sarah doesn't 'know if these medications are working or not' (p.11) and feels that she hasn't 'really been right since I have been on them' (p.11).

At the moment I don't think they are really working but then what would I be like if I wasn't on them? (Sarah, p.17).

As with so many of the resources available to students in the narrative wreckage phase, medication was, for some, a useful, even critical, aid, whereas for others taking medication was an unbeneficial or even deleterious experience.

5.5.8 General practitioner

The first port of call for the majority (n=22) of students during their narrative wreckage phase was their general practitioner (GP). The initial course of action taken by 13 of the students' GP's was to refer them on to a specialist

psychiatric service – either their local Child and Adolescent Mental Health Service (CAMHS), Adult Mental Health Service (AMHS) or a privately run psychiatric service if they had health insurance. Alicia’s GP referred her to her local CAMHS service. However, Alicia describes her experience there as ‘quite terrifying’ (p.17) and, after a couple of months, decided ‘there was literally no point’ (p.18) in continuing to attend. She chose instead to return to the care of her family GP: ‘that seemed like the better option’ (p.18). Like Alicia, Claire described a very positive relationship with her GP. She knows her ‘really well’, having been Claire’s GP ‘for a long time’ (p.21). Claire also described how her GP was ‘really helpful’ and says she has the ‘same kind of approach to it [her anxiety and depression] as I would’ (p.21): ‘I know she knows where I’m coming from I suppose, which makes it easier [to talk to her]’ (p.21).

For six of the students it was their GP who prescribed them medication. Mary spoke about how her GP had first mentioned counselling but when this wasn’t ‘massively beneficial...he recommended medication’ (p.5). Like Claire and Alicia, Mary described how her GP ‘has known me since I was a child’ (p.5) and how this meant that she trusted him enough to hand ‘over a little bit of power’ and take his advice to begin taking an anti-depressant. Like Mary, both Fiona and Claire were referred to counselling by their GP as well as being prescribed medication. Fiona was the only student in this group who decided not to fill her prescription and chose instead to focus on doing the work in counselling.

Ashley and James recounted negative experiences of turning to their GP’s for help. James says the GP he went to when he was struggling in the final weeks of his degree ‘fobbed me off’ (p.28):

He just didn’t want to deal with it...so that put me in a bit of a spiral. [I] was like ‘man there’s no support’ (James, p.28).

Ashley says that when she first went to her family GP for help as a teenager he ‘said ‘you’re too clever’’ (p.9) and suggested she ‘get some fresh air and exercise’ (p.9). Like many of the sources of support students turned to during

their narrative wreckage phase, their experience of GP's varied. For many students, their GP acted as a gate keeper to specialist services whereas for others their GP was able to provide all the medical support they needed or that they felt was most suited to their needs. However, one factor which appears to have been key in determining the effectiveness of the GP's intervention across the board, was the relationship between the student and their GP. This factor was also pivotal when it came to students experiences of engaging in 'talk therapy'.

5.5.9 Talking therapies

Talk therapy, in its various forms, featured in the stories of 19 of the 27 students who participated in this study. Of those 19, 17 went into more detail – outlining their experiences good and/or bad of talking to a trained professional about their mental health problems. Students sought help from counsellors, clinical psychologists, psychotherapists, psychoanalysts and cognitive behavioural therapists and a number tried a variety of these approaches before finding the right one for them. For Claire, psychotherapy 'wasn't proactive' (p.9) enough for her while Cognitive Behavioural Therapy (CBT) made more sense to her and appealed to her scientific orientation.

I felt like it was a medical thing, like a clinical thing that I need to sort out as opposed to just a situational [thing that] needed to be talked out (Claire, p.9).

On the other hand, Sophie found CBT 'unhelpful' (p.18). She spoke about how important it was to find 'the right kind of style for me' (p.18) which would help her 'get to the bottom of' her anxiety and depression. In Sophie's case this was a therapist from a more psychotherapeutic background and it was this approach that she ultimately 'found very, very helpful' (p.18).

However, as seen in section 5.5.8 'General Practitioner', the nature of the relationship between the student and their therapist appears to have been the crucial determinant in the success of the intervention. Adrianna says that 'being able to see someone and actually develop that relationship was one of the most important things in my life...it's one of the relationships I cherish most' (p.32). She says that the relationship she built up with her therapist, and the help she

found there, is ‘what draws’ (p.32) her to becoming a psychologist herself: ‘[I] want to give back a little of what I’ve been given’ (p.32). Fiona described how she ‘really got on with’ (p.5) her counsellor. Counselling proved to be an intervention that ‘really helped’ (p.7) her and Fiona described the various techniques her counsellor taught her to manage her anxiety as a teenager. Robert described attending two different counsellors during his time in college. The first he says ‘was phenomenal’ (p.4) but when he went back the following year this therapist was on leave so he was offered an appointment with another counsellor whom he described as ‘awful’ (p.7). He says that ‘thankfully [I realised] it was just a bad fit’ (p.9) and he decided to wait until the first counsellor returned from leave.

That experience made me really think of the people who go to counselling for the first time and are like ‘this is bullshit’ and they leave and then they have a poisoned view of counselling for the rest of their lives (Robert, p.9).

Alicia was one of those to whom Robert was referring. She described how she ‘did a bit of CBT but didn’t really click with the therapist...so I kind of stopped it really’ (p.2). Alicia has never tried any other form of therapy since that experience she had as a schoolgirl.

For a number of students therapy was ‘the key’ (Niamh, p.37) to their moving on through narrative wreckage. Kinsley described how he thought he could ‘do this on my own’ (p.15) when he was initially discharged from hospital but when he started seeing a psychologist six months later, after dropping out of college, he realised that he was ‘very much on the path of recovery and he [his psychologist] essentially helped me through it’ (p.15). John spoke about how counselling helps him ‘sort out what’s not reality and what is reality’ (p.2) while J.D. says it was his counsellor who ‘finally [began] asking me the right questions’ (p.18). J.D.’s counsellor helped him ‘organise my thoughts’ and start ‘getting coping mechanisms’ (p.19) – all of which ‘helped’ (p.19) him manage his anxiety and depression.

I started to deal with problems and figured out that I wasn’t an awful person (J.D., p.23).

Niamh spoke about how therapy was the first opportunity she had to explore the factors that led to her developing her eating disorder whereas, up until that point, the emphasis had been on ‘food and weight and percentile charts’ (p.43): ‘I was like it’s not about that, it’s nothing to do with that’ (p.43). Annie says ‘it was such a relief to offload’ (p.25) her thoughts to her counsellor: ‘it was good to go to counselling and talk about it there’ (p.25). She feels it can be hard to talk to her parents and her friends about the things that are troubling her because they are too close whereas counselling offers ‘a healthy distance’ (p.25) or boundary between the therapist and the client.

Sometimes it’s not even fair to off-load on somebody because you don’t know what they are dealing with either. Whereas the counsellor is trained and is able to deal with what you tell them (Annie, p.26).

While for Adrianna, Fiona, Robert, Niamh, Kinsley, John, J.D. and Annie therapy was a very positive and fruitful component of their experience, that wasn’t the case for all students. Ella described how, as a teenager, she ‘got given to a woman’ who ‘gave me a book to read, talked about her cats and then told my mum whatever I had told her’ (p.10). She, and her mother, were upset at this breach of ‘trust’ (p.10) and complained. She described how complaining got her ‘an upgrade’ (p.10) to a clinical psychologist who ‘was even worse’ (p.10). Ella described this second psychologist as ‘a pompous snob’ (p.12) who appeared more interested in how she was achieving in school than how she was doing in herself. He discouraged her from entering college through the DARE (Disability Access Route to Education) scheme ‘because admitting to mental illness in the academic field would put a black mark on my name’ (p.11). She feels that taking this advice ‘had a direct effect on my complete emotional and nervous breakdown...in my first year in college which led me to dropping out of college and having to restart’ (p.11).

Lauren described the first therapist she ever went to see when she was still in school as ‘crazy, she was more crazy than me’ (p.8). Niamh also spoke about how her first therapist ‘didn’t really have a clue to be honest, she should have been in counselling herself’ (p.37). While Niamh was fortunate to later find a therapist with whom she worked very well, Lauren says she has ‘done everything, I’ve done CBT, DBT [Dialectical Behaviour Therapy] and literally

every time I'm like 'you said it was going to work. It didn't work. You're lying'' (p.18). Like Lauren, Kate says she has 'been to a lot of therapy and a lot of different types of therapists' (p.6) and that she 'didn't get better' (p.24). However, unlike Lauren, she doesn't feel that anybody has ever lied to her, rather she has come face-to-face with the reality that nobody has the answers or is 'all-knowing about me and eating disorders and mental health' (p.7). Kate feels that 'some ways and methods work better for other people and for me, they didn't work' (p.24). One aspect of engaging in talk therapies that Kate disapproves of is 'when you go into a therapy session and you have people who already have ideas about who you are because you have an eating disorder. It cuts you off, you stop' (p.23).

They already have a type of language and a way of communicating that they give to you, for you to understand yourself through, but they are giving it to you, it's not your own kind of subjective 'this is how I experience things'. It's not and it doesn't work (Kate, p.24).

One of the other limitations of talk therapy, as highlighted by Adrianna, Marie, Ashley, J.D. and Fiona was the limited access and long waiting lists they experienced when they sought counselling. University counselling services generally offer free sessions to students but due to financial constraints the number of sessions are limited to six or eight – depending on the university itself. Adrianna says that 'if you have eight sessions, by the time you develop a relationship with a therapist it's like your sixth session' (p.35) which she felt made it a 'waste of time' (p.35) even though she found it helpful. Ashley described how she 'had got to a really good place with the counsellor I was seeing last year in college' (p.25) but this came to a halt when she ran out of her allocated number of appointments. J.D. described the frustration of being on a waiting list to see a counsellor ('for all they know I could've been suicidal' (p.35)) while at the time of Fiona's interview she had just plucked up the courage to attend her college counselling service only to be told 'there are no appointments, no appointments' (p.16).

In spite of service constraints, counselling was one form of intervention that students could access freely during their time in higher education. Indeed, many students accessed many of the interventions outlined in this section for

the first time while in higher education. For some it was their first contact with a psychiatrist, the first time they were referred for a hospital admission, the first time they found out what ‘it’ was or received a diagnosis, the first time they were prescribed medication and the first time they sought help themselves, either in the form of general practice or counselling.

Higher education itself provided a unique environment in which students could access professional help and be supported in creating a new story about themselves and who they are – a story that all students create during this formational life stage; not just those who have experience of psychological distress. The second part of this narrative wreckage features section examines more closely the features of students’ higher education experience and how these related to their mental health and well-being.

Part B Higher education

As can be seen throughout all four stages of the narrative plot, each student’s experience of psychological distress is unique in its own way. However, two characteristics unite all participants in this study; the first being that they have experience of mental health problems and the second that they are engaged in full-time higher education. The higher education environment acted as a backdrop to the students’ stories. It provided the stage upon which a critical scene of their lives played out.

The students who shared their stories as part of this research came to higher education from a variety of directions. Some came directly from secondary school while others entered higher education after more than 20 years out of the classroom. Some came with a long history of psychological distress, while for others it was during their college years that their mental health problems first began to emerge. Students came from a range of socio-economic backgrounds and attended a variety of Irish higher education institutions – north and south of the border. However, five main features specifically relating to the students’ experience of higher education punctuate the narrative wreckage landscape. These are; the transition to higher education; the ‘Disability Access Route to Education’ (DARE); university disability support

services; the experience of journeying through higher education with a mental health problem, and; studying a mental health related course while experiencing a mental health problem.

5.5.10 Transition to higher education

The transition to higher education represents more than just a transition from one education institution to another. For many it represents the first major step into adulthood and independence and all the expectation that this brings. For some it raises a number of practical challenges – moving away from home, family, friends and/or professional support systems. A number of students described this transition as being relatively smooth. For example, Millie described the transition as ‘a stressful time’ but says ‘it was a nice stress...I was looking forward to it’ (p.19). She feels that after ‘three years of having a really hard time’ with her mental health as a teenager, she feels she is able to ‘enjoy’ and ‘value’ her time in higher education ‘because I didn’t think I’d actually be here’ (p.19).

After an 18 year gap, during which he struggled with paranoid schizophrenia, Leon returned to full-time education. Beginning with two years with the National Learning Network, followed by a one-year university access course, Leon is now in the first year of his degree. He talked about how each step along his higher education journey he has been supported and encouraged and described ‘the attention and care and encouragement and facilities and infrastructure’ he has received as he transitions to higher education as ‘wonderful’ (p.13). Leon says ‘it was great to have that facility where I could go from being a stoner and a waster’ (p.13) to being a full-time student.

Joseph also took a slightly longer route to higher education. After a gap of 20 years, he did a one year access course at a local further education college but says that although the access course prepared him well, he found the university he transitioned to ‘much more stressful’ (p.25). He said he felt ‘very isolated and vulnerable’ as a mature student in a class with ‘19 year old kids’ (p.25) and although he is now well into his second year Joseph says ‘I still feel like that’ (p.25).

J.D. feels that making friends was ‘very important’ (p.27) in smoothing the transition to higher education. He also says that loving his course ‘makes things easier’ (p.27). Fiona too says that making ‘an effort to meet people’ (p.10) during the first few weeks of college helped her make the transition: ‘I think I surprised myself with how well I coped with such a big change’ (p.9). However, not every student described such smooth sailing. Alicia described how she ‘hit college’ (p.3) and ‘it all sort of triggered it [her anxiety and depression] again’ (p.3).

The whole thing was a major shock to me (Alicia, p.3).

Alicia said the large crowded lectures ‘freaked me out’ and caused her panic attacks to come ‘back again quite badly’ (p.3). It wasn’t long before she ‘wasn’t going to college’ (p.3).

John says that ‘as soon as I started college my mental health fell apart’ (p.13).

I was really depressed, really anxious, couldn’t function here in college, I was overwhelmed. My shakes were back, I wasn’t able to control my thoughts and the words would come into my head ‘I’m not intelligent’, ‘I’m not meant to be here’, ‘how did I get in here’[...]suicide kept crossing my mind and it came to a point where I wasn’t able to do my work (John, p.13).

John says it was at this point that he decided to go back on medication and says that ‘within a few days of taking my tablets I felt better’ and was able to get ‘back on track’ (p.13) in terms of his college work.

Ella described how she ‘dropped off the grid’ (p.11) when she moved away from home to attend college. She left the support system which had been in place since she was a teenager and, following the advice of her psychologist, ‘didn’t register with the disability service’ (p.11): ‘the preventative measures that had been put in place for me at 16...were just completely undone’ (p.11). She found herself away from home ‘with no help, trying to pretend it [her mental health problem] didn’t exist’ (p.11). Ella struggled to meet people she ‘clicked with’ (p.12); didn’t enjoy the course she was on; found herself living in a stressful living environment with strangers, and; shortly after she started

college, her relationship with her boyfriend ‘started to fall apart’ (p.12): ‘everything got terrible and I ended up just not going to college from January onwards’ (p.12). Ella dropped out of college at this point and returned the following September to start a course ‘which I enjoyed’ (p.19). She says the second transition ‘was still hard, but it was less hard, it kinda felt like I was on the path to becoming a bit better which was good’ (p.19).

Robert described how he struggled with the transition to college. He was ‘brilliant in school like, top of my year’ but when he got to college he realised ‘I actually had to work’ (p.14). This increase in difficulty coincided with an increase in freedom as Robert got his first part-time job which financed an active social life: ‘I was like ‘Yahooo!’’ (p.14): ‘Then I failed and I realised, oh you are top of the class in school but you are just standard in college’ (p.15). This failure ‘was crushing’ (p.15) for Robert and failing again in second year, he decided to drop out.

Marie described how she ‘felt a bit lost’ (p.18) when she started college. She says she ‘banded together’ (p.8) with two girls from her school with whom she had little in common and, during the first few weeks of college, ‘I was going out a lot, drinking a lot and it just wasn’t me’ (p.9). It wasn’t long before Marie found herself ‘worn out [and] exhausted’ (p.18) and decided to seek help from the student counselling service.

One aspect which facilitated many students transition to higher education was the Disability Access Route to Education (DARE) scheme.

5.5.11 DARE

A number of the students spoke about how they go into their third level course via ‘the DARE system’ (Sophie, p.23). The DARE, or the Disability Access Route to Education, scheme was introduced ‘as a third level alternative admissions scheme for school-leavers whose disabilities have had a negative impact on their second level education’ (Access College, 2016). It offers reduced points places to school leavers who can (a) provide evidence of their disability and (b) demonstrate that their disability has had a negative impact on their secondary schooling (Access College, 2016). Eight students spoke about

their experience of coming through the DARE scheme but it is likely that other participants availed of the scheme without it featuring in the stories they chose to share.

Sophie says she got into college ‘by the skin of my teeth’ (p.23). DARE represented a lucky break for her although she does say she ‘was actually quite disappointed by the system’ (p.23). She explained her understanding of how the system works as follows:

Basically you tick a box saying that you have a disability; you provide the paperwork ... verifying from whoever it is, your doctor or psychiatrist, stating that you have a disability. Then all the people with disabilities, whether it's cancer or dyslexia, all go into a separate points race. [...] About a fifth of places are reserved for mature, HEAR and DARE students. And basically they'll say 'we have two places here reserved for DARE students in this course, who has the highest points out of those with disabilities who applied?' (Sophie, p.15).

Sophie felt disappointed because she believed that the DARE scheme meant that the entry points for a course would be reduced granting equal access to all students with disabilities but ‘it’s not necessarily that they lower [the points], it’s a separate points race’ (p.25). Sophie felt let down upon this realisation and wonders if she would have had a better shot at her first choice course had she remained in the regular CAO points race.

Millie, in contrast to Sophie, says the DARE scheme ‘gave me about sixty points, maybe seventy points, so I got 410 and the course was 480 I think, I’m not sure’ (p.16). For J.D. it mattered a lot that he ‘got in off my own bat’ (p.26): ‘The fact that, even though I got DARE and I would have been in anyway, that I got in by myself’ (p.26).

Lauren says she ‘definitely wouldn’t have got into college’ on the points she earned in her Leaving Certificate and says that ‘no-one expected me to get into college so that was great’ (p.10). For Claire, coming in through the DARE scheme leaves her feeling that she was ‘lucky’ and with a sense that she ‘should overcompensate’ (p.14).

I need to prove I can do well if I try, and it's not that I'm just lucky to be where I am and I kind of slipped in the door (Claire, p.14).

Although she feels her getting a place in college was down to luck she feels grateful 'because if I didn't do DARE' she feels she would have ended up doing 'a level 7 or something, something I didn't want to do' which would have 'really hit my confidence' (p.16).

It's terrible how the past years have been but I'm where I wanted to be. It worked out better than I thought it could (Claire, p.16).

5.5.12 University Disability Support Services

One of the advantages of accessing higher education via the DARE scheme is that students are automatically registered with their university disability support service. The service itself, and the support it offers, vary considerably from university to university and indeed from student to student depending on how they wish to avail of the services available to them.

Louise described how her psychiatrist 'advised' (p.53) her to register with her college's disability service. She says 'I didn't know what to expect from the disability' (p.53) and when, during her first meeting with the disability co-ordinator, he asked her 'what supports are you looking for?' she didn't feel that she needed any.

I wasn't there looking for supports, you know, it would be different if I had dyslexia or, I don't know, I was hard of hearing or that type of thing...like, I didn't need anything (Louise, p.56).

John, in contrast, says that without the various supports available to him through his college disability service 'my life would fall apart within 24 hours' (p.20). He attends the college GP 'on a regular basis' (p.21) and receives one-to-one academic writing support which 'makes a huge difference' (p.22). John puts his successes in college 'down to the people around me' as well as his own effort and determination: 'I'm merely an individual that can't function without the help of other people' (p.23).

Mai also says ‘I think I’m doing so well because the disability service is there’ (p.1). Through her university’s disability support service Mai is able to access the support of an occupational therapist who helps her with ‘the practical stuff’ (p.23) around drawing up study timetables and breaking down assignments into manageable chunks. Students who were able to access the services of an occupational therapist service spoke very highly of the support it offered. Joseph, Greg, Mai, Fiona, Millie each spoke about how ‘helpful’ (Greg, p.13; Fiona, p.12) occupational therapy was.

[The occupational therapist] helped organise my time and task management which in turn took the stress away from me because when I had everything organised [...] It took a weight off my shoulders (Joseph, p.22).

Other supports mentioned by the students as being beneficial included access to a separate, smaller, exam centre; access to quiet spaces on campus where the students can take time out, ‘library privileges’ (Sophie, p.29), and; an additional ‘printing allowance’ (Millie, p.20). A separate exam centre seemed particularly important for the students: ‘you don’t have to go to the RDS where there’s like 3000 people. It’s a small room with 20 people...it makes a huge difference you know’ (Joseph, p.21).

In addition to those students automatically registered with their college disability service by virtue of entering through the DARE scheme, students were referred to the service by their tutors or other academic staff members; the student counselling service; their university psychiatrist and/or; their own psychiatrist/mental health team. Some students were encouraged to register with the disability support service upon returning to college after a period ‘off books’ [officially off the college register for a period of time] due to mental health difficulties.

Perhaps the greatest value of being registered with their college disability service, one that emerged repeatedly in the students’ narratives, was the sense of reassurance or ‘comfort’ (Millie, p.20) that being registered offered them; a sense of knowing there is a port should they ever run into a storm.

Just knowing that...if you really do need it, there is support there (Millie, p.20).

5.5.13 Navigating higher education with a mental health problem

This study sought to understand the lived experience of third level students with mental health difficulties as well as explore the meanings these students ascribe to their experiences. What emerged from the students stories of their time in higher education spoke directly to these two questions. Students' accounts were filled with day-to-day examples of the unique challenges they face in a university setting as well as what higher education, and education in general, means to them. This section explores both.

Beginning with the students' lived experience of navigating higher education; the students' accounts were peppered with struggles directly related to their mental health problems. These included the challenge to concentrate and stay focused (Claire, Greg, James); the struggle to attend lectures (Lauren, Claire); the effort required to stir up motivation or interest in their work when their mood was low (Greg, James); and the battle with perfectionism, procrastination and getting work in on time (Adrianna, Ella, Greg, Robert, Mai, Louise, Joseph, Ashley, James, Claire).

Lauren described the thin line she walks between 'not eating' (p.12) and not failing her continuous assessment and examinations. She described how she 'failed [first] year on attendance' (p.11) even before she reached the end of the first term and took the advice of her tutor who 'suggested going off-books and doing medical repeat' (p.11). She 'got through' (p.12) first year the second time round and, now, in her second year, says that her anorexia is presenting 'a bit of a problem, but not to the extent – I don't think I'll fail. I hope not, because I'm definitely not repeating [...] I think I'll just about make it, I think' (p.12).

While for Lauren every day involves a balancing act between the demands of her eating disorder and the demands of her degree, Sophie faces a similar balancing act but in her case it is between her introversion and social anxiety

and getting a degree. Sophie says 'I need to get an education, you know?' (p.31) but describes the 'academic setting' and 'class situation' as 'very daunting' (p.28): 'Having to socialise and chat to people and stuff, I was very intimidated' (p.28). After dropping out of college at her first attempt, Sophie came 'back into a situation that I knew I wouldn't be comfortable in 100% [and] knowing that there wasn't really a way out for me' (p.31). She described how she is 'learning all the time how to cope better' (p.29) with her anxiety but feels she has 'no choice' (p.33) but to do this if she is to get her degree: 'I can't just not do anything for the rest of my life' (p.35).

Sophie was one of eight students who described having to drop out or go 'off-books' and either repeat a year or come back and start another course the following year. Ella struggled with the transition to college. Moving away from home she lost all her supports and was discouraged from registering with her university support services by her psychologist who felt 'admitting to mental illness in the academic field would put a black mark on my name' (p.11). She found herself living with strangers, one of whom she thinks 'might have had some social issues' (p.12), and doing 'the wrong course' (p.12). Ella also broke up with her boyfriend during this period and says that 'everything got terrible and I ended up just not going to college...I got very depressed, very anxious. I got very, very anxious' (p.13). Ella dropped out of college before the end of her first year: 'it was the first time I'd ever really failed at anything in my life' (p.14). Although Ella came back the next year and registered with her university support services; started a course that she enjoys and found better living arrangements; she says 'I have a lot of insecurities about my academic work now' which she links to 'how I dropped out of first year...I'd never failed anything before' (p.21).

Greg, a second year PhD student, wonders if 'the tendency towards the depression and anxiety is incompatible with academia' (p.5).

The academic environment is a high pressure environment and one in which you feel as if you are being criticised constantly and you are expected to, kind of, criticise yourself or motivate yourself (Greg, p.4).

Greg finds that this pressure, combined with a lack of structure, ‘takes its toll’ (p.20). He is currently struggling with depression and becoming increasingly ‘disillusioned’ (p.20) with academic life. So much so, that at the time of interview, Greg had decided to drop out of his Ph.D. programme.

James, also studying for a PhD, described similar struggles to Greg – particularly when he first started his research. He spoke about feeling ‘quite depressed, very low motivation, wasn’t working hard at what I was doing, wasn’t interested’ (p.30). James says that one thing that helped him come out of his low phase was the realisation that, ‘if I fail the whole PhD and everything goes out the window, I didn’t have one starting. So that’s OK’ (p.49). He says he ‘can’t afford to obsess over my PhD’ as he ‘can’t bounce back the way other people can’ (p.49) and feels that maintaining perspective and ‘awareness’ (p.48) is important for him and his mental health.

Adrianna says she came into college with ‘a lot of leftover stuff, like you know, throwing up and self-harm and depression and changes in medication’ (p.15). Now in her third year Adrianna feels that although ‘I still have moments where things aren’t great’ (p.15) that ultimately she is ‘pushing forward’ (p.15): ‘It [the distress] comes back but it’s not plaguing me every day’ (p.15). Adrianna described how she ‘loves the subject’ she is studying and during her time in college has ‘used the resources’ available to her and year by year feels she is becoming ‘more solid, more able to deal with things’ (p.43). Higher education appears to have offered Adrianna a supportive environment in which to grow and develop personally as well as academically. Higher education for Adrianna, and for many of the other students, represents much more than the addition of a series of letters after her name.

The meanings students ascribe to their higher education experience are both highly personal and enormously significant. For John, education is the key to breaking the cycle of poverty and abuse he was born into. He says ‘I really do see society or life as a kind of circle and it’s very hard to get out of and I’m trying to get out of that circle’ (p.7). John described how he grew up ‘at the bottom of the pile’ (p.14) in terms of social class with both parents unemployed and living on social welfare benefits.

I don't want their [his parents] lives, you know. I don't know what my life is going to turn out like or what way my life is going to go but at least I'm trying to give life a go (John, p.16).

John described his early life as being dominated by 'deprivation', 'chaos', 'coldness', 'dampness', 'poverty', 'neglect', 'emotional abuse', 'verbal abuse' and 'sexual abuse' (all p.9). By the time he reached his early 20's John was living alone, away from home, unemployed, 'constantly living in really bad accommodation...I had no friends really, isolation and no qualifications or no education' (p.12). One friend he did meet along the way was a man who 'really emphasised the importance of education' (p.29).

He said to me 'If you get your education nobody can take it away from you' and that's why I want to get it, I want to get something that nobody can take away from me (John, p.29).

John's friend suggested he wasn't 'able for college' (p.29) right away but that he should begin with a level four qualification and 'build it up' (p.29) from there. John successfully completed his level 4 certificate, was offered a place on a one year university access programme which, in turn, led him onto his honours degree course at that university. He is now in the second year of his degree and says 'I really like this new life' (p.24).

I'm trying to break that circle you know, I'm desperately trying to break it (John, p.33).

Joseph told the story of how he 'returned to college to fulfil a lifelong ambition' (p.15) after almost twenty years out of the classroom. This move took a lot of courage for Joseph, particularly as he had struggled for all of his adult life with crippling anxiety and panic attacks. He described the first day of his one year pre-college course 'thinking oh God can I do it?' (p.13).

I was sitting there trembling and I remember pins and needles all over my hands and coming up my face and I, so many times nearly left the room. I was scared, nervous, twenty years since I was in a classroom (Joseph, p.14).

But Joseph 'hung in there' (p.14) and after the pre-college course started on a four-year degree programme in university. University presented a number of significant challenges for Joseph and he says he gets 'totally overwhelmed' (p.25) at times but Joseph has a 'passion' (p.17) for his subject and hopes to continue to go a specialist masters degree in order to fulfil his 'dream...to work in a museum' (p.32).

Kate described how, even as a young girl, she thought deeply about the world and 'questioned the meaning of life and why people are here and why people do what they do' (p.23). Developing anorexia nervosa as a teenager curtailed her education and although she 'left school in 5th year' (p.9) she sat the Leaving Cert: 'I failed the Leaving Cert but I did sit it' (p.9). At a particularly low point in her early twenties, Kate says she 'was very sick and I had tried to kill myself a number of times' (p.8). During that time Kate 'questioned a lot like the meaning of life and why people are here and why people do what they do' (p.8) and, on the recommendation of a family friend, decided to travel to Pakistan to speak to a man 'that many people go to for help' (p.9). One of the things this sage-like man suggested to Kate was that she should pursue her passion for learning and knowledge.

So when I was in Pakistan, this guy said to me, 'Study', he said 'study as much as you can, study and learn as much as you can' and in my head I was like 'Yeah that's not possible' (Kate, p.9).

However Kate 'came back and started Googling possibilities and options of what I could study' and within weeks of returning from Pakistan started a degree with the Open University. Kate completed her degree and is currently in the first year of a two-year masters degree programme. Although she says she feels she is 'winging it' and feels 'like a fraud' (p.32), education and learning for Kate has a much deeper significance: 'sometimes I feel in my life I am to learn things intensely' (p.31). In returning to education she 'wanted to understand, I wanted to understand people, I wanted to understand myself' (p.32).

What I am doing is trying to form a path of some type of understanding or knowledge, like there is no way I am going to know everything or even much at all, but I am going to see what I can learn. If over the years I

have been so willing to let go of this life in an instant, well then I need to understand why I should be here (Kate, p.34).

While for Kate, higher education offered her a chance to satisfy the deep curiosities and questions that had shaped her life, for Leon it offered him an opportunity to gain ‘social approval’ (p.19). He describes himself as ‘the black sheep’ (p.8), particularly after he was diagnosed with paranoid schizophrenia at the age of 18. He says ‘it has been a long road but I’m getting there’ and, after two years at the National Learning Network and one year doing a university access course, Leon is finally in the first year of his undergraduate degree. This offers him ‘the social acceptance of being a student’ (p.15) at a prestigious university which has ‘helped my mental health as well, you know, because I have that social approval now’ (p.17).

I was the type of guy that your mother didn’t want you hanging around with but now I’m the type of guy that everybody’s mother would love to see [it’s] as simple as that (Leon, p.17).

This section has examined the challenges faced by students with mental health problems in higher education. Some of these, such as the struggle to attend or to complete assignments on time, were more universal than others. The meaning of higher education extends far beyond the day-to-day challenges for many students. Indeed it is this meaning that motivates many students to continue in the face of significant adversity. For John, education was his way out of the cycle of poverty and abuse he was born into. For Joseph it was the chance to ‘fulfil a lifelong ambition’ (p.15). For Kate, education was a means of answering some of the bigger questions that shaped her life, particularly the question of whether life was truly worth living at all, while, for Leon, being a third level student offered him a chance to earn the social approval that he felt he lacked as a result of having a mental illness.

5.5.14 Studying a mental health related subject as a student with mental health problems

Ten of the 27 students who participated in this research were studying a mental health related course. Six were studying psychology – three at undergraduate level (Adrianna, Thomas, Sophie) and three at post-graduate level (Kate, Mary,

Niamh). The remaining four were studying mental health nursing (Faye, Louise, Mai) and social work (Annie).

Adrianna spoke about how, for her, studying psychology is a means of getting the ‘qualification’ (p.32) to back up the knowledge and understanding she has gained through experience: ‘being able to say ‘I understand it’’ (p.32). She was drawn to the area because she feels that a therapeutic ‘relationship was one of the most important things in my life...and [I want to] give back a little of what I’ve been given’ (p.32). She says that this ‘sounds soppy’ (p.33) but, unlike her fellow psychology students, Adrianna hopes to enter the profession with the understanding that she ‘can’t really help people’ rather ‘be there with people and help them get through what they’re going through and just be that person, maybe the first person people talk to’ (p.33).

Annie described how her school guidance counsellor told her ‘Oh God, you can’t be a social worker – you’re mentally unwell’ (p.30). Many of the students spoke about how they were discouraged from studying a mental health related course on the grounds of having experienced mental health problems themselves. Annie says she doesn’t ‘think it’s fair to say that because I have had things in my life’ (p.30) that she shouldn’t go on to fulfil her childhood ambition to become a social worker. She feels she has ‘more experience to deal with other people’s hardships when I’ve been through my own’ (p.30). Annie believes that having ‘somebody who can actually relate to the client’ (p.30) would be a really useful addition to any mental health team.

I don’t think it’s fair to ask every social worker to be in tiptop condition when they are dealing with people who aren’t (Annie, p.30).

For those students studying mental health nursing, having personal experience created a number of additional difficulties. The exception to this was Faye who appears not to have disclosed or discussed the mental health problems she experienced as a teenager with any of her course co-ordinators. She feel that this experience doesn’t impact on her mental health nurse training except to give her unique ‘insight’ (p.13) into issues such as self harm and personality

disorders. Louise and Mai's experience, however, appears to have been less smooth.

Louise says she 'always had it in my head to do nursing' (p.2) and after she finished school she did a pre-nursing course and later worked as a care assistant before applying for a mature-entry place to study nursing at university: 'I applied for general, intellectual disability and psych, the three types' (p.51). While she was unsuccessful the first time, after two years as a care assistant she was offered a place on a mental health nursing degree course at the university that was linked with the mental health services she was still regularly attending.

I found out then that it was psych I got and it was great news, I was really, really happy but really, really afraid as well (Louise, p.52).

She immediately went to see her consultant who offered to 'suss out' (p.52) the most appropriate course of action with contacts at the university: 'he was advised to tell me to make sure I'm honest in application forms, honesty really was what they were saying was the big thing. Register early with the disability service...that was basically it' (p.52). When filling in the paper work, Louise was careful to be honest but brief; 'If they wanted to know more well they could ask but I wasn't giving away anything really that could stop my chances' (p.52).

While her consultant was happy to provide written verification of Louise's fitness to undertake a nursing degree course, she received what she experienced as opposition from other facets within the college. These included the Disability Officer she had been assigned ('He was already insinuating that because of the background I have I'm going to act crazy' (p.54)); Occupational Health ('She said to me "As you are sitting here in front of me now are you thinking of killing yourself?"'(p.59)); and her Clinical Placement Co-ordinator ('the CPC said "Louise [Surname], you are not the girl who had all the trouble with occupational health are you?" (p. 76)). In spite of this opposition Louise has successfully completed her placements and exams. While she enjoys her time on placement she sometimes does 'find it, kind of, pulls on me in ways.

There is people there who just draw me straight back to everything' (p.64). Louise has successfully negotiated the first half of her first year but says she is 'constantly' on edge - aware that 'this can be taken away on me' (p.77) should she slip up in the slightest.

Like Louise, Mai studied a pre-nursing PLC course and, when completing her CAO form the following year, 'put down general nursing first and then psychiatric nursing' (p.11). She says that now she's 'delighted I got my psychiatric nursing instead of general' (p.11). Mai feels her own experience allows her to 'empathise really well with the patients' (p.22): 'I understand what it's like, how scary it is to have a panic attack because you *do* think you are going to die (p.22)'. She says that 'when I am on placement I'm happy' and knows that mental health nursing is something 'I will like working in' (p.22). However she also says that 'placement can be hard' (p.20) – particularly when she sees patients with 'similar' problems 'getting help' and 'getting better' (p.22): 'you are like, Oh my God, why can't mine get better' (p.22). Mai was discouraged from disclosing her mental health problem while on placement and gets 'annoyed' (p.20) with the sense of hypocrisy that lingers in the mental health field.

You are either a nurse or a patient, like you can't have mental illness while you're a nurse. [You're told you] should practice what you preach and yet it's still like that's 'them', the mentally ill, and we're 'us' and we're, like, immune to it (Mai, p.20).

Mary also appears to be painfully aware of the stigma around being a mental health professional with a mental health problem. She spoke about how she wouldn't seek help for her depression and anxiety in the college where she was doing her postgraduate research because she feels that 'whether you realise it or not sometimes people can use it against you' (p.25).

[M] You're trying to maintain that professional, I don't know, veneer. No one is going to take you seriously if they think you deal with a mental health problem. And that is the reality of it. I'm not ashamed of it but it's how other people perceive you, you can't control how they're going to see it. [...] It would be difficult to be taken seriously. They'd be like 'oh, that person has a mental health problem', you know.

[E] So you think that they would view you in a negative light?

[M] Yeah. I think they would see you as less professional, less competent.

While students' higher education landscape was punctuated with just five features (transition; DARE; university disability support services; the experience of journeying through higher education with a mental health problem, and; studying a mental health related course while experiencing a mental health problem), higher education acted as a quiet backdrop before which many students' crisis/interruption, narrative wreckage and post-narrative landscapes played out. It is subtly present in their attempts to creating meaning during the narrative wreckage phase – providing access to intervention (5.5 part A) as well as scaffolding their attempts to live with 'it' (5.5 part B). These efforts form the basis of the following section.

Part C Living with 'it'

This third grouping of narrative wreckage features follows on from its predecessors, intervention and higher education, in that it explores many of the key features that emerged time and again in the stories the students shared. Grouped together under the heading 'living with it' these features relate to how the students managed 'it', their mental health difficulty, on a day-to-day basis. This section begins by looking at whom the students identify as being important sources of support in their immediate social circle; who they chose to tell about 'it' and how they go about doing this; what it's like to live with a mental health problem and; how they go about managing it as best they can. This part C also uncovers how the students make sense of their experience of psychological distress; the 'pros' and 'cons' of having a mental health problem; as well as how this experience orients them towards helping others. This third sub-section then concludes by exploring some of the roadblocks or challenges the students identified as preventing them from 'recovering' or moving on from their mental health problem.

5.5.15 Supportive others

Students identified three main sources of non-professional support; parents, friends and partners. Alicia says her parents are ‘so supportive’ (p.10) and that it ‘terrifies me the thought of people who have to go through it [a mental health problem] without strong family support, like, I don’t know how they do it’ (p.10). Mary described her parents as her ‘coping mechanism’ (p.7). She says that when she feels ‘a bit stressed’ she will call her mother and ‘talk it out with her and try and figure out why I’m feeling stressed’ (p.7). She says that if things get ‘really, really bad I’d just pack up, hop on a bus and head home to my family’ (p.36) for support. Sarah also feels that ‘telling my parents what is happening...does really lift the load’ (p.5). She says that ‘for so long I didn’t tell them anything because I was afraid I would hurt them’ (p.6) but more recently has begun to open up to them and they have become ‘a big safety net’ (p.7). Sophie says she is ‘so close’ (p.9) to her parents.

Through everything they’ve always been there and they’ve always been very understanding...I’ve always felt I could talk to them about anything (Sophie, p.9).

While for Sophie and the others it was their parents that provided a regular and consistent form of support, for some students it was their friends who were there for them in times of need. Adrianna says she has become ‘more trusting of people’ (p.42) in recent years and has begun to open up and tell her friends her story. She says that she has become close to one friend in particular and wonders if this is because they have ‘a shared story’ (p.36) – both having come through quite similar experiences. Faye described how she doesn’t ‘go to counselling anymore’ but ‘if anything gets me really stressed out I would organise to meet up with [my friends] for a chat – just to let them know what is going on’ (p.6). J.D. also describes his ‘two best friends’ as ‘really supportive’ (p.24):

I could literally talk to them about anything and I know there’d be no judgement. I could say anything to them and they’d be OK with it and they’d still love me as a person (J.D., p.24).

For J.D. it was just ‘the fact that they were there’ (p.24) that made his friends a reassuring presence when he was going through a tough time. Annie also

described how her friends were a great source of support when she struggled with her depression in her first year in college: ‘even though they didn’t know they were supporting me in any way, they were very helpful’ (p.18). She recounted how they would ‘come in everyday’ (p.23) and encourage her to get up and out of bed: ‘one of them brought me ice cream one of the days and I was like Oh God [laughs] I do have to get out of it’ (p.23). She feels ‘there’s a balance there’ (p.27) and that her friends are as likely to come to her for support as much as she is to go to them – a balance that means a lot to Annie. Marie describes meeting her friends in her second year of college as ‘a turning point’ (p.28). She says that they ‘accepted’ her and ‘looked after’ (p.28) her when she struggled with her mental health and described the different ways in which they create fun for themselves during the week in college and at the weekends doing ‘outdoorsy stuff’ (p.48).

Leon, Claire and Mary spoke about how important their partners are to them, particularly when they are in ‘that stressful anxiety place’ (Mary, p.36). Mary described how ‘it’s definitely much easier’ now that her boyfriend knows what ‘it’ is and ‘is aware of it’ (p.28).

If I’m feeling really stressed out I can just say I’m feeling really anxious and he’d be like, we can talk it through and he’ll do something nice to make me feel better (Mary, p.28).

Leon says his partner ‘is just wonderful – she has turned my life around’ (p.11). He described how she believes in him, even when others around him don’t: ‘[She] gets me through it because she gives me all the love I need’ (p.17).

Drawing on the support of those around them began, for all students, with them opening up and telling them. This seemingly straightforward act forms the second feature of the ‘living with it’ sub-section.

5.5.16 Telling people

A number of students talked about the complexity associated with telling those around them that they were struggling with a mental health problem. Some students say they are ‘happy to say to a basic stranger that, yeah, I suffer from panic attacks and anxiety’ (Alicia, p.14) believing, as Marie put it, that ‘it’s

easier for me if people know' (p.50). Leon too feels 'it's so much handier to have everything out in the open' (p.20) but, like Alicia and Marie, Leon didn't always feel this way. He says 'you are always conscious of what people are saying or thinking about you' (p.14) and says 'you don't want to be treated different but you are treated different' (p.17). Fear of being looked at in a different light or being treated differently by someone once they know they experience a mental health problem was a major concern expressed repeatedly by students in this study.

I was afraid that if my family, if my brother and sister knew, that they would look at me differently and see me as that unstable person (Mary, p.34).

A second major fear around telling people was the fear of being judged.

I just hated the thought of people knowing because I just thought that everyone judged me. I thought that people would look at me not as me [but] as me with something wrong with me (Fiona, p.20).

Students also described the fear that people 'won't understand it' (Alicia, p.14) and indeed, Mary says she will only tell someone 'when I feel like they'll understand and support me' (p.16). Sarah described how she 'lost a lot of friends through it' because they 'just didn't understand at all' (p.7) when she told them about her mental health problem.

You are told to tell people what is going on with you but then when you tell some people they just can't grasp it or can't deal with it (Sarah, p.7).

For Faye and Louise, the fear that made it very difficult for them to open up and talk to someone about 'it', particularly when they struggled as teenagers, was the fear of that person 'not believing' (Faye, p.8) them: 'they are not going to believe me saying that there is something wrong' (Louise, p.8).

While many students undoubtedly had negative experiences of opening up and telling people about their struggles, others were pleasantly surprised to find that 'some people are actually really supportive' (Fiona, p.19). Time and again it appeared that the key to receiving a non-judgemental and accepting response

was knowing who to tell. Annie says 'you kinda have to know the person' (p.26).

I don't think there are any signals or signs; I think you just have to trust your instinct. I think you know yourself (Annie, p.26).

However, Annie does 'think you have to know a person very well' in order 'to know that they're not going to share your information with other people' (p.26). Mary also spoke about how she is very wary of giving someone 'that kind of ammunition' which they may 'use against you' (p.34). That's why she says she will 'only tell people who were really close to me' (p.34). Like Annie, Mary says 'I think you do get a sense from a person; you just know from people whether or not you can tell people and whether or not there is trust there' (p.16). For all students trust seemed to be the key to them sharing their personal experience but knowing when somebody was trustworthy appears to be challenging with many students having to rely on their instinct. Indeed many students, J.D., Millie and Ashley for example, felt it easier just not to tell people: 'I don't tell any of my friends or anything; it is very much a private matter' (Millie, p.13).

You have to be a little bit tactical about it, you know what I mean? Certainly if you met a new woman and it was your first date you wouldn't be very forward with telling her that you are a crazy man [laughs]! (Leon, p.21).

Ashley says she's 'definitely not public in my discussions of these sort of things' (p.1). She says that this is not because she doesn't want to talk but rather because 'people aren't willing to hear' (p.10). Ashley says its 'disappointing' when 'as soon as things start to go bad and your head goes into a space where it is not good, they don't want to hear. It frightens them and it hurts them [and they] don't want to know' (p.26). Ashley described how she 'would use helplines a lot because nobody else is going to listen' (p.26).

It does feel lonely sometimes that they don't want to hear (Ashley, p.26).

J.D. says he's 'not a big fan of people saying people with depression should just talk about it and they'll be fine because I think that really undermines

people and it makes people feel worse who deal with depression but can't get over it by talking – that was me for a long time' (p.24).

You see ads on TV and everything is like so great – just talk about it and then you're fine. But that doesn't do anything, you need to probably talk to someone who knows what they're doing, who's been trained. That's why I don't like those ads because talking to someone, a friend, about it – yes it's good and it should be done but if you're really having that much trouble you need to talk to someone who has a fancy paper on the wall (J.D., p.24).

For many students the higher education environment provided a more open and accepting space in which they could be more forthcoming about their mental health experiences. Alicia says she 'definitely' feels college 'students will talk a lot more and are a lot more OK with it' (p.14) than other areas of society. Millie feels that in her college 'there is all these kind of breaking stigmas of mental health campaigns' (p.24) and says that 'even coming talking to you' and taking part in the research is a sign that she is 'definitely more open to talking about it' (p.24) than she was when she was in secondary school. Telling people and knowing who to tell was one aspect of students' attempts to live with and manage 'it'.

5.5.17 Living with/managing 'it'

One of the more defining features of students' narrative wreckage experiences was the manner in which they accommodated 'it'. It appears the initial, and often most painful, first step in learning to live with and manage 'it', was accepting 'that this is in your hands' (Adrianna, p.16). Adrianna spoke about reaching the realisation that professionals 'can only help you when you're in their office and that *you* have to your shit together' (p.16) [student emphasis].

It's about accepting, I think first of all accepting that this is your life...[and secondly] figuring out that it's actually just you who can fix it (Adrianna, p.17).

When Sophie first started 'going through severe bouts of depression' (p.5) as a teenager she says 'I pitied myself and felt very much like 'poor me' - how will I ever cope with this?' (p.20). She feels that this was 'a perfectly natural response' to the injustice of her situation 'but at the same time I hated myself

for not being resilient and for not somehow having the means to cope with it' (p.21). Sophie described how she initially believed 'everything will work out happily ever after' but 'as the months went on' (p.21) it became clear that this time the ending was unlikely to be quite as happy and straightforward as she hoped.

I remember sitting there thinking there's no one coming on a white horse to save me. It really was a slap in the face. It was the first time I realised that I could be in serious trouble, because there was no help in sight [and] I didn't know how to help myself (Sophie, p.21).

Sophie says that 'for me as a young person it was the first time I was not equipped to handle what came my way and that was a very frightening feeling' (p.21). She didn't realise that coping was 'something that you learn' (p.21).

Ella, Joseph, Lauren, Marie, Ashley, Claire and James all spoke, unprompted, about how, once they had come to terms with the reality that 'it's always going to be there' (Lauren, p.13) that they can then 'learn to manage it better' (Lauren, p.13).

Marie says 'I'm always going to have to look after myself and I find that frustrating sometimes but I think I just need to learn to deal with it' (p.54)

It's hard being a 23 year old college student when you know you need to be in bed by 11 so you're not down the next day. You know? I need to watch what I eat, I need to make sure I exercise (Marie, p.54).

Marie knows 'the statistics aren't great' (p.55) and feels that mental health problems are 'always going to be part of my story' (p.54) but she says that 'every time it happens I learn a little bit more' (p.55) and feels that right now she just needs to 'keep working on figuring myself out – that the plan' (p.55).

Like Marie, Ashley says 'I don't think it'll ever be fixed' (p.15) but feels that she needs to 'make the adaptations and learn the strategies and things that are going to make things doable' in spite of her bipolar disorder (p.11). However, for Ashley, her 'main problem is that' being consistent 'gets boring' (p.15). She says 'I do miss the element of chaos in my life' and since 'things have gotten together' and have 'been good recently' she feels she has 'lost a chunk

of identity' (p.15). James also thinks 'bipolar's for life' but he doesn't 'think that means it has to control' him. These words reverberated in the story of Joseph who says 'I don't think you can cure anxiety' (p.29). He says that when 'Bressie, the guy from the Voice of Ireland, stated that he suffered from anxiety and panic attacks, and it's gone, I actually felt jealous' (p.29). Joseph described all the ways in which he has been 'just trying to deal with it as well as I possibly could' (p.7) since he was a teenager. It has been a long struggle for Joseph but he says that 'every step I took made a difference' and now, after '24 years of suffering' (p.29), he is 'managing my anxiety as well as it [can] be managed' (p.28).

Ella described herself as 'a ticking time bomb – there's always a chance I'll go bad again' (p.23).

I think to deny that it's going to be there forever is to turn your back on a tiger. It's not about recovery, it's about managing. It's about accepting it and also learning how to manage it and learning how to deal with it and to predict – in a way to predict the unpredictable (Ella, p.23).

One thing that has been hard for both Ella and Mai to come to terms with is the sense of wonder they both have as to what might have been had they not had mental health difficulties to contend with. Ella says 'I should really get a first' class honours degree but because of her daily struggled with anxiety and depression she says 'I'd be very surprised if I do' (p.22): 'what will annoy me will be it won't be a lack of capability, it will be having been so distracted and the mental, I do think the mental illness will have impacted it a lot' (p.23). Mai spoke about how she had the opportunity to sit a scholarship exam which, had she been successful, would have meant that she 'would have been able to move out of my house, not get verbally abused by my family' (p.16) anymore: 'I couldn't do it in the end, I got too sick' (p.16).

Students described a variety of way in which they manage their mental health on a day to day basis. As discussed in section 5.5.16, talking to those around them was a strategy students commonly mentioned. Routines and scheduling emerged as another key component of students efforts to stay well. Marie identified early on that 'structure is really good for me' (p.2) and when her

mental health really began to deteriorate she ‘had to get very good at making plans and schedules’ (p.47). James and Ashley both spoke at length about how ‘when I lose my structure I start to get stressed’ (Ashley, p.21). For Ashley, ‘stress and alcohol are the two big things’ that affect her moods and are the two things she is most learning to keep under control. James spoke about how he finds it ‘very difficult to establish a routine’ (p.12).

When you miss sleep, and that was the worst one as well, where you could go for days with like four hours sleep a night, you were in way worse moods and then you’re fuelling yourself with sugars throughout the day which is ups and downs all day long (James, p.16).

For James, ‘bipolar’s for life’ (p.44) but he can ‘manage it’ (‘I’ll just continue with the diet, continue with the lifestyle and continue meditating’ (p.44)) in the knowledge that ‘if you’re not managing it, it could go out of control’ (p.44). Keeping busy is another important strategy for James, one which Sarah, Lauren and Marie spoke about too: ‘it’s probably better to be busy than to be not doing anything at all’ (Lauren, p.2). For Lauren living with ‘it’ meant living within the limits of her eating disorder. She is very aware of ‘what I can and can’t do’ (p.19) – something that her friends have become aware of too. She knows that, when her friends invite her for lunch, ‘I can go to Marks and Spencer’s and there’re two things I can have there; there’s one thing I can have in Costa’ that ‘fits the calories I’m willing to have’ (p.2).

Sarah spoke about all the things she does to nurture her mental health: ‘I love art and I really find when I’m doing that it really helps, but it’s hard to get the motivation to do that’ (p.20); ‘I think using your hands really helps, like drawing and painting and I was doing a dressmaking class as well’ (p.20); ‘I started basketball last week so hopefully that will help’ (p.20); ‘I do keep myself very busy and my father and myself did the couch to 5km and we go for runs together and I think that is really good’ (p.20); ‘I do mindfulness every night, well, me and my mum do it as a ‘workout’’ (p.16).

I suppose what is frustrating me about everything is I try so hard to fight and beat it. Like, they tell you if you eat healthily, they tell you if you exercise and they tell you if you talk you’re going to...but I do everything and get no relief (Sarah, p.20).

Sarah's struggle to understand why, in spite of doing everything right, she is still unable to 'beat it' (p.20) reflects a deeper struggle – the struggle to make sense of it.

5.5.18 Making sense of 'it'

Each student, over the course of their conversational interview(s), offered insight into how they come to terms with or make sense of 'it'. Sarah's efforts to manage 'it', as outlined above, and the frustration she experiences when they fail to alter her situation, offers a window into her wider experience of confusion and struggle to make sense of it. Throughout her two interviews Sarah pondered repeatedly 'what is happening to me? Why is it happening? Why me?' (p.13). Her questioning related not only to why 'it' happened to her but also what it means for her future: 'is this my life? Is this what my life is going to be like?' (p.14).

If it's been like this for this long it is probably something I am going to have for the rest of my life and that, I feel, is really hard to come to terms with. It's hard to think that my life will be like this. It is hard for me to understand why does my life have to be like this? Why me? (Sarah, p.28). I really don't understand why some people experience this and some people don't at all. I find it so hard to comprehend. Why do I feel like this and why someone else might go through life without ever experiencing it? I don't understand that. I don't think it's fair, you know (Sarah, p.29).

Sarah was by no means alone in her struggle to make sense of it. Millie says 'it's something that I'm still trying to make sense of. I haven't been able to completely understand why it happened. What did I do?' (p.25). She described how she sometimes feels 'an anger towards God' and wonders 'just what did I do to deserve it?' (p.25).

Ella says that 'seeing it as an illness is the only way to stop yourself from going crazy' (p.22). Not only does the medical model offer Ella a way of making sense of 'it' but prevents a situation where 'you start to either blame yourself, or worse, blame you parents' (p.22). For Ella, 'the only way to stay sane about it is to go 'it's an illness, it's no one's fault'' (p.22). Claire too considers 'it' to be 'a chemical problem as opposed to a situational [problem]' (p.4). She spoke

about how her parents have both experienced anxiety or depression at some point in their lives and Claire feels 'I just got the bad of both of them' (p.4). However, later in that same interview Claire spoke about how college affects her mental health and said that 'I think it's [her anxiety and depression] just going to be one of those things that's slightly situational, kind of depending on what's happening at the time' (p.24). For Claire it appears that her understanding of it involves a delicate interplay between biochemical and 'situational', as she calls it, factors. The relative weight of each of these two factors seems to be a little less clear in her mind. James too described how he sees his bipolar disorder as an intricate balance of 'chemical imbalance' and 'lifestyle' (p.32). His early fascination with sport and physical training offered James a thorough grounding in appreciating the factors that affect his body and its performance and this understanding, combined with his science studies, appear to shape his understandings of his mental health. Just as he had developed physical training plans, he realised upon diagnosis with bipolar disorder that he 'needed a management plan' (p.30). This plan involved yoga, meditation, 'mind management' (p.30) as well as maintaining good diet, sleep and exercise habits. He says 'I suppose it's maybe handy coming from the gym side of things because it's like a muscle...my brain is a muscle' (p.52): 'if you work a muscle 24 hours a day it's going to have unhealthy moments, it's going to get inflamed, you're going to get migraines or get really depressed it's like that's kind of the natural cycle of your brain' (p.52). This way of making sense of it works well for James and offers him 'a more natural way' of managing his mental health without the need of a 'drugs strategy' (p.30). Beyond this James says 'you don't need to put a reason on it, you don't need to put a rhyme on it' (p.45): 'maybe this is your one shot, like don't focus on what's coming next and be stressed now, maybe now is time just to enjoy life' (p.45).

One way of making sense of it that a number of the students made reference to, was the sense that 'it's something that's part of me' (Marie, p.54) or 'it's entirely part and parcel of who I am' (Alicia, p.15). Seeing it as 'part of who I am' (Ella, p.23) echoed through the understandings of Claire, Marie, Ella, Mary, Alicia, J.D. and other students. These students explored the pros and cons to 'it' (as discussed in the next section, section 5.5.19) but ultimately they felt 'it's always going to be part of my story' (Marie, p.54) and that was that.

Kinsley recounted two modes of understating offered him by the mental health professionals he encountered following his experience of psychosis. His psychiatrist and the team that cared for him in the hospital left him with ‘this sense that my leg was broken and now it was fixed again [and] it was just making sure I didn’t break it again’ (p.15). He described how, upon discharge, ‘I walk out of [hospital name] and I immediately think OK, I’m totally cured’ (p.8). Within a few months Kinsley was faced with the painful realisation that ‘episodes of mental health aren’t sorted out that easily’ (p.9). At this point Kinsley began ‘seeing this psychologist [and] he was like no you are very much on a path of recovery’ (p.15): ‘The way he made me look at it, which was a way I hadn’t looked at it at all before, was that it was a trauma. It really was you know...[the] absolute madness that was felt, that is all quite traumatic’ (p.15). Kinsley described how ‘what happened is still very much with me you know’ (p.20) but says he is focused on ‘trying to move on’ and ‘keeping it [psychosis] as far away as possible’ (p.22).

While it made sense to Kinsley to think of his experience of a psychotic episode as a traumatic event, Mary perceives ‘all of these things, depression, anxiety’ (p.11) as heightened emotions.

I think they are all just human emotions. At different periods in our lives we go through different difficulties and they are going to be heightened. The thing that heightens for me is anxiety. It’s a human emotion, it’s not something that defines me (Mary, p.11).

Mary even says ‘I don’t associate with having a mental health problem. I see it as in I have anxiety, it’s a normal human emotion, it gets heightened at different stages’ (p.33). Indeed she feels that ‘sometimes it’s actually very useful because I’m very careful and very security conscious where a lot of other people aren’t. There are definitely benefits to it. I really don’t see it as a negative. I just see it as part of me’ (p.33). Mary was not the only student to identify the benefits of her mental health experience.

5.5.19 **Upside of 'it'**

In spite of the 'difficulties' their mental health presented, the students were able to recognise the positive impact this 'part of me' (Marie, p.54) has had on them overall. Ella described how 'it's had its downsides but it's also taught me a lot and definitely made me more compassionate, made me a lot more humble and made me a lot more willing to accept my own faults' (p.23). Ella also clearly articulated the 'downsides' to her anxiety and depression (explored in section 5.5.20) but says that that 'focusing on the positives, it's just something you have to do because you have to focus on the positives or else you end up resenting who you are' (p.23).

Kate described how 'my mam used to be 'oh if I could take this away from you, if you didn't have to suffer this'' (p.31).

Yes there is lots of parts of this that are absolutely shit, but the people I have met, the experience it has given me, the opportunities, even if they are just so small [as] to have met such generous and kind people, yeah, it's nothing that I would ever take back (Kate, p.31).

Kate spoke about how much and how 'intensely' (p.31) she has learned as a result of her experience, something that Adrianna also described. Adrianna says 'you learn from it' and that 'you know things because' (p.4) of the type of experiences she and the other students went through. For her there is a difference between knowing and understanding and that her life experience has left her with 'a different kind of understanding' (p.4). Kinsley too feels that 'huge experiences like that change you' (p.28):

I'm a bit more wise and terrible as my experience was it really taught me a lot. In a weird way it was one of the most educational things that I have ever encountered. I mean, it has completely altered how I live and how I'm going to live for the rest of my life (Kinsley, p.28).

Marie says 'I like what it's done to me' (p.54). She feels her experience has made her 'a much more empathic person' with 'much more understanding' and a greater 'self-awareness' (p.54). Claire doesn't think she 'would be the person I am today if I didn't have it' (p.26). She feels it makes her a 'more rational' human being and is 'sure it'll stand to me in the future' (p.26).

James spoke at length about how his experience has ‘forced’ him to start ‘appreciating the simplest things’ (p.46) in life. He feels that learning to live with bipolar disorder has meant that he ‘can look at things a little differently to other people’ (p.50) and gives him a perspective on what’s truly important in life. He feels this perspective and appreciation of life comes from having ‘been to the very bottom’ (p.47): ‘I think if you make it out the other side you’ve a huge advantage in life in terms of you’ve seen the worst of it’ (p.46).

Millie also described how having come through the worst of times she ‘can now appreciate when I have it good’ (p.4). She feels ‘the mental illness kind of taught me to look at things differently’ (p.4). However, while many of the students could identify the upside of ‘it’, they also clearly acknowledged the challenges ‘it’ presents them, particularly as they try to move on in their lives.

5.5.20 Challenges/roadblocks

By their very nature, mental health ‘difficulties’ presented the students with a range of complex and often quite powerful challenges as they sought to negotiate the narrative wreckage stage. The narrative plot described in this chapter may provide an unhelpful illusion of a smooth progression through each individual stage where the reality for the students was quite. Rather than a point on a linear progression from crisis to recovery, narrative wreckage, for the majority of students, was filled with stops and starts, progress and reversion, hope and discouragement. As made clear by Ella in the previous section, in order to maintain optimism the students felt the need to focus on the positives. However, challenges and roadblocks also had a profound impact on this landscape.

Many of these challenges have been discussed before in relation to other stages of the narrative plot. For example trauma, described in the ‘pre’ narrative phase, was felt by the students throughout their lives. John, for example, spoke about how angry he is at abuse and neglect he experienced as a child and how ‘no one had ever questioned’ (p.31) his poor physical and emotional state as a little boy. He says that it’s ‘no wonder one would have problems’ (p.31) after the horrific start he had in life. John spoke about how the abuse he experienced

‘impacts your mind’ and ‘influences or messes with your development’ (p.32) and feels that ‘I still carry a lot from that, from my upbringing’ (p.32).

The perfectionism outlined in the pre-narrative phase, and its association with self-worth, is another feature that permeates all stages of the students experience.

*I kind of feel if it's not going to be perfect what's the point in doing it?
(Robert, p.13)*

Perfectionism by its very nature is a double edged sword and while, on the one hand, it meant that many of the students were very high achievers academically, it also led to cycles of anxiety and overwhelm particularly for those students whose self-worth is entwined with their ability to achieve externally. For example, Marie described how ‘I tie a lot of my self-worth into how I’m doing academically’ (p.29) and when, in her end of year exams, she ‘got a 2:2 and everybody around me was getting firsts’ she ‘took that very badly’: ‘I remember, carving 2:2 into my leg because, you know, it wasn’t good enough’ (Marie, p.29).

Often the greatest challenge students face is presented by ‘it’ itself. Alicia described how ‘it’ comes in ‘waves’: ‘like I might go through periods of bad anxiety but I might be fine for ages’ (p.3). The ebb and flow nature of ‘it’ was something that a large number of the students made reference to but, as Annie points out, what makes it particularly challenging is ‘you just can’t forecast your bad days’ (p.35). As Ella says, trying to prepare for the bad periods is like trying ‘to predict the unpredictable’ (p.23).

Adrianna described the ‘paradox’ of having coping mechanisms, such as self harm and not eating, that are ‘conscious attempts to self-destruct’ (p.29). On the one hand these coping mechanisms help Adrianna cope and live her life but equally she worries that they’re ‘probably going to kill’ her one day (p.29).

Louise spoke about the struggle she feels ‘in my head’ (p.74) between the desire to ‘take an overdose’, which she feels ‘would settle me’ and offer her

‘relief’ (p.73), and the knowledge that she has ‘a lot to lose’ if she does that (p.73): ‘In my head, still if it came to it, I would take the chance and hope in some way I wouldn’t lose everything’ (p.73).

A number of the students spoke about the impact ‘it’ has on their relationships with others. Ella described her concern that ‘there’s a chance I’m going to pass this down to my children, there’s a chance I won’t be able to handle small children’ (p.23).

Being mentally ill is difficult for me, it’s difficult on my parents, it’s difficult on my partner, it has a negative effect on everyone around me at one time or another (Ella, p.23).

Ashley also spoke about how she has been ‘completely shut down’ to the possibility of ‘a relationship’ because she doesn’t ‘think it is fair on another individual to have to deal with me’ (p.30). However she is ‘hopeful that I’d get myself in check and that that [a relationship] might happen’ (p.31) at some point in the future.

5.5.21 Helping others

The final accentuating feature of the narrative wreckage landscape is that of students desire to help others in their world. For some, such as Adrianna and Leon, this was motivated by a desire ‘to give back a little of what I have been given’ (Adrianna, p.32). Leon described the ‘attention and care and encouragement and facilities and infrastructure and income’ he has been afforded in his life as ‘wonderful’, particularly, he says, ‘for someone who hadn’t done much for anybody’ (p.13). For Leon, the charity he and his partner set up to raise funds for a local children’s hospital is his opportunity to give back to a ‘society [that] has been very good to me’ (p.9). Ashley spoke about how a traumatic experience in her teens left her with a sense that ‘Oh my God, I’m a horrible person, I deserve nothing’ (p.24): ‘I decided at that point I was going to try and get medicine and be a doctor because that’s the only way I could make it up to the world’ (p.24). She felt that by working hard to ‘try and help people’ that ‘that might make up for the bad thing that I’m after doing’ (p.24). Although she didn’t ‘get medicine’, Ashley spoke about how she hope

to use her current degree and find a way ‘to give back to the mental health community’ (p.31) that she feels has helped her so much.

Niamh described how studying psychology offered her an opportunity to combine her ‘own experience’ with intellectual learning in order to ‘apply what I know, what I’ve experienced with research’ (p.47) so that she may help other young people who may struggle with their mental health.

I just want to use what I’ve learned to help other young people and show them that recovery is possible (Niamh, p.48).

Millie described how, for her, ‘helping the poor, helping the disadvantaged’ (p.18) is something she wants to ‘devote’ (p.18) her life to. Helping others offers Millie a sense of ‘satisfaction’ and she described how ‘there’s this sense in me that I’ll be able to actually feel completely content when I’m doing things for others’ (p.18).

Mary described how helping others, particularly through her postgraduate psychology research, creates a sense of ‘meaning’ (p.28) that is very important in her life.

Helping people in some small way, like if you can even help one person, if you could change one person’s life, then it will have been worth it (Mary, p.28).

The meaning offered by helping others was particularly important to Thomas. He says ‘I just want to help people, it’s all I want to do’ (p.5) and adds ‘I would not see any purpose in life if I could not help people’ (p.30). Over the course of his two conversational interviews, Thomas mentioned 13 groups, charities, voluntary organisations and extra-curricular activities that he has been involved in over the last two years and says that giving back to his community and helping others makes him ‘feel like my life [has] meaning to it’ (p.14).

5.5.22 Conclusion

The word ‘meaning’ is one which pops up repeatedly throughout student’s accounts of their narrative wreckage phase. This phase is all about coming to

terms with 'it' and what it means both for the student's present and their future. It looked at the forms of intervention or support students sought in the aftermath of their crisis/interruption and attempted to examine whether students found these various supports to be of benefit. Higher education, and the meaning of education in general, formed the second of the three major sub-sections in the narrative wreckage landscape with aspects of the students' higher education experience such as transition, disability support and the impact of their mental health difficulty on their ability to engage with the higher education environment, all under focus. Meaning emerges as a prominent feature of the third narrative wreckage sub-section entitled 'living with it'. This section looked at what it was like to live with and manage 'it'; who the students turned to for support and; how they understand and make sense of 'it' in their own minds.

The majority of the students who took part in this study occupy the 'narrative wreckage' phase. What separates these students from those few who are deemed, somewhat subjectively and arbitrarily, to have progressed through narrative wreckage forms the focus of the fourth and final phase in the narrative plot; 'post-narrative'.

5.6 Post narrative

The post narrative represents the final phase in the narrative plot. However, post narrative must not be confused with some utopian destination which, upon arriving, offers the student eternal protection from any further distress. Post narrative reflects the 'space' a student has generated between crisis/interruption and the present. Students who identified this space as they told their stories spoke of 'it' as something in the past: 'I had depression' (J.D., p.13). They also spoke of it as something that is 'part of me' (Mary, p.39) – an aspect of themselves they have come to terms with and have come to live with. This section outlines the factors that determined whether a student had progressed through narrative wreckage and into post-narrative. It looks at the features of students' accounts of this phase and attempts to convey the sense of impermanence, a sense that was stronger for some students than others, that underlay the students' post narrative accounts.

Of all the phases in the narrative plot, the markers by which those students who had moved into this phase may be identified are most subjective and malleable to bias in the post-narrative phase. Saying that, seven of the students who took part in this study spoke about 'it' as being something from which they have either created distance from or developed an acceptance for. Looking at the narratives of these seven students in relation to the remaining 20, three factors appear to have offered the former greater leverage in progressing through narrative wreckage. These are the severity and complexity of 'it'; the time that has elapsed from (the last) crisis/interruption and; the level of social support available to the student – particularly family support.

The severity and/or complexity of the mental health difficulty appears the strongest factor determining whether a student has moved away from 'it' or is still in the midst of narrative wreckage. Comparing complexity or severity is a dangerous game however, research, by its very nature, inherently suggests comparison of one kind or another. For example, J.D., who identifies his depression as something that is in his past, experienced a single crippling bout of depression in his early teens. At that time he and his family sought a diagnosis and professional intervention in the form of counselling and he drew on the support offered by his friends and his Christian faith. While the six intervening years have been far from plain sailing for J.D. he says he has reached the point where he no longer considers himself to have a mental health problem: 'I *had* [J.D.'s emphasis] a mental health problem but I don't want it to become something that defines me in life' (p.28).

Obviously there's going to be periods of time where you're stressed and, if you have a past, which has depression in it, that's obviously going to be in the mix as well. But there was never a stage where I felt like I couldn't deal with it. There was never a stage where I felt overwhelmed. I suppose that [is] the difference (J.D., p.26).

In contrast, John grew up in a home marked by parental 'alcoholism', 'mental illness', 'poverty', 'deprivation' (all p.4), 'neglect', 'emotional abuse', 'verbal abuse' and 'sexual abuse' (all p.9). By the time he reached his teens he was using alcohol himself to cope 'alcohol made me feel really good' (p.9). By his

late teens John realised he ‘had a problem with drink’ (p.11) and although he started attending AA meetings giving up alcohol brought John face to face with the mental health problems that lay underneath. By the time he was 22 John was living alone in Dublin ‘with no friends, isolated and no qualifications or no education’ (p.12). It was during this time that he first attempted suicide:

The hopelessness of life - why struggle through all this? What was the point? What was the point of all this torture? You know, constantly not having money, having no support and not knowing how to live, not knowing how to integrate and seeing, just seeing people that I went to school with go on to college and get on with their lives whereas I was really stuck in a rut (p.12).

In the years since this low point John has struggled to build a ‘new life’ (p.24) for himself. Although his Herculean efforts have brought him from the stage he described above to a place where he is in the second year of an honours degree in university, John still struggles with his mental health. He is still ‘desperately trying to break’ (p.33) the cycle of poverty and abuse he was born into and described the constant work his mental health requires on a day to day basis. John says ‘I still carry a lot from that, from my upbringing’ (p.32) and feels ‘I have a long way to go’ (p.27) before he can move beyond the struggle he currently experiences.

A second factor that appears to separate those who experience narrative wreckage from those in the post narrative phase is the length of time that has passed since the student’s last crisis/interruption. Many students experience(d) more than one crisis – reflecting the cyclical nature of developmental journeys. One noticeable factor about students in the post narrative phase is that they described a degree of space between them and ‘it’ in its most critical form. For example Leon introduced himself as someone who ‘suffer[s] from paranoid schizophrenia’ (p.1) yet it has been more than 20 years since he experienced a psychotic episode. In that time he has, with the help of medication, learned to manage ‘it’, become a parent, returned to education, re-built his life, set up a charity and is now in the first year of his degree at university. Leon says ‘it has been a long road, but I’m getting there’ (p.8) and now describes himself as ‘happy’ (p.11). Completing the four years and getting his degree, for Leon,

‘would really be a dream come true. It would be, you know, it really would’ (p.23).

Louise, in contrast to Leon, has enjoyed less of a distance between where she currently is and, taking an objective milepost, her last hospital admission. As explored in section 5.5.14, although she has embarked on a path to achieving her goal to become a qualified nurse, Louise still struggles with her mental health and the impulse to harm herself: ‘I my head still if it came to it I would take the chance [and take an overdose] and hope in some way I wouldn’t lose everything’ (p.73). ‘It’ very much over-shadows Louise’s lived experience where time appears to have offered Leon some space in which to build up a life between him and ‘it’.

A third factor which appears to have scaffolded students through narrative wreckage and into post narrative is the social support they received – particularly the support of their parents and immediate families. Alicia says the support of her parents, particularly her mother who had experience depression herself, ‘was really helpful actually’ (p.11). When Alicia first began to experience anxiety and depression in her early teens she spoke to her parents ‘and they understood it and straightaway we got on it and went to the GP who referred me on to the psychiatrist’ (p.17). Alicia described how her parents would empathically support her through panic attacks and she says ‘they never stopped trying to think of things that could help’ (p.11): ‘Just knowing that they were there was a major part of it’ (p.11).

It terrifies me the thought of people who have to go through it without strong family support. Like I don’t know how they do it, you know, it’s terrifying to think about it (Alicia, p.10).

In contrast, Adrianna described living amidst her parents tumultuous relationship. She and her mother moved ‘countries about every year, it was usually because of my father, so my mom would take me and kind of move away and then she’d change her mind and go back and go back and so forth’ (p.3). Eventually Adrianna and her mother settled in Ireland but continued to move around within the country with her parents finally going through a painful divorce. Throughout this time Adrianna struggled with anxiety, self

harm, depression and eating disorders. In direct contrast to Alicia she says the first time she went to her mother to ask ‘to see someone’ (p.9) she was told ‘No you don’t, you don’t need to talk to anyone, you know, just get over it, you don’t have problems, you’re 11’ (p.9).

My parents were fighting, my dad was kind of verbally abusive... I was really stressed but I couldn’t talk about it because my mom has been depressed for years and there was always that fear that she was going to hurt herself or leave or something like that so I listened to her problems and I didn’t talk about mine (Adrianna, p.9).

The severity and/or complexity of ‘it’, the time and space between the student and the most recent crisis/interruption, and the level of social support they had access to all appear to be factors that influence the students’ likelihood of entering the post narrative phase. Other elements that students in the post narrative phase spoke about included that sense that ‘you learn to manage it, you learn to live with it and if you make the changes, the lifestyle changes like I did, you can nearly eliminate it, you know’ (Joseph, p.29). Mary echoed this sentiment and, for her, making sense of it appears to have allowed her move through narrative wreckage, taking ‘it’ along with the understanding that it is ‘just part of me’ (p.39).

At different periods in our lives we go through different difficulties and they are going to be heightened. The thing that heightens for me is anxiety. It’s a human emotion, it’s not something that defines me. It’s just one tiny little part of me that I now understand. I’m not angry that I have it, or I’m not upset that I have it, it’s just something that I deal with (Mary, p.13).

In addition to learning to live with it and coming to terms with it, as described by Joseph and Mary above, Kinsley’s post narrative phase was founded upon a sense of progress. Kinsley described how following ‘one hell of a psychotic episode’ (p.5) in the summer after his third year in college, he embarked ‘on the path of recovery’ (p.15) with the support of his parents and his psychologist. He spoke about how he took a year out of college and began ‘working every week towards this recovery’ (p.16) during which time he ‘started getting joy back into my life a bit again’ (p.18). Now back in college Kinsley says the ‘last semester was a big success’ (p.18). However, he takes

care to add that ‘that being said what happened is still very much with me you know’ (p.20). He described ‘this completely new relationship’ (p.20) with his mental health and says that ‘it’s not something that you can establish and then that’s it – you have to continue, keep with it, you know?’ (p.20): ‘Now I know where it can go if things go wrong’ (p.20).

I think for me personally, I’m sure it’s different with people with kind of more, you know, permanent issues and stuff, but for me I have only had one isolated incident, so far anyway, and just trying to, trying to move on as much, you know. I mean a lot of time has passed since then but just keeping it as far away as possible in everything I can do, you know (Kinsley, p.22).

Creating distance and ‘keeping it as far away as possible’ require, in Kinsley’s view, commitment to looking after his mental health. He thinks ‘something everyone should do is to look after their mental health’ but adds ‘I suppose when you actually have experience with it you obviously, you’re more awakened to that necessity’ (p.28).

Perhaps the most critical point to present in relation to the post narrative phase is the sense which underlies the stories of students in this phase that ‘it’ has not gone away. The students acknowledge how they have to manage ‘it’ and outline the precautions and adjustments they make to accommodate it in their day to day lives. Each story contained a ‘if it comes back’ clause as each student was not blind to the fact that they may confront crisis in their future.

For example Kinsley described how ‘if I ever come across an event like, oh I don’t know, like bereavement or unemployment or anything like that’ he ‘will take precautions’ and go back in ‘a small dose’ (p.22) of anti-psychotic medication. He also says he ‘knows all the warning signs now as well’ (p.22) which he feels will enable him to anticipate and respond more quickly and effectively should he ever experience another psychotic episode. Kinsley and the other students currently in post-narrative phase were under no illusions as to volatility of their situation. However, for these students ‘it’ was something that could be managed and integrated into the greater context of their otherwise entirely ‘normal’ lives.

5.7 Conclusion

This chapter presented an overview of the findings that emerged from the analysis of data generated as part of this study. Divided into four main sections the chapter explored the data relating to students' experiences of each of the four narrative plot phases – 'pre' narrative, crisis/interruption, narrative wreckage and 'post' narrative. 'Pre' narrative examined the features of the students' lives before 'it'; features they felt played a part in 'its' development. Adverse childhood experiences, difficulties in school, perfectionism, existential thinking, as well as the sense that there was no 'reason' for 'it', all featured in this stage. The second phase explored both the wider landscape of crisis/interruption as well as the features that punctuated this landscape – namely self harm and suicidal ideation/attempts. This phase also included a deeper exploration of what 'it' was actually like in all its many forms. The third phase presented the narrative wreckage landscape and its features. These features were grouped under three headings – intervention, higher education and living with 'it'. The fourth and final section of this presentation of findings chapter was concerned with the 'post' narrative phase. It surveyed the 'post' narrative landscape and took in the features that appear to separate students in this phase from those still in the midst of narrative wreckage. The findings presented in this chapter, and their wider implications and meanings, will be explored in the next chapter, chapter six 'Discussion'.

6. Discussion

6.1 Introduction

This study set out to understand (a) the lived experience of third level students with mental health problems and (b) the meaning these students ascribe to their experiences. It is all about understanding and understanding two things in particular – lived experience and meaning. In light of this, this discussion chapter will begin by attending to what it actually means to understand.

Polkinghorne (1983) suggests that there are two ways of understanding – ways that may be distinguished but not entirely divorced. The first of these, is understanding with a small ‘u’. This form of understanding represents any type of comprehension, including the comprehension of physical relationships (e.g. ‘I understand why the ball falls’), and mathematical relationships (e.g. ‘I understand that one plus one makes two’). The term ‘Understanding’ (with a capital ‘U’), in contrast, refers to a very specific type of understanding – the understanding of meaning (e.g. ‘Do you understand what she meant by that?’). This form of Understanding is neither inductive nor deductive, rather it is generated through ‘a to-and-fro movement from part to whole and back to part again’ (Polkinghorne, 1983, p.217) (i.e. the hermeneutic circle). The ‘richest source of information’ for researchers who seek to Understand, comes in the form of ‘linguistic expressions’ (Polkinghorne, 1983, p.264) in their written and oral forms. The researchers task is to collect these linguistic expressions, examine and ‘abstract the “flow of meaning”’ and ‘form it into concepts which can be represented’ (Polkinghorne, 1983, p.217). The first two of these three steps form the focus of the earlier chapters of this dissertation. The latter step, that of forming the meaning abstracted into concepts that can be represented, began in chapter five, ‘presentation of findings’, and will be taken up in earnest in this discussion chapter.

The earnestness of this discussion is limited, however, by the constraints of the PhD structure which determines the ‘space’ which the discussion can fill. Word

count limits require a focus on those elements of the abstracted ‘flow of meaning’ that specifically relate to the thesis’ original contribution to the field. As such, the discussion will pertain more specifically on the meaning students ascribed to their experiences (the second research question) which, in itself, leans heavily on the students’ lived experiences (the first research question). Beginning by exploring the concept of meaning itself, the discussion will examine the role of culture in shaping how the students made sense of their experiences. It then turns to the manner in which students structured their experiences into meaningful wholes, paying particular attention to the narrative structure that emerged in this study. The latter half of this discussion chapter considers each phase of the narrative plot and what each can reveal about how the students made sense of their experiences of psychological distress.

6.2 Meaning

As human beings we strive to order the world around us so as to create a sense of control over the chaos that is existence. Perhaps the most basic way in which we do this is through the construction of accounts or stories which help us make sense of the world and our experiences within it. By structuring our often diverse experiences into a coherent narrative we can create order and ‘make sense’ of these experiences, which in turn lends itself to a sense of control over, and security within, the world in which the experiences occurred. Making sense of experiences is to ascribe meaning to these experiences and story, or narrative, is ‘the primary form by which human experience is made meaningful’ (Polkinghorne, 1988, p.1). As Mishler (1986) points out ‘telling stories is one of the most significant ways individuals construct and express meaning’ (p.67).

Meaning making is a process. It is a process that involves ‘noting the contributions that actions and events make to a particular outcome and then [configuring] these parts into a whole episode’ (Polkinghorne, 1988, p.6). To put it more simply the meaning of an experience is produced by the part it plays in a greater ‘whole’. Our role as meaning-makers is to order, relate and/or connect experiences into a meaningful whole. We do this ordering and

connecting through narrative – narrating experiences into meaningful entities, either in our own minds or in recounting our ‘story’ to others.

We learn to create meaning from a young age. Neuroscientist Antonio Damasio (1999) suggests that ‘consciousness begins when brains acquire the power, the simple power I must add, of telling a story’ (p.10). The tools we need to create meaning are ‘already “there”, deeply entrenched in culture and language’ (Bruner, 1990, p. 11). Our culture offers us a shared set of beliefs, norms and values which teach us ‘how to think about and act in our life worlds’ (Kleinman, 1988, p. 5). It offers us ways of making sense of experiences, such as the experience of illness, and ‘thus we can say of illness experience that it is always culturally shaped’ (Kleinman, 1988, p. 5).

Cultures determine what meaning is attributed to experiences and actions by imposing structures of categorisation based on normative criteria. The individual’s sense of reality is thus determined by the internalisation of these cultural constructions which occur through the medium of language and ensure continued adherence to the established social order.

(Crowe, 1998, p. 341)

The established social order plays a large part in determining the ‘structures of categorisation’ by which we make sense of experiences. As seen in chapter three, we, as a society, have interpreted the experience of ‘madness’, over time, as possession by evil spirits, punishment by the Gods, moral weakness, social deviance, degeneration, biochemical imbalance, learned behaviour, maladaptive thinking, the effects of past traumatic experiences and, more recently, faulty genes. Each mode of interpretation reflects the dominant cultural beliefs, values, norms and social order of each period in time.

Currently, we live in a society in which ‘health and mental health care...are embedded in Western science and medicine, which emphasize [sic] scientific inquiry and objective evidence’ (US Department of Health and Human Services, 2001, p. 25). It is a society that appears to prize ‘the self-correcting features of modern science’ (US Department of Health and Human Services, 2001, p. 25) over ‘the swampy lowlands of human experience’ (Barker et al., 1999, p. 1).

The 'structure of categorisation' (Crowe, 1998, p. 341) offered by biomedical explanations of mental distress can be a very helpful means of making sense of the experience of mental health problems. Lindlow (1996) suggests it can relieve a person of feelings of guilt and blame. Ella spoke about this eloquently when she said 'seeing it as an illness is the only way to stop yourself from going crazy' (p.22). The medical model not only offers Ella a way of making sense of 'it', but also prevents a situation where 'you either blame yourself, or worse, blame your parents' (p.22). For Ella, 'the only way to stay sane is to go 'it's an illness, it's no one's fault'' (p.22). Ella was by no means alone amongst the students who took part in this study in making sense of 'it' in this way. Indeed, other studies too have highlighted the manner in which those experiencing distress that lacks a physical basis, use medical frames of reference to create a 'self-protective narrative' (Casey & Long, 2003, p. 93; Nettleton, 2006; Peters, Stanley, Rose, & Salmon, 1998). Nettleton (2006), in particular, notes how making sense of 'unexplained symptoms' in biomedical terms reflects the way in which our sense-making is 'not only shaped by contemporary society but, in many respects, is emblematic of it' (p. 1167).

While biomedical conceptualisations can serve as a reassuring structure upon which to frame experiences, they have also been critically described as 'dehumanising' (Fisher, 1999, p.131), 'reductionistic' (Kleinman, 1991, p.143) and even 'little more than an ideological security blanket' (Barker et al., 1999, p. 5). Davidson (1998) feels that 'it is much easier to call experiential suffering and its results 'illness' and treat them as such' (p.59). However, few students in this study appeared to subscribe solely to the biomedical framework of explanation for their distress. Instead the majority of student participants identified 'the science' (Claire, p.9) as one of many factors shaping their understanding of their experiences. Overall, the greater number of students incorporated biomedical explanations as one of many explanations for the complex phenomenon of psychological distress.

Perhaps what is interesting to note is that the degree of emphasis placed by the student on the biomedical model as a means of explaining their distress, seemed to relate to their course of study. Students who were studying science-related courses were more likely to place greater emphasis on the role of

biology in shaping their experience – regardless of the ‘disorder’ they described experiencing. For example, Claire, a second year science student, feels her anxiety and depression are ‘a medical thing, like a clinical thing’ (p.9). She described how ‘when I was diagnosed with depression, straight away a big weight felt lifted because, it was just, it’s not just how I feel, it’s like, it’s something wrong with me and I can be fixed’ (p.11). Claire described how medication is ‘a good approach for me’ as it appeals to her ‘scientific mind’ and feels it’s ‘an actual cure for what’s going on’ (p.12). Marie too described how she ‘wasn’t completely averse to the idea’ of taking medication for her depression and says that this is ‘because, I suppose, studying science, I wouldn’t be...you know, depression has a biological side to it’ (p.21). James, a science PhD student, also spoke about how, for him, his bipolar disorder is an intricate balance of ‘chemical imbalance’ and ‘lifestyle’ (p.32) and he appears to focus his energy on using the latter to balance the former.

In contrast, Kinsley, an arts student, described how he left hospital after experiencing a psychotic episode with ‘this sense that my leg was broken and now it was fixed again. I was just making sure I didn’t break it again’ (p.15). However, he felt that this understanding didn’t reflect ‘the immensity of what had just happened’ (p.9) and he quickly learned that ‘episodes of mental health aren’t sorted out that easily’ (p.9). For Kinsley, it was meeting a counsellor who ‘made me look at it [in] a way I hadn’t looked at it all before’ (p.15) that helped him begin the process of making sense of his experiences in a more meaningful way: ‘It was trauma, it really was, you know...the absolute madness that was felt, you know, I mean that was all quite traumatic’ (p.15). Sophie too spoke about how the support she was provided as a teenager with depression and anxiety was ‘very much on the medical side of things and my actual stuff wasn’t being dealt with’ (p.8). She described how it is ‘very important for me to get to the bottom of it’ (p.18) and found more clinical approaches ‘unhelpful, because I wanted to know, it was very important for me to see the causes [of her distress]’ (p.18): ‘I really needed to see what had caused this fall from grace...once I found someone who would work with me to do that I found it very, very helpful’ (Sophie, p.18).

What appears to be most important in these cases is not which structural framework is more 'right' but which one makes more sense to the individual. Perhaps it is coincidental that students with a more scientific orientation to the world adopt a more science-based structure of categorisation, and students more inclined to study arts-related subjects gravitate towards what Helman (2007) refers to as 'cultural and symbolic healing approaches' (p.272) with an emphasis on understanding what it all means. However, the key, it appears, is finding a way to make sense of 'it' that appeals to, or reflects, the student's existing personal and cultural frames of reference.

6.2.1 Structuring experiences into meaningful 'wholes'

Structure is the foundation of meaning. It 'makes individual events comprehensible by identifying the whole to which they contribute' (Polkinghorne, 1988, p. 18). Bruner (1990) notes that 'people do not deal with the world event by event or with text sentence by sentence. They frame events and sentences in larger structures' (p. 64). Plot is the narrative structure by which individuals order and connect life events and decisions into meaningful wholes. Or, as Charon and Montello (2002) put it, 'plot is meaning' (p.81).

Plots function to compose or configure events into a story by: (a) delimiting a temporal range which marks the beginning and end of the story, (b) providing criteria for the selection of events to be included in the story, (c) temporally ordering events into an unfolding movement culminating in a conclusion, and (d) clarifying or making explicit the meaning events have as contributors to the story as a unified whole.

(Polkinghorne, 1995, p. 7)

Disciplines such as narrative analysis and narratology study aspects of narrative structure such as directionality (Gergen & Gergen, 1983), motive (Burke, 1969) and form (Bruner, 1987). However, for the purposes of this discussion the focus will be on how the structure of stories people tell can reveal much about how they make sense of the experiences contained within those stories. Indeed, Polkinghorne (1988) reminds us that 'the goal of research into the production of meaning is to produce clear and accurate descriptions of the structures and forms of the various meaning systems' (p.10). To understand how people make sense of experiences, we must look at how they tell their stories – how they impose structure on the flow of their experience.

As outlined in chapters four and five, very early on a pattern emerged in how the students structured their experiences. In terms of emplotment, the structure drew on the more basic aspects of plot – temporality and causality. However, what it revealed was the students made sense of their experiences in terms of it being ‘a journey’ (Niamh, p.35). Making sense of illness as a journey goes back as far as John Donne (1624/1959) who, in his text ‘Devotions Upon Emergent Occasions’, recasts his illness, probably typhus, as a spiritual journey. Friedrich Nietzsche (1882/1974), who suffered with a range of undiagnosed chronic health problems, described his pain as a dog with whom he journeyed through life: ‘I can scold it and vent my bad mood on it, as others do with their dogs, servants, and wives’ (p.250). Frank (2013) talks about how in calling his pain ‘dog’, Nietzsche renders a new relationship with the illness. By describing their experiences as a journey, with a beginning middle and ‘a sense of an ending’ (Kermode, 1967), the students too were negotiating a new relationship with the phenomenon and their experiences of ‘it’.

Perhaps the most famous account of the narrative structure of a journey is that of Joseph Campbell in his classic work ‘The Hero With a Thousand Faces’ (2004). While Campbell’s monomyth has been criticised as ‘a New Age spice sprinkled indiscriminately to season almost any experience’ (Frank, 2013, p. 117) it nevertheless represents a powerful form of reflexive monitoring.

Although consisting of 17 stages, Campbell’s hero’s journey can be reduced to three main phases, mirroring the basic beginning, middle and end narrative structure. The first stage is ‘departure’, beginning with a call to action. In the case of illness stories, Frank (2013) suggests the call is the symptom. When this call can no longer be denied or refused, the individual crosses what Campbell (2004) calls ‘the first threshold’ (p.71). Crossing the threshold begins the second stage, ‘initiation’ and begins the journey along ‘the road of trials’ (Campbell, 2004, p. 89). The end of this journey is marked by what Campbell calls a ‘boon’ or a learning, blessing or benefit that is bestowed upon the ‘hero’ which they, in turn, must bring back and share for the benefit of human kind. This bringing back marks the third and final stage, ‘the return’. The hero, particularly in the case of illness narratives, now joins what Schweitzer (1990)

calls the ‘brotherhood of those who bear the mark of pain’ (p.195), becoming ‘master of the two worlds’ (Campbell, 2004, p. 212).

Although the narrative plot that emerged in this study varies considerably from Campbell’s monomyth structure it does share with it an emphasis on ‘the call’, unwelcome as it may be, to action, and the idea that the only way out of the ‘agony’ (Campbell, 2004, p. 148) is through. It shares an emphasis on the narrative structure of a journey with distinct phases and a sense of an ending that cannot be predicted, known or planned for. However, in the case of the journey of those who experience mental health problems there may be no ‘boon’ to bring back or, if there is, no sense of there being a place to bring the learning back too. This was something a number of the students highlighted as being what this research study offered them – a space to share their experience, be listened to without interruption and the knowledge that their story may, in some way, help another. In response to the check-in emails sent to each participant after every interview, a number of students commented on this: ‘I really feel listened to and I appreciate that so so much, so thank you’ (Thomas)/ ‘I appreciate you taking the time to listen to my story’ (Marie). As Ella pointed out in her check-in email, ‘it can be frustrating at times having to put a lot of energy into an area of my life that I can’t put on a C.V.’. The research interview offered her a rare space where the extent of her perseverance and effort could be borne and acknowledged. However, what many students sought, perhaps more than somebody to bear witness to their journey, was a sense that what they went through, and what they learned, might in some way help another who may be going through a similar experience.

That’s why I volunteered to do this, because like, having lived with mental health since I was 17, I have 24 years of suffering...I would feel so happy if I could help even one person out there to avoid the mistakes I made... I’m hoping that other people do not have to suffer like I did.

(Joseph, p.28)

6.3 The narrative plot

The structure that emerged in this study, as previously discussed (chapters four and five), consists of four phases. ‘Pre’-narrative, the first of the four phases,

represents the students' reflections on their lives before 'it'. Crisis/Interruption marks the point at which 'it' makes its presence known. The third phase, narrative wreckage, sees the student engage in the process of examining the wreckage of the narrative they had been constructing about themselves and their being-in-the-world and begin to construct a new narrative that incorporates 'it'. The fourth, and final phase, relates to the 'post' narrative – the space beyond narrative wreckage where the student has managed to build or 'salvage' a sense of who they are and where they stand in relation to 'it'. What follows is a discussion around what we can learn from the landscape of each of these four phases. Beginning with 'pre'-narrative, each phase will be discussed in terms of what it reveals about the nature and meaning of psychological distress. The section will then conclude with a review of what the narrative structure overall can tell us about how the students in this study made sense of their experience, as well as a discussion on the role of meaning in recovering, or 'moving-on', from experiences of psychological distress.

6.3.1 'Pre'-narrative

Each of the four phases of the narrative plot reveals something about how the students made sense of the phenomenon of psychological distress. However, the pre-narrative phase is unique in that, in addition to illuminating the elements that the students retrospectively felt contributed to 'it', the data highlighted the manner in which the approach taken influenced *what* the students revealed. To return to Diogenes' anecdote (chapter two), the lamp chosen in this study shed light on the phenomenon in a way that allowed for meanings and experiences that often lie in the shadow of pre-emption, to be illuminated. The approach's open nature meant that what could be 'seen' was not pre-ordained by the hypothesis being tested, but rather created a space where the students themselves could speak about what *they* felt was important. The first of the study's two research questions, what is the nature of the lived experience of third level students with mental health problems, acted as the only, albeit broad, frame within which participants were asked to shape their accounts of their experiences.

While a number of the features that punctuated the pre-narrative landscape were, in many respects, recognisable (e.g. childhood trauma, bullying,

difficulties in school), other more subtle, yet significant, features such as perfectionism, existential thinking and the sense that there was ‘no reason for it’, also had the space to show themselves. The latter feature, in particular, goes against the grain of conventional understandings of mental dis-ease. A search of literature and online databases failed to bring up a single study devoted to there sometimes being no reason for ‘it’. Yet, seven of the students spoke explicitly about how they couldn’t identify a reason for their distress and how this directly impacted their experience of the phenomenon as well as their ability to make sense of it.

Perhaps even more alarmingly, those around the students who found it difficult to come to terms with the fact that there may be no ‘reason’ for it, themselves sought to apply ‘reason’ to the situation. This was something Alicia and Kate spoke about, with Kate in particular describing how one mental health professional she worked with really struggled to accept that there was no distinct cause for her eating problems.

I haven’t a clue why I have an eating disorder. [...] I had one therapist who refused to believe that I wasn’t abused. She said ‘until you can admit it, you are never going to get better’. She would give me books about not remembering being abused and I was like ‘But I wasn’t fucking abused!’

(Kate, p.23)

The need to apply a cause to an effect reflects a wider, mechanistic, world view (Pepper, 1942). With roots in Cartesian philosophy, the mechanistic world view, as described by Pepper (1942), has played a dominant role in shaping Western culture, values, and scientific thought (Lyddon, 1989). Mechanism, in the meta-physical sense, is the belief that natural wholes (particularly living things) are like complicated machines composed of discrete parts related to other parts in some systematic way (Pepper, 1942). This world view sees events as the products of the transmittal of forces (Pepper, 1942; Sarbin, 1986). As Sarbin (1986) points out, ‘modern science has taken this world view as its metaphysical foundation – a view that supports the scientist’s search for causes’ (p.6). Psychiatry, psychology and to a certain extent, sociology, all operate from within the mechanistic world view (sometimes referred to as ‘the technological paradigm’ (Bracken et al., 2012)). It is a view that shapes much

of how we think about the world – one that we rely on particularly when things ‘go wrong’. Negative effects, such as life-threatening anorexia and bulimia in Kate’s case, that do not have an apparent cause, threaten our very way of being-in-the-world. Kate, J.D., Fiona, Annie, Sarah and Claire all spoke about how difficult it was to experience a problem, or an effect, without a recognisable cause. It was difficult, not only for them, but for those around them. We all need a sense that things happen for a reason and when they don’t, or when we struggle to name that reason, it generates a degree of existential uncertainty (Adamson, 1997).

Adamson (1997) suggests that ‘the normative assumption’ within mechanistic, scientific, approaches, is that the uncertainty around the cause of distress ‘will be overcome by the eventual discovery of new findings, rules, laws, methods, procedures, experiments’ (p.135). However, in spite of considerable research into biological, neurological and genetic sources of mental distress, ‘in most cases, no one is sure precisely what the cause of a mental health problem is’ (MIND, 2016, p. 12; Thomas, 2014). The findings of this study support the view of those who feel we need to adopt a hermeneutic approach to mental health (Bracken, 2015; Bracken & Thomas, 2005; Bracken et al., 2012; Kleinman, 1991). It suggests that, instead of searching for the ‘causes’ of distress in increasing reductions of our nervous system or DNA, we ought to step outside the comfortable familiarity of the mechanistic world view and into what Pepper (1942) describes as a contextualistic world-view.

Contextualism, with its root metaphor of history, or as Sarbin (1986) proposes, narrative, emphasises the manner in which context is central to our actions, judgements and inferences about the world (Price, 2008). Existential, including hermeneutic, phenomenology is very much aligned with the contextualistic world-view proposed by Pepper as is represented by its most fundamental concept being-in-the-world. The contextualistic worldview reiterates the point that human beings cannot be separated from the world in which they exist. That the world itself is part of the fundamental constitution of what it means to be human. However, its emphasis on interpretation and uncertainty means that, ‘to those steeped in the traditions of mechanistic science, traditions that emphasise order, predictability, and causality, contextualism at first appears chaotic’

(Sarbin, 1986, p. 6). It is challenging to those of us who find safety and solace within the predictable and consolable mechanistic world view. But, as Bracken (2015) reminds us, if we are to effectively and empathically open to the phenomenon of psychological distress, in all its unpredictability, we must learn to tolerate ambiguity and uncertainty. For it is through opening up, and turning towards, that we create the possibility of finding ‘the value and meaning of emotional discontent’ (Davies, 2012).

6.3.2 Crisis/interruption

The crisis/interruption phase represents the point at which ‘it’, each student’s particular form of psychological distress, makes its presence known. It is the point at which ‘everything fell apart’ (Kate, p.6). As a phase in the narrative plot, crisis/interruption reveals much about *how* things ‘fell apart’. It sheds light on the subtle but critical points in the overall ‘journey’ – the point at which the student first became aware that something was ‘wrong’; their attempts to assign words to often unknown experiences and, then, how, and to whom, they went about articulating these experiences to in order to get help and support.

While each student’s experience of crisis/interruption unfolded uniquely, a number of striking patterns emerged in how the distress ‘builds’ (Millie, p.7) and becomes a recognisable entity in the students’ lives. The first of four patterns revealed how, for a number of students, ‘it’ slowly crept into their lives; its onset and progression almost undetected, ‘like ageing’ (J.D.): ‘You don’t even notice yourself getting worse’ (p.12). This silent progression continued over often an extended period of time, until ‘all of a sudden’ (Claire, p.9), something happens to draw ‘it’ out into open consciousness. A number of students described how it took them reaching ‘breaking point’ (Ella, p.9) to realise that something was wrong. It was almost as if these students needed to reach crisis point before they ‘would have ever accepted that this is a problem’ (Mary, p.14). However, this is particularly risky, especially for those students whose crisis point was the point they realised they ‘just didn’t want to live anymore’ (Sarah, p.11). Students who follow this first pattern represent those for whom early intervention would potentially prevent the distress associated with having to reach crisis point.

I think if I had gotten help earlier I wouldn't have gotten as bad and that means that I would've gotten rid of it sooner (J.D., p.34)

The case for timely and appropriate intervention is strong amongst these students, particularly those for whom crisis point represented thoughts about ending their lives. As Kessler et al. (2005) point out, 'given the enormous personal and societal burdens of mental disorders...[there ought to be] a focus on early interventions aimed at preventing the progression of primary disorders and the onset of comorbid disorders' (p.601). Kessler et al. (2005) continue by citing the statistic that approximately 75% of mental disorders emerge before the age of 25. Much emphasis has been placed on how the mental health system is weakest where it needs to be strongest (Headstrong, 2013; McGorry, 2007) yet, for the students in this study, systems and support were things that they could only access when they were aware that they had needs which could and/or ought to be supported. This gap was particularly evident amongst the students in the second grouping.

The second pattern by which crisis/interruption unfolded was the 'interruption' pattern. For these students 'it' was something that they had come to think of as part of them and who they were: 'I just thought it was me, that it was my fault. I'm feeling crap because I'm a bad person' (J.D., p.11). For students in this category it was only when someone, or something, drew their attention to the fact that what they were experiencing wasn't 'just me, this was just how I am' (Marie, p.3) but rather something more than that. For students in this group, someone (teachers, parents, tutors, friends), or something (a talk, a TV documentary), 'interrupted' the story they had been creating to make sense of 'it'. It was only after this interruption that the students began to see 'it' for what it was - 'a problem' (Marie, p.20).

In even the few years since Marie and many of the younger students who participated in this study would have been in school, a greater emphasis has been placed on the role of schools 'in the promotion of positive mental health in young people' (Department of Education and Skills, Health Service Executive, & Department of Health, 2013, p. v). In the 2013 'Well-Being in Post Primary Schools: Guidelines for Mental Health Promotion and Suicide Prevention' the Department of Education and Skills emphasise the role of the

Social, Personal and Health Education (SPHE) programme in increasing ‘levels of emotional literacy amongst students’ (p.21). However, some research suggests that insufficient time is given to the SPHE programme in schools and the subject is viewed as less important than examination subjects and therefore loses out in terms of time and resource allocation (NicGabhainn, Barry, O’Higgins, Galvin, & Kennedy, 2007). Wellbeing as an individual subject is due to be introduced as part of the new Junior Cycle reforms, starting in September 2017. This subject is set to ‘incorporate learning traditionally included in PE, SPHE and CSPE’ and will ‘provide learning opportunities to enhance the physical, mental, emotional and social wellbeing and resilience of students, and to enable students to build life-skills and to develop a strong sense of connectedness to the school and to their community’ (Department of Education and Skills, 2015). However, as the course curriculum is currently in the early stages of development, it is not year clear if the increased emphasis on wellbeing and whole school approaches to mental health will offer ‘interruptions’ to the narratives Marie, J.D. and the others described creating about themselves and their struggles.

A third pattern, described by five students, represented an accelerated version of the first. Instead of a slow, ‘creeping’ (J.D., p.12), onset, ‘it’ burst into the student’s lives in a rather more ‘thunderous’ (Kinsley, p.4) manner. Alicia and Joseph described how their first panic attack came ‘out of the blue’ (Alicia, p.2) and began a battle with anxiety that would pervade these student’s lives over the years that followed. One of the most challenging aspects for these students was their struggle to ‘pinpoint’ (Alicia, p.2) what triggered this sudden onset. Kinsley and Leon, in contrast, link their respective psychotic episodes to heavy cannabis use as young men going through a time of stress and/or transition. Thomas also described a rather rapid escalation to crisis, one he associates with the pressure he faced as he entered his leaving certificate year in school.

The fourth and final pattern that emerged in how the students’ described their experience of crisis/interruption, related more specifically to those students who described a childhood laden with adversity. Adrianna, Louise and John each described experiencing the pain and turmoil of neglect and abuse. For

these students, crisis point was represented by an overwhelming sense of ‘the hopelessness of life’ (John, p.12) and the struggle to find the will to carry on. The needs of these students were deeper and more complex, and their subsequent journeys represented the manner in which crisis is not something that happens just once in people’s lives. For these students, and many of those who were described in the previous three patterns, crises would unfold time and again over the course of their lives. Students in this group remind us that human beings rarely follow linear narrative plots, much as we would like them to, and that ultimately ‘life is a messy business’ (Plummer, 2001, p. 78).

The four patterns that emerged in how students described their experience of the crisis/interruption phase reveal much, not only about how this stage unfolded for them, but also how they made sense of the experience. The first group describe a slow and silent onset, often marked by attempts to ‘ignore it’ (Annie, p.3) or ‘cope with it’ (Millie, p.7), until ‘it’ becomes overbearing and the student reaches ‘breaking point’ (Ella, p.9). These students spoke about how, in hindsight, they feel they needed to reach breaking point before they could see it for what it was and do something about it: ‘Sometimes it takes something really big to realise that you really do need help’ (Fiona, p.15). They appear to have made sense of it as something that had to happen, a ‘call to action’ that needed to be heard loudly before it could be responded too. For those in the second pattern the call to action came from someone or something external to them. This call ‘interrupted’ their way of making sense of ‘it’ in relation to their being-in-the-world. The students in the third pattern described a much more abrupt experience of crisis. Some of these students were able to articulate the factors that led to this rapid onset crisis while others struggled to ‘pinpoint’ (Alicia, p.2) what was behind ‘it’ – a struggle that added to the distress overall. The students who described the fourth pattern appear to perceive their initial crisis as a build up of distress and adversity until they reached a point at which they ‘ended up snapping’ (Louise, p.29). However it unfolded crisis/interruption represents the point at which ‘it’ becomes acknowledged as ‘a problem’ (Marie, p.20) - one that needs to be named and addressed.

6.3.2.1 *Articulating experiences and asking for help*

With the exception of those students' whose narratives were interrupted by somebody who pointed 'it' out to them, participants spoke about the challenge of identifying something was 'wrong', naming 'it', and then formulating the words needed to convey 'it' to others. Marked by four stages, or hurdles which the student must overcome, the process of articulating experiences and seeking help is subtle, yet of profound consequence. The student must identify something is 'wrong', name that 'something', and then figure out who to consult in order to 'right' their 'wrong'. Then, they must finally find the words to describe their distress in a way that can be understood by the mental health professional sitting across from them. The first step, however, is to recognise that something is 'wrong'.

The complexity of this step alone is reflected in the stories of the five students in the interruption category who had to have it pointed out to them that what they were experiencing was more than 'just me, this was just how I am' (Marie, p.3). J.D. described how it wasn't so easy to identify something was wrong:

The problem is it's so slow creeping up on you. People think that it's like the flu, you're fine one day, you're sick the next. It's not - the awful thing that happens is it takes months. It happens so slowly that you don't even notice yourself getting worse; it's kind of like people aging. If you're with them every day you can't see it, but if you don't see them for two years then you notice it.

(J.D., p.12)

In J.D.'s case, it was a friend who 'noticed it' and shared his concerns with J.D.'s parents. While he spoke about how obvious it seems in retrospect, at the time he had no idea that what he was experiencing was 'wrong'.

The second step in this process requires the student to label their experiences with the appropriate words. Frank (2013) talks about how, from a young age, those with physical health issues learn how to name these issues and how to articulate what they feel, as well as what is acceptable, or unacceptable, to share with others.

From their families and friends, from the popular culture that surrounds them, and from the stories of other ill people, storytellers have learned formal structures of narrative, conventional metaphors and imagery, and standards of what is and is not appropriate to tell.

(Frank, 2013, p.3)

This bank of sociocultural knowledge from which those experiencing physical illnesses can draw does not seem to be as available to those experiencing mental health difficulties. In generating the data, it emerged time and again how much the students struggle to describe what it was *actually like* to experience ‘it’ – whatever ‘it’ may be. For example, Sarah spoke about how she ‘couldn’t really articulate – I still can’t – what goes on for me, like, in my head’ (p.9). She spoke about how she struggles to ‘put words on it’ (p.5). This was something that Millie, and other students also described: ‘when I was going through it I couldn’t actually grasp what was going on so I didn’t really know how to explain it’ (Millie, p.7). Millie too spoke about how ‘it wasn’t like ‘oh I feel sick’ or something’ and highlighted how articulating experiences of psychological distress is considerably more complicated than telling somebody she ‘feels sick’. One of the factors that is said to impair people’s ability to articulate mental health experiences, and their confidence in sharing their experiences with others, is the stigma that surrounds mental health difficulties (Crowe, Averett, & Glass, 2015; Eisenberg, Downs, Golberstein, & Zivin, 2009). Although a number of students felt that the college environment was uniquely open about mental health, and ‘breaking the stigmas around it’ (Millie, p.24), the kind of sociocultural memory ‘bank’ of knowledge and linguistic resources we see supporting physical health problems, takes time to build.

Some researchers (Steiner, 1997) have suggested that children should be encouraged to develop emotional literacy from an early age, although this approach has not been without its critics (Ecclestone & Hayes, 2008). Moreover, establishing a standard repertoire of words to describe the experience of psychological distress is difficult, if not impossible, as reflected in the highly subjective nature of the phenomenon as well as its multiple interpretations (as outlined in chapter three). Indeed, each professional interpretation of the phenomenon comes with its own discursive repertoire. As

language shapes how we make sense of the world (Bruner, 1987; Vygotsky, 1962), adopting one particular stock of words, for example adopting the language associated with the medical model, shapes how the phenomenon is understood (e.g. as an illness). The multiplicity of understandings of the phenomenon, while reflective of its unique and complex nature, means that, unlike physical illness which come with a more standard range of words and terminology (e.g. I have a throbbing pain in my head, my ankle is bruised and swollen), a standard set of words or terms is less readily available for those who seek to describe their experience of psychological distress. This means, that for many, assigning words to their experiences that make sense to themselves, and also to others, is no mean feat.

The third step, once the student has identified what is troubling them and assigned appropriate terms or idioms to convey their experience, requires that they find who best to convey these experiences to in order to receive support. The first port of call for the majority of students in this study was their General Practitioner (n=19). However, while their GP was their first port of call, it was by no means the last for each of these 19 student participants (as exemplified in Figure 11: Negotiating narrative wreckage – Adrianna). For most students, finding what worked best for them involved attending a variety of professional services and trying a number of different approaches. For many, a combination of approaches suited them best. Marie, for example, has drawn on the support of counselling, general practice, psychiatry, medication, hospital and group therapy over the last three years and, at the time of interview, was concurrently attending her psychiatrist, taking medication and participating in group therapy. This pattern, with a variety of combinations, was repeated throughout the stories of the students who participated in this study. This again suggests that there is no ‘one size fits all’ approach to addressing mental health problems, but instead the student must try a variety of sizes and styles in order to find the one that ‘fits’ best for them. Unfortunately, however, for those who have just identified something is wrong, and found the words to convey ‘it’, this scattered landscape of supports, often marked by waiting lists, financial costs and even stigma, can be intensely challenging to negotiate.

Upon successfully negotiating these three steps the student is faced with a fourth – that of bridging the ‘language gap’ (Solomon, 2016) between themselves and those from whom they are seeking help. Ashley described how she ‘could never really explain’ (p.7) what she was experiencing when she would seek help from a health professional: ‘you go in and you desperately want someone to help so bad that you can’t communicate what’s going on so they can’t understand and then they can’t quite get there’ [in terms of offering help] (p.7). Ashley is describing the gap between her attempts to articulate her experience and the professional’s inability to locate this fragmented description within their professional frame of reference (Kleinman, 1988). For Ashley, the experience she described above occurred when she was a teenager. This failure to bridge the language gap meant that it took four years, and a trip to ‘rock bottom’ (p.18), before Ashley could finally be diagnosed with bipolar disorder and receive the support she needed. All the students who participated in this study had received help of one kind or another, with the vast majority (n=25) receiving a formal diagnosis from a Psychiatrist or General Practitioner. Therefore, all had successfully negotiated the language gap, albeit, for many, after multiple attempts. The voices that this study fails to capture are those who have fallen through the language gap. Those who have either failed to find the preordained words necessary to negotiate the divide or those whose experiential descriptions did not sit comfortably within the professional’s frame of reference.

On the other side of this divide is the professional, and students spoke time and again about the importance of feeling like they were being listened to, of ‘feel[ing] understood’ (Ashley, p.9), and feeling that the professional ‘knows where I am coming from’ (Claire, p.21). The accounts of students who didn’t experience these ‘feelings’ serve to reinforce the critical importance the role listening to understand plays in mental health – particularly, as research reminds us, as it is the non-clinical or ‘non-specific’ (Thomas et al., 2013) aspects of the therapeutic encounter, notably the quality of client-professional relationship, that are the biggest predictor of change (Jensen & Kelley, 2016; Wampold, 2001).

The students' narratives offer rich insight into the complexity associated with the seemingly straightforward task of knowing something is wrong and asking for help. Their accounts highlight a multitude of factors that must be considered by those who seek to smooth the process of help-seeking – particularly for young people. The complexity associated with negotiating the crisis/interruption landscape was, for many, just the beginning. This perplexity continued, if not intensified, as the students moved beyond the initial crisis or interruption and into the narrative wreckage phase.

6.3.3 Narrative wreckage

If narrative is the primary means by which we make sense of our experiences (Polkinghorne, 1988), there is no time when we need narrative more than during times of crisis and disruption. Becker (1997) suggests that 'when their health is suddenly disrupted, people are thrown into chaos' (p.37) and narratives offer a way of reinstating order to this chaos. Indeed, Frank (2013) suggests that illness itself is 'a call for stories' (p.53).

An illness is a major disruption to one's biography. When the body is assaulted by a serious illness, one's sense of wholeness, on which a sense of order rides, disintegrates. One must reconstitute that sense of wholeness in order to regain a sense of continuity.

(Becker, 1997, p. 39)

A number of authors have written about individuals' attempts to make sense of the 'disruption' (Becker, 1997), 'biographical disruption' (Sandelowski, 1994) and 'narrative wreckage' (Frank, 2013) afforded by physical ill-health. However, such accounts less prevalent in mental health – an area where the reconstitution of a sense of wholeness, as Becker (1997) puts it, is particularly critical. Becker (1997) suggests that 'narratives of disruption are people's efforts to integrate disruption and its aftermath with prevailing cultural sentiments' (p.15). If this is the case, the continuously shifting nature of cultural sentiments towards psychological distress, as outlined in the historical overview provided in chapter three, make the integration of experiences of mental health problems a perplexing and uncertain affair.

The narrative wreckage landscape is vast and peppered with a variety of thematic features. The presence of 18 major thematic features alone highlights the labyrinthine nature of the narrative wreckage stage of the students' stories. Listening to and carefully analysing the students accounts of this phase revealed three major elements that, like many of the elements seen in the landscapes of the narrative plot, are subtle yet critical in determining the students' trajectories. The first of these relates to the critical role of supportive others in students' attempts to make sense of 'it' and incorporate 'it' into the story of themselves and their lives. The second element spoke to the importance of turning towards 'it' and how, in order for the student to move on, with or without 'it', they first needed to face it and acknowledge its presence and significance in their lives. The third and final key element of the students narrative wreckage landscape centred on the complexity of the landscape itself and how challenging it was for students to navigate its terrain.

The level of support from those in their immediate social circle varied considerably amongst the 27 students who participated in this study. Interestingly, the seven students who appear to have moved through narrative wreckage into 'post' narrative all reported high levels of support either from parents, partners or friends.

Good relationships consistently top the list of what people with mental health problems consider most helpful when they are struggling (Wallcraft, 2002; Tew, 2005; Mental Health Foundation, 2000). Wallcraft (2002) identified respectful listening, closeness, love and practical support as the most helpful aspects of relationships with supportive others.

The presence of a supportive other is particularly important at the early stages of recovery, when people with psychiatric disabilities tend to feel more hopeless and discouraged. Ironically, consumers often hear the most despairing and discouraging messages from mental health providers when first diagnosed with a serious mental illness. A supportive relationship instilling hope slowly breaks the closed circle of despair that tends to stagnate the person and limit involvement in recovery-promoting activities.

(Rusinova, 1999, p. 52)

The presence of ‘One Good Adult’ in a young person’s life has been shown to be ‘associated with the likelihood of the young person being able to face their difficulties rather than turning away and trying to avoid them’ (Dooley & Fitzgerald, 2012, p. 95). The My World Survey (Dooley & Fitzgerald, 2012) highlighted the manner in which the presence of a supportive adult increased the likelihood that a young person would adopt active coping strategies such as problem-solving and professional help-seeking. Conversely, the absence of one good adult was associated with avoidant coping strategies where a person denies that something has happened or denies the impact it is having on him or her (Lohman & Jarvis, 2000). Moreover, the presence of a supportive adult was also found to increase a young person’s self-esteem. As Dooley and Fitzgerald (2012) point out, self esteem reflects a person’s belief in themselves and ‘has a direct effect on how they navigate themselves around the world’ (p.95). Self-esteem and active coping strategies are two, somewhat jargon-heavy, ways of describing how important the role of a supportive other is. This is particularly true for those struggling to come to terms with a mental health problem and who are trying to navigate themselves, and ‘it’, around the world that Dooley and Fitzgerald describe above.

The second key element of students’ narrative wreckage landscape, one hinted at in the quote by Dooley and Fitzgerald, highlights the importance of turning towards ‘it’. Ella, as seen in chapter five, described how to turn away from ‘it’ ‘is to turn your back on a tiger’ (p.23). For her, and for many students, narrative wreckage was marked by attempts to get away from and get rid of ‘it’. However, in the majority of cases this wasn’t effective. A number of writers have spoken about our tendencies to want to fix, cure and generally get rid of the things that cause us distress in our lives (Bracken et al., 2012; Goffman, 1961; Szasz, 1961). This is the natural response, particularly within a mechanistic world view (Pepper, 1942), but, as already discussed, mental health problems don’t sit comfortably within this model of reality. Adrianna, Sarah, Kinsley, Ashley, Niamh, Sophie and others spoke about the desire to ‘fix the problem...but it’s not about fixing the problem’ (Niamh, p.48). Instead of fixing or getting rid of the problem, students are forced, often after multiple interventions or attempts, to ‘come to terms with it’ (Annie, p.33). They spoke

about the pain of accepting ‘it’ yet described how this turning towards was an important step in making sense of ‘it’.

The third element of the narrative wreckage landscape centres on the uncertainty and chaos that permeate this phase. Figure 11 (p.182) charts the journey of Adrianna, alphabetically the first student participant on the list, through narrative wreckage. While it only captures the sources of support she sought, and offers little more than an overview of the various modes of conceptualisation she was offered, it does highlight the complexity and ‘messiness’ associated with navigating this stage.

Order, according to Becker (1997), ‘is at the foundation of structures of meaning in human life’ (p.37). Yet, there is no order to narrative wreckage. There is no ready-made structure the student can follow in order to make sense of ‘it’. It is the ‘road of trials’ Campbell (2004) spoke about and it is a road without a map. Mental health problems themselves act as a reminder of the lack of order in existence. Becker highlights how we even like our narratives, the means by which we create meaning, to follow a particular order with a beginning, middle and end. We expect ‘the event that precipitated a sense of chaos to be followed by a gradual resumption of normalcy’ (Becker, 1997, p. 38). We need an ending, or at least a sense of an ending (Kermode, 1967), in order to ‘believe that order prevails’ (Becker, 1997, p. 38). A happily ever after’ helps us feel secure in our existence yet, for many of the students, there is no ‘happily ever after’ – or at least not yet. The ending, for those few, as we will see in the next section, who have progressed to ‘post’ narrative, is often marked, not by a reinstatement of order, but a coming to terms with chaos.

6.3.4 ‘Post’ narrative

If the narrative plot that emerged in this study were to follow the ‘beginning, middle, and end’ structure of ordered narratives, the ‘post’ narrative would mark the end, or at least bring us up to the present day. In an ideal world the ‘end’ would be happy and, in mental health terms, this would be marked by ‘recovery’. Recovery has been described as a ‘polyvalent concept’ (Pilgrim, 2008) and a ‘working misunderstanding’ (Hopper, 2007) largely, according to Hopper, because of the different meanings attached to it by different

communities of interest. Clinical definitions of recovery conceptualise it in terms of the ‘alleviation of the symptoms that cause a person distress or ill health and/or a return to his or her premorbid level of functioning’ (Davidson, 2003, p. 43). This conceptualisation itself reflects the mechanistic world view from which it stems - one which sees recovery as ‘the final phase of the repair cycle’ (Goffman, 1961, p. 290). One of the most commonly cited definitions of recovery, a definition that emerged to provide the ‘guiding vision’ for recovery-oriented mental health services in the 1990’s, is provided by Anthony (1993).

Recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.

(Anthony, 1993, p. 527)

The ideas of ‘unique’, ‘process’, ‘change’, ‘hope’, ‘meaning’, ‘purpose’ and ‘growth beyond’ all permeate the students accounts of moving into ‘post’ narrative. What emerged was not the sense that they had ‘returned to’ or ‘recovered’ their previous selves, but rather had progressed and grown beyond the crisis that had so catastrophically, to borrow Anthony’s words, disrupted their lives.

A number of factors appear to separate those students in narrative wreckage from those students who described themselves as having ‘moved on’ *from* or, more commonly, *with* ‘it’. More practical indicators include the severity and complexity of ‘it’ (i.e. a single period of severe anxiety or depression as opposed to years of struggling with eating distress); the time that has elapsed since (the last) crisis/interruption, and; the level of support available to the student – particularly social support. But ‘moving on’, a term, in this case, deemed more appropriate than recovery, required much more than these three factors alone. Moving on, first and foremost, involved making sense of ‘it’. The term meaning appears in almost all definitions of recovery but it is a flesh-less and largely unexplored phenomenon. The struggle to make sense of ‘it’ is seen particularly keenly in the narrative wreckage phase. Sarah, for example, spoke a great deal about her frustration at not being able to make sense of it:

‘What is happening to me? Why is it happening? Why me?’ (p.13). This sense of uncertainty creates an ominous and somewhat hopeless outlook for her future.

If it’s been like this for this long it is probably something I am going to have for the rest of my life and that, I feel, is really hard to come to terms with. It’s hard to think that my life will be like this. It is hard for me to understand why does my life have to be like this? Why me?

(Sarah , p.28)

Millie too spoke about how ‘it’s something that I’m still trying to make sense of. I haven’t been able to completely understand why it happened. What did I do?’ (p.25).

As discussed above, ready-made frameworks for understanding provided by the various professional perspectives offer a useful structure upon which students can hang their experiences. However, in time, the students appeared to develop their own framework that incorporated elements of the various professional perspectives. James, a student who described himself as having moved on with, in his case, ‘it’, provides a good example of this. As seen in his narrative summary, James drew on his passion for science as well as his love of sport, physical fitness and performance, in order to make sense of his experiences of bipolar disorder. For him, ‘it’ was a combination of ‘chemical imbalance’ (p.32) and ‘lifestyle’ (p.32) and living with it involved a ‘management plan’ (p.30) similar to the training plans he developed as a fitness instructor. In James’ case his management plan involved the support of his family, girlfriend and friends, commitment to meditation and ‘mind management’ (p.30) as well as attention to lifestyle factors such as diet, sleep and exercise. Reading about and practicing meditation in particular has offered James the insight that sometimes ‘you don’t need to put a reason on it, you don’t need to put a rhyme on it...maybe this is your one shot...maybe now is time just to enjoy life’ (p.45).

James is a good example of another key aspect of moving on – learning to live with ‘it’/ in relation to it. The first step in learning to live with it appears to involve coming to terms with it: ‘It’s about accepting, I think first of all

accepting that this is your life' (Adrianna, p.114). Sophie described how, for a long time, she believed that 'everything will work out happily ever after' but 'as the months went on' (p.21) it was clear that her story was not going to have the neat, happy ending she desired.

I remember sitting there thinking there's no one coming on a white horse to save me. It really was a slap in the face. It was the first time I realised that I could be in serious trouble, because there was no help in sight [and] I didn't know how to help myself.

(Sophie, p.21)

Sophie spoke about how this 'was the first time I was not equipped to handle what came my way and that was a very frightening feeling' (p.21). In time, she would come to realise that leaning to cope and live with it is 'something that you learn' (p.21). Learning to live with it also involves accepting that 'there's always a chance that I'll go bad again' (Ella, p.23).

It's not about recovery, it's about managing. It's about accepting it and also leaning how to manage it and learning how to deal with it and to predict – in a way to predict the unpredictable.

(Ella, p.23)

In addition to making sense of it and learning to live with it, moving on seemed to involve a degree of learning from it or at least seeing the 'upside' of it. Ella feels that 'focusing on the positives is just something you have to do because you have to focus on the positives or else you end up resenting who you are' (p.23). The students spoke about how 'you learn from it' and how it offers 'a different kind of understanding' (Adrianna, p.4) about themselves and the world. Recognising that there is learning to be found at 'the very bottom' (James, p.47) of life's experiences, learning that not everybody has access too, offers at least a sense of consolation as well as a sense that there was a point to 'it'.

Anthony (1993) highlights the sense of purpose, as well as meaning, in his conceptualisation of recovery. The desire to help others and, in many cases, to use what they have learned for good, emerged strongly in the narratives of the students who took part in this study. Of the 27 students who participated, 10

were studying a mental health related course. Whether this was a cause or an effect of the high level of interest in helping others that resonated throughout the dataset is unclear, but helping others appears, at the very least, to offer students a sense of purpose as they move on through their lives.

Helping people in some small way, like if you can even help one person, if you could change one person's life, then it will have been worth it.

(Mary, p.28)

A final element that stood out in the narratives of those who described themselves as having moved on from/with 'it', is the sense of an ending in their stories. They were more likely to describe it as something in the past ('I had depression' (J.D., p.13)) but also something very much with them ('it's just one tiny little part of me' (Mary, p.13)). Their stories were more complete with a beginning, middle and a resolution, if not an ending. They had, to a large degree, made sense of 'it' – not cured it or fixed it – but had integrated 'it' into the narrative about themselves and their lives in a way that made sense to them.

Meaning has an essential place in mental health. Yet, our responses to the phenomenon of psychological distress tend to place little, or no, emphasis on meaning. This study has highlighted, amongst other things, the importance of coming to terms with, and making sense of, 'it' if an individual is to move on and lead a fulfilling life. Narrative is 'the primary form by which human experience is made meaningful' (Polkinghorne, 1988, p.1). If we are to support individuals in ascribing meaning to their experiences, whether through telling stories to others or to themselves, we must look at creating spaces where they can be supported in doing this. Spaces where the individual may engage in a to-and-fro dialogue with a compassionate other in order to Understand (with a capital U) the meaning of their experiences.

The phenomenon of psychological distress is complex and multi-faceted. It means different things to different people and, while there are some experiential similarities, trying to apply a 'one-size-fits-all' solution to this phenomenon is limited at best. What this study has revealed is that what appears most important is not which intervention, treatment or perspective on

the phenomenon is more ‘right’ or ‘effective’ than another, but which of these makes most sense to the individual in light of their previous orientations to, and understandings of, their world. Unfortunately, for those in narrative wreckage desperately trying to find a way to re-build their lives and their narratives, this offers little consolation.

This point brings to light a deeper issue that permeated students’ attempts to make sense of their experiences of psychological distress. As long as we operate from a mechanistic world-view, without at least a nod to the contextualistic factors, we are limiting our openness to what the phenomenon reveals about the nature of existence itself, as well as constricting opportunities to move beyond ‘it’ in a more meaningful way. To return to Heidegger (Heidegger, 1927/1996), we are ‘depriving the world of its worldliness in a definite way’ (p.94). Changing world-views is no mean feat but we are currently in a time of change in relation to how we understand and respond to psychological distress (as described in section 3.3.8 ‘21st Century: A Liminal Space?’). The current epistemological ‘crisis’ (Thomas, 2014, p.13) in mental health provides ripe conditions for a ‘paradigm shift’ (Kuhn, 1996). Only time will tell if we can shift our understandings away from the ordered, but limited, mechanistic world-view to a more chaotic, but meaningful, contextualistic world-view.

Finally, perhaps above all, this study highlights how if we are to truly Understand the phenomenon of psychological distress we must understand what it’s *actually like* to experience the phenomenon. Through adopting a hermeneutic phenomenological approach and developing a methodology rooted deeply in the phenomenology of Heidegger, Gadamer and others in the existential lineage, this study was able to shed light on the nature of the lived experience of 27 students with mental health problems. The methodos, or way, set out by this study may act as a guide to others who seek to Understand a phenomenon in a deeper and fuller manner.

Understanding is perhaps one of the most important gifts one human can give to another. If we learn not only with our minds but with our spirits, the meanings of experience, we might better be able to say ‘I understand’. [...] Isn’t that what we all wish for – to be understood?

6.4 Conclusion

This chapter has discussed the Understanding generated over the course of this study. It revisited the two questions that guided the research as well as explored what it means to understand. Focusing on the meaning of the lived experience of the 27 student participants, the chapter looked at meaning itself; what it is, how it is created, and how we can gain an insight into how others have made sense of their experiences through examining the structures that support their narrative accounts of these experiences. The structure that emerged as underpinning students' efforts to make sense of, and move on from/with, 'it' consumed the latter half of the discussion. Particular attention was paid to what each of the four phases of the narrative plot reveals about the nature of the lived experience of psychological distress and the manner in which students strive to make sense of these experiences. The limitations of the study at hand, as well as its implications in terms of theory, research and practice will be explored in the next, concluding, chapter.

7. Conclusion

7.1 Introduction

This research started with a sense that the wisdom and knowledge that lies within accounts of lived experience was under-represented and under-valued in mental health research. It aimed to develop a method for mining the depth of insight that lies within lived experience, and re-present these depths in a manner befitting the ‘rigours’ of academic research. Guided by two research questions, the study sought to understand (a) the nature of the lived experience of third level students with mental health problems, and (b) how the students made sense of, or ascribed meaning to, these experiences.

From here the study began by outlining the principles of hermeneutic phenomenology, the philosophical approach that guided this attempt to understand lived experience. Beginning with the key contributions of phenomenologists Husserl, Heidegger and Gadamer, the chapter moved then to consider the strengths and weakness of adopting a hermeneutic phenomenological approach to research. Heidegger (1927/1996) suggested that in order to enter the hermeneutic circle of understanding ‘in the right way’ (p.153), we must explicate our prior understandings and presuppositions of the phenomenon under study. This exercise formed the basis of chapter three, **forestructures of understanding**, which began by examining how we, as a society, have historically tried to make sense of, and respond to, mental health issues. This chapter also attempted to draw out the main assumptions of the three dominant professional frames of reference in mental health (psychiatry, psychology and sociology). It then concluded by laying out the researcher’s own ‘prejudice’ and prior understandings and exploring how these may, or may not, influence the research process.

The **methodology** developed in order to address the study’s two research questions was outlined in chapter four, with particular attention being paid to the study’s efforts to uphold the highest standards of ethical and trustworthy

research. The **findings** generated using this methodology were presented in chapter five according to the narrative plot that emerged in the study. This chapter explored the ‘landscape’ of each of the plot’s four phases as well as the 34 thematic features that dotted each phase’s landscape. Chapter six, **discussion**, offered an opportunity to delve into the study’s main contributions to the field and explore how the students made sense of their lived experiences of psychological distress. This concluding chapter aims to draw together some of the key understandings generated in this study and discuss their potential implications.

7.2 Conclusions drawn

The following ‘conclusions’ are not conclusions in the sense that they are absolute, but rather conclusions that may be drawn from this particular hermeneutic cycle and used to inform future forays into the hermeneutic circle of understanding.

We need to think about, and respond to, mental health issues in a different way.

What the stories of the 27 students who shared their experiences as part of this research reveal, perhaps above all else, is that there is no ‘one size fits all’ solution to psychological distress. Indeed, there is no ‘solution’ at all but rather a series of processes and relationships that support an individual in working their own way through ‘it’. Western culture is shaped, if not defined, by a mechanistic world view (Pepper, 1942). Based on the machine-like principles of cause and effect, this world-view perceives ‘problems’ as the effect of a cause which needs to be identified, responded to and ideally removed in order to address the effect (problem). However, what this study has highlighted is that mental health problems, and indeed human beings, do not operate like machines. We have seen how, for many students, there is no reason for ‘it’ – there is no identifiable cause. We see that ‘it’ (the effect) is a highly subjective experience that varies considerably from person to person – even amongst those with the same diagnostic label. And we have seen that there is no ‘one size fits all’ response or intervention that can remove the cause and appease the effect. Indeed, the stories of the students in this study reveal how ‘it’ is not

something to be cured or gotten rid of, but something to be experienced and journeyed through. The stories themselves bring us into closer contact with our own vulnerability as well as the uncertainty and unpredictability of existence. They highlight the many anomalies that exist in our current dominant social understandings of, and responses to, the phenomenon of psychological distress and suggest that perhaps now is time for a Kuhnian revolution in mental health.

The importance of meaning in mental health

A number of authors have highlighted the importance of meaning in recovering from physical health issues (Becker, 1997; Charon & Montello, 2002; Frank, 2013; Kleinman, 1988). This study suggests that meaning is as, if not *more*, important in mental health. A mental health problem acts as a major disruption to a person's biography – the story they had been telling themselves and others about themselves and their lives. The challenge for that person, is not just in coming to terms with 'it', or figuring how best to respond to or deal with 'it', but also to make sense of 'it'. To integrate 'it' into their biography. To reinstate their sense of wholeness - their sense of who they are. Integrating experiences of mental health problems is considerably more challenging than integrating the experience of most physical health problems. This is largely because this integration occurs, not only within an individual's own sense of self, but also within a wider context of 'prevailing cultural sentiments' (Becker, 1997, p. 15). The prevailing cultural sentiments around mental health are precarious and unclear. In one sense it appears that we, as a society, are becoming more open about our mental health (something students in this study spoke about with hope), but equally trends suggest that stigma and prejudice towards those who struggle with mental health problems, particular those problems considered more severe or threatening like schizophrenia or psychosis, are as strong as ever (Pescoslido, 2013; Pilgrim & Rogers, 2011). In order to move on, or 'recover', a person must negotiate the narrative wreckage caused by 'it'. This involves making sense of 'it' in whatever way they can, integrating 'it' into their biography and, in turn, reconstituting that sense of wholeness that will ultimately offer them a sense of order and continuity in their lives.

What makes a difference is whatever makes most sense.

The mental health field is driven by the search for the most evidence-based intervention - that intervention that can scientifically and categorically be shown to make the greatest difference in terms of reducing psychological distress. What this study suggests is that what is important in determining the outcome of an intervention is not which intervention is more 'right' or 'effective' but rather the degree to which a particular intervention makes sense to an individual in light of their existing personal and cultural frames of reference. It appeared that students with a more scientific orientation to the world are more likely to favour and respond to more technical interventions such as medication or Cognitive Behavioural Therapy, while students who lean more towards humanities and arts courses favoured approaches that supported them in making sense of 'it' in a more meaningful way. The majority of students, however, appeared to approach 'it' with a combination of both medicine and meaning but what this study suggests is that if we are to effectively support somebody in moving on from, or with, 'it', we must first consider what intervention makes most sense to them.

The need for structure and order amidst chaos

Ill health has been described as 'a call for stories' (Frank, 2013, p. 53). Stories, or narrative, provide a means by which people can draw out, organise and work through their experiences. This process offers them an opportunity to order their often overwhelming and deeply unsettling experiences into meaningful wholes, which in turn helps reinstate a sense of order to the chaos induced by 'it'. As Becker (1997) points out, 'plot forms give stories coherence and order' and these plots can be 'used as a tool to mediate disruption and promote self-healing' (p.27). The plot forms offered by our culture can help us make sense of unfamiliar experiences. It is said that in mental health in particular, 'there is a need for some conceptual map, some frame of reference from which individuals in mental distress and those hoping to help them can gain guidance' (Casey & Long, 2003, p. 95). As already discussed (chapter six), existing cultural plots around mental health can be misleading (e.g. 'mental health problems are like a broken leg'), can result in a sense of hopelessness (e.g. the effects of trauma), and/or can leave a person feeling weak or ashamed (e.g. 'need to pull your socks up'). These plots all stem from a mechanistic world

view and reflect how our attempts to approach the phenomenon from this perspective are limited and limiting. Instead, what the plot that emerged from how the students themselves were making sense of their experience reveals is the idea of 'it' as something to be faced, addressed and journeyed through. That the best way out, to borrow Frost's words, is through. And that our job, as fellow human beings, is to act as companions on this journey, supporting and encouraging. The narrative plot that emerged from this study offers a structure that may help those who are struggling through narrative wreckage apply a sense of order to their experiences which may, in turn, alleviate the distress of chaos and uncertainty.

Recovery as moving on

Ireland's current mental health strategy, a Vision for Change, outlines a 'commitment to the recovery principle' (p.105) yet fails to define what it means by the term 'recovery'. For the students in this study recovery was very much about 'moving on' and not about recovering something lost or returning to an earlier, healthier state. The idea of recovery throughout much of the mental health literature is, again, based on mechanistic assumptions which view recovery as 'the final phase of the repair cycle' (Goffman, 1961, p.290). Yet, for the students who appeared to have moved beyond narrative wreckage and into 'post' narrative, recovery was about making sense of 'it', learning to live with, or in relation to, 'it'; and learning from and/or using 'it' for good. Recovery was not about getting rid of the source of their distress but rather turning towards it and negotiating a relationship with it that allowed the student to move on in their lives. Viewing recovery in this way, rather than as the removal of symptoms, is deeply challenging but ultimately offers a more meaningful and measured way forward for the student.

Negotiating the language gap in mental health

The challenge of finding the words to ask for help emerged particularly vividly from the stories of the students who participated in this study. It appears that there are four discrete hurdles at which an individual might fall in their attempt to articulate their experiences and translate these into a language that may result in them receiving the appropriate support. They must first recognise something is wrong, then find the appropriate words to label often confusing

and inarticulable experiences. Following this, they must figure out who best to convey these experiences to in order to receive the support they need and, finally, if they get that far, they must successfully bridge the language gap between themselves and the professional or individual from whom they are seeking help. Written down, these steps appear almost trivial but in reality they present major challenges to those who wish to/need to access support for their distress. In this study, five students initially fell at the first hurdle and three spoke at great length about their struggle to overcome the second. All students, to a greater or lesser degree, found it difficult to find the right person or professional for them, and four went into particular detail about the challenge of accurately conveying their experiences to professionals once in their office or therapy room. The students in this study have helped illuminate one of the most significant challenges in the field of mental health – the fact that the vast majority of those who struggle with their mental health are unlikely to look for help or receive it (Hunt & Eisenberg, 2010; Kessler, Demler, et al., 2005; Thornicroft, 2007; Wang et al., 2007).

The importance of non-professional forms of support

While accessing professional support was key for students, particularly during times of crisis or acute distress, non-professional forms of support, chiefly family, partners and friends, appeared essential in helping a student make sense of ‘it’ and move on with their lives – particularly over the longer term. The role of family and loved ones in supporting an individual who is struggling with their mental health is sometimes underappreciated in mental health (Kartalova-O’Doherty, Tedstone Doherty, & Dermot, 2006) and what the students’ accounts in this study reveal is how essential this role is in determining the students’ long term prospects and prosperity.

7.3 Limitations

As with all research, this study has a number of limitations

- The contextual, shared and inter-subjective nature of the understandings generated limits the degree to which the data generated is generalisable to the wider population of students with mental health problems.

- Moreover, the need to maintain ethical standards and ensure the researcher could access support for any student participant should they need it, meant that the majority (n=24) of students attended the same university – reducing the sample’s representativeness.
- The hermeneutic nature of the research means that what is represented here is one individual’s interpretation of the text. While every effort was made to ensure the credibility and dependability of the interpretations, interpretation itself is a highly subjective act and it is likely that other readers may draw different conclusions and place emphasis on other aspects of the narrative data.
- The word count restrictions of the PhD limited the degree to which the analysed data (which itself is words) could be presented and discussed within this document. Therefore decisions had to be made about what could and could not be included which limited the representation of both the breadth and depth of understandings generated.

7.4 Future considerations

This study was all about understanding and understanding two things in particular – the lived experience of third level students with mental health problems and how these students made sense of their experiences. Its emphasis was on Understanding (with a capital ‘U’) – not ‘doing’, ‘proving’, ‘testing’ or ‘qualifying’. As van Manen (1991) points out, this type of research ‘does not offer us the possibility of effective theory with which we can now explain and/or control the world, but rather it offers us the possibility of plausible insights that bring us in more direct contact with the world’ (p.9). While these insights may compel us to action, the primary aim of hermeneutic phenomenological research is to draw us into closer contact with a human experience. Unlike other forms of research, the understanding generated cannot be severed to produce categorical results or an authoritative summary. What it can produce, however, is a series of insights or questions that may form the starting point of future forays into the hermeneutic circle of understanding. The type of questions this research raises is likely to vary from reader to reader, depending on their own horizon of understanding, but three questions emerged for the researcher in particular which may be used to guide further inquiry or

research. The first of these centred around those students who failed to bridge the language gap and seek support for their distress. As we have seen in the accounts of the student participants, for many the act of identifying something was wrong, naming 'it', figuring out who to turn to for help and finding the words to convey their experiences presented real hurdles at which many of them fell a number of times before successfully overcoming them to ask for help. Further consideration of the experiences of those who fail to negotiate these hurdles, or at least those who have struggled to overcome them, would provide useful insight that may go towards addressing the statistic that as many as 70% of those who struggle with their mental health don't receive help (Kessler, Demler, et al., 2005; Thornicroft, 2007).

This study brought to light the importance of meaning in mental health and particularly its role in helping students move-on from, or with, 'it'. Further research focusing on the role of meaning in recovery would deepen insights available to guide those who are struggling to make sense of 'it', as well as those whose role it is to support people with mental health problems in moving on in their lives in a meaningful way.

The essential role of non-professional forms of support in determining student outcomes and experiences also emerged strongly in this study. Further consideration of the nature of these relationships, and what makes them so help-ful, would add considerably to our understanding of the important role key relationships play in shaping the experience of somebody who is struggling with their mental health.

7.5 Conclusion

Understanding, according to Heidegger (1927/1996), unfolds and develops ontologically within the hermeneutic circle. This particular voyage towards understanding commenced with an examination of what we already know, our pre-understandings, which themselves are heavily influenced by our culture and our place in time and history. We then engaged in a to-and-fro interplay between part (individual student's experiences) and whole (the overall meaning) in order to arrive at the understanding presented in the latter chapters

of this thesis. However, it does not end there. Understanding is not a destination but rather a continuous journey. The hermeneutic circle never ends. We just re-enter it from a different starting point.

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Appendix 1 Participant Information Sheet

You are being invited to be part of a research study which aims to understand the lived experience of psychological distress (also referred to as mental health problems or mental illness). This study, entitled ‘Understanding the lived experience of psychological distress: A hermeneutic phenomenological approach’, is currently being carried out by Emma Farrell, PhD candidate in the School of Education, Trinity College Dublin.

As you know, mental health is the number one health issue for young people in Europe. It is estimated that more than half of all Irish young people will experience a mental health problem at some stage before the age of 25, a time when many are in Higher Education. Given the importance of early intervention, it is unsurprising that there is a wealth of research charting the incidence, prevalence and severity of mental health problems amongst third level students. However, while this data is a useful indicator of the scope of this issue, it fails to capture its depth.

This study is all about the depth. It’s about understanding *what it’s actually like* to be a student who experiences a mental health problem. I believe that if we are to best support students who may be struggling with their mental health, we first understand what it’s like for these students. This is where I hope you, and your valuable experience and insight, may help.

Am I eligible to participate?

You are eligible to participate if...

- ✓ You experience/have experienced a mental health problem and;
- ✓ Are studying/have studied at higher education (HETAC levels 6-10)

What will be involved?

In this study you will be asked to take part in one to two conversational interviews. These conversations, which will take place at a location and time convenient for you, will be informal and shouldn’t last for more than one hour.

In the conversational interview(s) you will be asked to share a little about yourself, your life and your experience of psychological distress. The interview(s) will be recorded using a digital voice recorder, and transcribed verbatim in order to aid interpretation. Original data will only be accessible to the lead researcher (and research supervisor if necessary), with all contributions thoroughly anonymised in order to protect your identity (see overleaf).

What are my rights if I chose to participate?

- ✓ You have the right **not to answer** any questions you are uncomfortable with.
- ✓ You have the right to **withdraw** at any time.
- ✓ You have the right to **anonymity**. All information you share will be anonymised and your name and any other identifying characteristics will be removed to avoid identification.
- ✓ You have the right to **confidentiality** *except* if the researcher is concerned that you or others are at immediate risk of harm. In this instance, and this instance only, contact will be made with relevant mental health support services in order to best support your needs.

Anything else I need to know?

Yes! Firstly, it is important that you are aware that you know you can discuss any concerns or issues, positive or negative, which may be raised through participation in this study with the lead researcher, the research supervisors (contact details below) and that additional therapeutic support can be made available to you if necessary.

The data (both the recordings of the interviews and their transcripts) will be stored securely throughout the research process in accordance with the Data Protection Act 2003 and destroyed 6 months after completion of the project. This data will **only** be accessible to the researcher and the research supervisor.

So what now?

If you feel you would like to participate please contact Emma at farrele9@tcd.ie.

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Appendix 2

Consent Form

Dear Participant,

My name is Emma Farrell, a Ph.D. candidate in the School of Education, Trinity College Dublin. This project, as you will have read in the information sheet, aims to explore these stories, *your* lived experience. I am thrilled that you are willing to participate in this project and hope it will create a space where your story may be heard, recognised and respected.

I wish to thank you for agreeing to participate in this study and kindly ask you to complete this consent form. You will be given a copy of this consent form to keep and refer to at any time. I encourage you to take time to read the form carefully. I am happy to answer any questions you may have. I also provide the contact details of both research supervisors whom you may contact at any stage should you have any questions or concerns.

Many thanks,



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Please make your selection by circling your answer:

- | | | |
|---|-----|----|
| Have you received sufficient information about the study and the intended use of the information collected? | YES | NO |
| Do you feel that you meet the criteria for participation; i.e. you have experience of a mental health problem and are/have been in third level education? | YES | NO |
| Do you understand that you are free to withdraw at any time, without having to explain your withdrawal? | YES | NO |
| Do you understand that you will not be disadvantaged in any way regardless of whether you take part or you do not take part? | YES | NO |
| Do you consent to take part in this study? | YES | NO |
| Do you understand that if the researcher has a serious concern regarding your safety/ welfare they may wish to contact you key worker and/or the emergency services? | YES | NO |
| Do you consent to the processing of personal information for the purposes of this research study; <u>and</u> do you understand that such information will be anonymised in all disseminations based on this study and that it will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 2003? | YES | NO |

Please fill in:

Name.....

Signature..... Date.....

For the researcher to sign:

I confirm that I have carefully explained the nature and demands of this study to _____ this _____ informant.

Signature..... Date.....

Appendix 3 Critical Friend Report

Background to Role

Broadly understood within the context of educational research, a critical friend can be defined as ‘a trusted person who asks provocative questions, provides data to be examined through another lens, and offers critiques of a person’s work as a friend (Costa & Kallick, 1993, p. 49).

Framed this way, my role is to offer an independent, impartial and balanced interpretation of these data. Somewhat akin to a binocular approach, whereby clarity emerges only by means of convergence, the function of my role is to offer an unencumbered perspective on the cogency of the warrant ascribed to the extrapolated conclusions within the data-sets assigned to me. In each and every case, the critical friend asks: are there sufficient warrants (reasons) to draw such conclusions? Set against this backdrop, inferences are screened and interrogated by means of a metacognitive lens, whereupon the critical friend assumes the role of a sceptical inquirer tasked with simply following the evidence, and nothing more. In summary, a critical friend seeks to:

- Offer a fair and impartial appraisal of data
- Scrutinize the credibility (truth values) of all inferences
- Make an informed judgment on the transferability, or inductive force of particular phenomena/situations making sense outside of the context-specific confines of the subject
- Formulate a cogent justification of the ‘dependability’ of all generated inferences – in other words – would a rational agent, after careful consideration of the data, have generated similar inferences to the candidate?

Credibility (truth values)

One of the first tasks facing a critical friend is the problem of establishing the credibility of generated inferences, which are based on the process of

interpreting data-sets. Central to this process is the question of whether the justificatory reasons underpinning the generated thematic conclusions are sufficiently robust and defensible.

To guard against favourable bias (either implicit or explicit), the critical friend analysed four data-sets in isolation from the thematic headings generated by the principal investigator. A conscious choice was made to exclusively focus on the written text from the interviews, as opposed to the audiotaped versions. The reason for this approach is that the critical friend wanted to scrutinize the written word as distinct from the emotive inflections and narrative of the subject. It was hoped that this approach would add an extra layer of cautious objectivity, and perhaps in some way, prevent the critical friend from re-living, or reinterpreting the experience of the subject through the medium of their audible experiences. Put another way, focusing on just the words added a further step between the audible world of the subjects and that of the critical friend. This was deemed a necessary step in order to guard against the doubly powerful rhetoric of the written and audible word, and by extension, worlds.

After reading the interviews, the critical friend concluded that the principal investigator held sufficiently compelling reasons (warrant) for generating the thematic conclusions. There were strong, impartial and convincing reasons for the careful choices executed throughout. Alternative viewpoints were discussed and eventually discounted, principally because the reasons for such a judgment were significantly weaker than the *a fortiori* reasons in favour of the original thematic headings.

Transferability (applicability)

To answer this question, one must formulate a rational, informed and defensible judgment regarding the extent to which the narrative stages are applicable to other cases outside the original study.

After scrutinizing the narrative stages, the critical friend was satisfied these stages were transferrable to situations outside those of the scope of the study. There were many overlaps with current literature in philosophy and

psychology, more specifically, the work of x and y.....Though the language used to name the stages differ, there are significant synergies between the endeavours of these inter-disciplinary domains.

Not only would the narrative stages make sense to an outside researcher, but a strong argument could be advanced in favour of including these stages in further qualitative studies of this nature.

Dependability (consistency)

At stake here is the issue of establishing whether the study was dependable, and moreover, were the investigator's conclusions transparent and justifiable.

With regard to the four data-sets consulted, the critical friend determined that the conclusions were transparent and based on sound, and ultimately, convincing reasons. For each narrative stage, cogent reasons were offered in support of the given decision. These reasons were clear, well-conceived and convincing.

After careful consideration, the narrative stages were judged to be a fair and accurate representation of the subjects' narrative experiences. Over and above the narrative rubric, the forensic analysis exemplified a careful, robust and justifiable interpretation of the lived experience of each of the subjects.

