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Living in the borderlands; writing in the margins: an autoethnographic tale

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A prerequisite to helping others is, arguably, some semblance of understanding of one's own self. But, how does one *do* self in a way that satisfies the integrity of psychotherapeutic theory, or the tenets of qualitative research? Moreover, what are the implications for the morally marginalized and uncertain in an era of epistemological and ontological certainty? These questions preface the raw data that constitutes the bulk of this paper: messy-text emails, reflections and comments from others, in relation to the breakdown experiences of two mental health academics/practitioners/teachers/supervisors. The methodology is autoethnography, thus the aim evocative. The textual presentation is in triple-column form: in the first is the accounts of the protagonists, Short and Grant; the second contains reflections from friends and family, and the final is Clarke's pan-theoretical reflections on both.

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Introduction

Understanding one's self is perhaps the starting point of attempts towards helping others: however, the concept possesses both hybridist (and not unproblematic) origins. How, for example, does one conceive of self and its constituents: already this constitutes a dilemma. Some sociologists – notably Goffman (1959) – advise that the self is really a conglomerate of roles demarcated by a thousand demands, necessities, desires and needs, all of them socially mediated in one way or another. Many psychologists will disagree although not always in entirely similar ways. Psychoanalysis accords human beings considerable but not exclusive control over their destinies: it subdivides man/woman into a system of exchange rate mechanisms with a fair amount of old style bartering determining how things go: I (Ego) will swap you a bit of repression if you (Superego) will give me some civilization in return. Outside the confines of breakdown and therapy, it seems to work quite well albeit, outside these confines,

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Dramatis Personae: Alec Grant, Principal Lecturer and Course Leader MSc Cognitive Psychotherapy, University of Brighton, Cognitive Psychotherapist in Private Practice, Mental Health User and Survivor. Nigel Short, practices as a Cognitive Behavioural Psychotherapist. Has used mental health services. Professional Doctorate Student. Liam Clarke, Reader in Mental Health, University of Brighton. Reviewers 1 and 2: The 2 USA prepublication reviewers of *God and Planes* (Grant 2006). P-N (Psychiatric-Nursing jiscmail contributor). Marian (Prof Doc Student friend of Nigel). Jane (CPN friend of Alec's and wife of Graham, Alec's friend of nearly 40 years). Ian (friend and colleague of Nigel). Neil (friend and colleague of Nigel). Adrian (friend, colleague and postgraduate student of Alec). Mary (Alec's wife). Mark H (friend and colleague of Nigel). Mike H (friend and colleague of Nigel).

what does not? The behaviourists – by whatever name they give themselves – turn matters on their head with the self, apparently, a series of learned constructs derived from external constraints and permissions: an immediate advantage of this is that altering the constraints *et al*. may refocus the person's constructs, a more expeditious and even successful business than addressing the person directly. Given the sophistries of contemporary cognitive behaviour therapy (CBT), the above may appear crude but crudity has its place: arguably, the more primitive the therapy the greater its chances of effectiveness. Erudition, in this context, promotes confusion, not clarity, and the wood may be missed for the trees. For instance, as David Malan (1979) – a psychoanalyst – points out, there does not exist, in psychiatric history, a single case of obsessive compulsive disorder ameliorated by psychoanalytic therapy: the behaviourists, and their offshoots, can count such ameliorations in their thousands. But surely, you will say, there is much more that Freudian therapy can do? Perhaps so: but this paper is about breakdown of a serious sort: it is also about mental hospitalization, medication and abstinence. In fairness, post-Freudianism and post-Behaviourism now lay claim to cross influences usually from the camp of American Humanistic (or Rogerian) theory, the third arm of the therapies and the one with the greatest purchase on 'the self'. If Behaviourism, Psychoanalysis and Role Theory steal from us much of our self-determination, both Rogers and Maslow put 'us' firmly back into the driving seats of our futures. While they may recognize some degree of 'organismic failure', nevertheless, humanistics believe that, ultimately, persons will out, will 'choose', will 'grow' towards 'actualization' and in essentially (morally) good ways. I have always doubted this alleged 'truth': here is Hugh Dudley (1996, p. 268), a physician of Rogers' generation, expounding on this:

> Many of us have had difficulty in understanding man's inhumanity to man. Yet, my own experiences in the Far East in the late 1960s have forced me to the view that it is the exception to find that the human race is good. There is a long and complex argument here on the matter of sin and redemption, but I believe that it is right to adopt the negative stance that man is bad though whether there is the possibility of perfection, only the slow if inexorable march of natural selection – perhaps modified by the feedback from humans themselves – will establish. This is incontrovertibly a European voice – a voice that is generations deep, and it calls into question impossible complexes of morality and character and the dangers that lie in wait if one attempts too singular a description of the human condition in extremis or too straightforward solutions. But, we look to ourselves – in relation to others – as in this autoethnography presumably in making some kind of sense that will roll over into the lives of others? Or is it an embarkation designed expressly or substantially with self in mind?

Doing self

But how do you *do* self? Allowing that we have ended up with a concept of self – however problematic – how, then, do you *be* genuine, which we all the time tell our students to be? Surely, being anything brings us back to Goffman and the idea 'presenting' ourselves in the sense of 'putting our best foot forward', whatever that might be in the circumstances. and if we were skilful enough actors with the capacity to be other than what we are would acting not be the thing to do if therapeutically more effective? The trouble with the last sentence, is how on earth do we know what we is to begin with?

OK, so let's agree that we can make a stab at genuineness: where does this take us? It means, by implication, being a Rogerian and let's be fair and credit him, at least, with popularizing and proselytising the person centredness beloved by many. The question then becomes whether that is enough: can we have a stab at curing clients with obsessive compulsive disorder by forming warm and empathic relationships with them, or someone with schizophrenia for that matter? A warm relationship will not do any harm and it is sure a required ingredient of all therapy: not strategically, though; morally. In fact, psychiatric nursing literature groans under the weight of 'therapeutic use of self', 'nonjugmentalism' 'empathy, trust, respect' and all the rest. However, it is an ageing literature and fast on its heels are the evidence wolves snapping and snarling at the immeasurableness and unaccountability of it all, insisting that whatever the value of relationships something *else* seems needed, something over and above mere relationship. There is a rich debate to be had here, but crucially the assertion is that matters are not just about centralizing individual experience as a totality but rather as a starting point for the intrusion of something from the external, knowable, world.

Researching persons

But, in endeavouring to be scientific, we run a risk of ending up with a psychiatry of bits and bobs as did academic psychology before us, which, also seeking to be scientific, embraced methods which required life's *itemization*. In the rush to assess, treat and cure, there resulted a consequence where, as John Shotter (1975) observed:

> man [became] buried beneath the debris of a million investigations.

This battle, between persons and pieces, was resolved in psychology (or amicably submerged) and has passed to psychiatric nurses where it continues to rumble within the realms of research. No need to rehash the central debate here – to RCT or not to RCT – other than to assert this paper as an addition to or deepening of the ethnographic ambition or, perhaps, from a marginally moral perspective to go behind the paper into the distressing experiences of its two protagonists, Alec and Nigel.

Liam Clarke

Alecs' and Nigels' accounts	Alecs' and Nigels' relatives', colleagues' and friends' accounts	Liam's account
Alec: In 2005 I wrote an account of my breakdown in a paper for the *Journal of Psychiatric and Mental Health Nursing* and what I imagined at the time constituted my complete recovery Grant (2006)	Reviewer 1 Grant (2006). Does this 'commentary' inform the readership about an aspect of mental health practice? – Definitely! Hearing the stories of people who have experienced, as this author puts it, 'breakdown and recovery' contribute to understanding the subjective experience which needs to be integrated with other sources of / types of knowledge / evidence and inform practice. I particularly appreciated the author's reflections on what was helpful and unhelpful. There are professional communities where one would be ill advised to disclose the experience of psychiatric illness. This commentary prompted my reflection on the stigma associated with psychiatric illness and how sometimes healthcare providers can be the worst offenders. Related to this is the artificial and for some, seemingly protective boundary between mental health care 'providers' and 'consumers', a boundary notably absent in this commentary. The author writes (or seems to write) from a perspective in which the roles of clinician, educator, researcher and patient can coexist within one individual, which of course they can, but it is a perspective that I do not think is widely held. In reading this commentary I am acutely aware of particular environments in which it would not be safe for a clinician or an educator to speak openly about 'my experience of breakdown and recovery' and I am thinking about what ways I might contribute to changing that. I am also curious about the author's professional context and what contributes to making it possible for him to openly share his experience. In reading this sentence 'It's too easy to romanticise such experiences and equally easy to forget, play down, not recognise or realise the painfulness that comes with them'. I wondered how does one neither romanticize nor minimize the pain. The sentence seems to imply a middle ground or path between those extremes, and if that is so, I am curious about how the author finds and holds that place of neither romanticizing nor forgetting. I want to ask 'how do you do that?' not expecting a simple answer but wondering if the author has more to say about that. I had the sense of an opening and then what felt like a premature closing with or too big of a leap to the final sentence about increased empathy. Reviewer 2 Grant (2006). Thanks for this opportunity. This highly candid story was personally moving and provided insights into a persons lived experience. I certainly feel it will inform the readership. What was extremely telling were his comments about what was helpful and not helpful to his recovery? I admire his open self-disclosure which in my experience is rare and not well nurtured in our culture. The truths of his experience, I hope, will help us reconsider our attitudes that not only diminish peoples experience but continue to create the 'Othering' attitude and demonstrate lack of respect for the individual. We have a lot of work to do . . .	According to philosopher Charles Taylor (1989) Christianity proclaimed the insurgent notion that the lives of individuals were precious in themselves. As Terry Eagleton (2005) adds: 'God is incarnate in the poor and the sick' and salvation lies not in the adoption of some esoteric cult but in whether or not you take the time to feed the hungry and/or look after the sick: that, of course, would include looking after one's self. Whatever about the concerns listed in column two just to the left, the early Christians quickly picked up on the interactive benefits of their beliefs and, in time, declaring one's self – giving witness – within one's community, and thus finding place within it, quickly found favour. Among the first Christians, for example, confession was a communal event and 'washing one's dirty linen in public', publicising one's transgressions, was not seen as all that unusual. It would be well in excess of a thousand years before human transgressions would be fully hidden and disposed of within the dark confines of the Counter-Reformation's confession box. No doubt, too, the ever increasing attachment to 'sins of the flesh' added enormously to the ambiance of secrecy, the whiff of sin smothered from within that dark guilt-ridden Catholic box: in truth, the true progenitor of the psychoanalytic space and *its* guarded formulas. In terms of putting pen to paper, St. Augustine (1961), in his *Confessions*, famously begged God to make him good and holy, to drag him away from the sins of flesh and self-abuse, but adding, even more famously: 'not yet'. But, more importantly, was it Augustine's *Confessions* which introduces the individual's central place. For it is Augustine, for the first time in the world, who uses the word 'I'. He it is who begins our ages long progression to our current preoccupation with self and 'the assumptions of experience' as transcendent. Am I right to assume, at least in part, that this is the fundamental basis from which autoethnography derives and is this a good development? If the writer to the left asks: 'how is it done', then this too can be answered from the perspective of individuals finding their own 'golden mean': or, more aggressively, expressing a view that the world is what I make of it: subjectivity creates reality. However, one then asks how to construct a moral code or, further, how to value things in the world as they are. An interesting question then becomes by what moral impetus do the writers in column one seek to establish their own sufferings as having some higher or better value – be it educative, curative or whatever, over the trials and tribulations of others? This seems to me to be a much more unanswerable question than determining the psychological value of what this paper is about. What, in this regard, does the research literature on 'self disclosure' add to this? Indeed. But, phenomenologically, it may not matter a damn what it has to offer allowing for the auto ethnographic status of what is being written here.
Alec: I had the disappointing (rather than surprising) experience in Spring 2006 of spending 3 days in an NHS acute ward. I was very disturbed, distressed and frightened. Apart from the intake assessment done by a nurse, I had no conversations with any of the nursing staff. They came to my side room to check that I had not committed suicide, every half hour. Interaction consisted of a brief smile and nothing else. I'm sure that some of the nurses had excellent interpersonal skills; from my point of view it is a shame they did not use them	**Adrian**: Dear Alec, I can remember you becoming unwell and visiting you at home while you were on sick leave. At the same time I was also working for the Community Mental Health Team (CMHT) in your location and with the Psychiatrist who was your Responsible Medical Officer (RMO). It was noted by the team that your mental state was deteriorating due to an increased number of calls to the duty team and concern was expressed about your general well-being. It was recognised by the team and I that alcohol was a major contributing factor to your decline. Despite attempts by the RMO and myself to address this issue, you found it difficult to accept as at that time you were using it as a coping strategy. Your mental state and the relationships around you became increasingly strained. I was in touch with your wife, close friends and colleagues who all expressed a great deal of concern about you. If I recall rightly, I came to work one Monday morning and was informed by a colleague that you had been admitted to the local Psychiatric Inpatient Unit. I felt shocked by this, knowing the conditions on the unit and was immediately concerned about	I am curiously struck about the degree to which both Alec and Nigel's commentaries touch on the behaviours of others and even, on occasions, the supposed thinking of others. I imagine this reflects the balance between the self as an expression of culture as well as the ethnographic desire to frame experience within the ambit of others within the story. The poet Patrick Kavanagh (1904–1967) likened the self to 'an illustration' a belief hardly in keeping with the fashions of his later years or now. Indeed, the 'auto' in ethnography surely takes the terrain of qualitative research to its furthest edge both in form and content. Yet, it is the second commentator (to my left) who, although ostensibly well, comes across as more personally revealing (at this stage), more declarative of the emotional effects of psychiatric hospitalisation. In psychiatry, there exists a conservation history of containing professionals when they become mentally unwell. At all costs, find a more exclusive 'attic' in which to shore up the secrecy of their distress: hide from the world's gaze the astonishing idea that being mad is not 'other' but 'we'. Thus do the 'revelations'

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on me. Although they were very busy, there were times when I saw them gathered around the nursing station at the end of the corridor when I opened my door to occasionally peek out. A few days pass and I'm moved to a private clinic.	your well-being. My first action was to phone you and ask if you were alright and if you wanted to remain there. You told me that it was terrible and asked me to help you find a better alternative. I spoke about your situation with a number of people we both know. In particular I phoned a close colleague who was a mutual friend and had also been supporting you. We spoke about your situation and what could be done to help you and both agreed that you were in the wrong place. There was a consensus that the staff did not have the appropriate specialist skills to help you overcome your problem and due to your position in the University relational difficulties would interfere in any potential treatment. I then decided to contact your RMO and discuss your circumstances with him. The RMO also felt that you could not be treated effectively in the Inpatient unit. Not only had you taught some of the nurses working on the ward but due to your position in the University it would be likely that you would teach them in the future. He suggested that I contact members of the Out of Area referral's funding panel and make them aware of the circumstances of your admission, along with the potential difficulties associated with your existing or potential future relationships with members of staff on the ward. Within a matter of minutes the RMO replied via email supporting my request and this was soon followed by emails asking me to contact members of the ORR's panel directly via their mobiles. The Director of Specialist services who knew both you and me personally was immediately supportive, questioning why you had been admitted to the local Unit in the first place. He asked me where I thought you should go and we agreed that The Priory would be the most appropriate placement due to the specialist Alcohol Programme that they run. Another member of the ORR's panel was less supportive, stating that there was nothing The Priory could offer that the local Unit could not do. She was argumentative with me and I felt she was condescending about the manner in which I was approaching your potential treatment. She questioned my every decision and displayed a lack of empathy towards the circumstances of your admission and the potential impact this had on the ward staff. Despite her obvious objections the support of the Director of Specialist Services and your RMO appeared to show more favour and within a few hours I was informed that your transfer to The Priory would happen later that day. When I visited you at the local inpatient unit I was met by members of staff that I knew and had also taught in the past. They were all intimidated by your presence and unsure how to approach your case. I consulted your notes and found a basic care plan that did not even identify alcohol as being a contributing factor to your admission. There was no treatment contract present and no recorded breathalyser results. The only notes recorded mentioned that you had 'settled in well to the ward and were socialising with other patients' and that you had 'slept well'. I became aware later that you were in fact drunk when you were admitted and I was surprised that the admitting staff had not addressed this issue. When I saw you I was shocked, you appeared somewhat agitated by the experience of being on an admission ward with other extremely disturbed patients. The environment was cold and Spartan and there appeared to be no therapeutic interaction with staff bar the distribution of medication and checks every so often to see if you were actively suicidal. When I left you I spoke to members of staff and they were open about feeling out of depth in regard to your case and agreed that you would be better treated at The Priory. Some spoke of their amazement at the fact that you had been admitted to the ward in the first place. The transfer to The Priory took place the next day and when I visited you a week later and saw the therapeutic programme you were engaged in I knew that my persistence and consultations towards transferring your care had been worthwhile. I am continually amazed to see your recovery. You have excelled in not only getting yourself better but improving your quality of life. Having only witnessed NHS inpatient treatment before, it goes to show that the right treatment in the right environment can work. I hope this is of some help to you. Let me know if there is anything else you would like me to add.	which determine this autoethnography, while not unique, represent an important step in demystifying the historical furtiveness that surrounded a professional's breakdown. Whatever the motivation of either protagonist – be it good intentions, anticipation of usefulness: be it narcissism or, even, be it despite narcissism, it is a brave thing nevertheless to cross the line from therapist to 'other' or: to try to absorb both categories into one's person such that the very idea of 'other' is diminished. That said , removal to another place did occur and one might inquire must it always be the case that affected individuals be *still* separated from those who have known them professionally? Perhaps so: but why? Given that the expressed concerns seem to have been about obtaining specialist *treatment* options and not about the dangers of personal confession to those otherwise professionally known, why the removal to another place? Granted, the Priory possessed better facilities for managing alcohol related problems. However, is that everything that can be said about the shift? Or does there remain, still, a concern to distance the psychiatric problems of practitioners, metaphorically as well as geographically from the true awfulness of their occurrence in the presence of that audience that knows, and has known, one as a 'non-other'. And yet, here is the autoethnography: a grander declaration to a potentially wider audience and including those who are colleagues. Well perhaps, albeit pen on paper is a more controlling and controlled activity than that which is spontaneous, uninhibited, unreflective and enraged. I can but only refer here to my own studies which also reflect poorly on the very same units Clarke & Flanagan (2003) albeit such criticisms are not restricted to these units. However, taken as a straightforward, realist, critique of mental health practice, does what is described here explicate, within its experiential terms, the nature and extent of the anguish, embarrassment, and conflict engendered by these inhospitable situations?
	Nigel to Alec: I sat in the waiting room. There were three newspapers. Two broadsheets and a tabloid. I pretended to read	Most of the practitioner contributors to my left are trained in or conversant with CBT and will be familiar with Albert Ellis's

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	them. I had forgotten my glasses. The arm chairs were comfortable and Isat thinking that NHS wards are nothing like this; why is this? You were having your lunch. It was comforting to know you were eating. You came in and met me and took me to your room. En suite bathroom. I could see your trainers on the floor and a few books on the bedside locker. You looked grey and tired. You showed me your weekly plan. Lots of activities. You were enthusiastic about the programme. Your friends Graham and Jane arrived. We saw them through the window. You greeted them and we all said hello to each other. You wondered off somewhere with a nurse. Jane then asked me lots of questions. I felt uncomfortable. It reminded me that I perhaps had not done enough for you.	'concept' of 'musterbating': I'd like to place beside Ellis's idea an even more prevalent, if related, anomaly, namely 'onlyisms' 'if only I had done this; and 'if only I had not done that'. Actually, I feel that such reactions are probably universal and only important when expressed in the extreme. But there does seem to be a remarkable prevalence of 'onlyisms' and one wonders what may have laid behind an avoidance and reluctance that would later lead to such regret. Here, 'if only' is projected onto the NHS as though it were some faceless, depersonalised, organism with a mind of its own: true, as Alec has shown in his academic work Duncan-Grant (2001) organisations are a neglected force when looking at how people work within them. But that is not to say, surely, that individuals are exonerated from their actions: we cannot have it both ways: eulogising the powers of the self one minute and then blaming its contexts and/or social structures for its ills next. 'A man of such education and intelligence': Jane's question 'when did the insight end?' reminded me of the same question when put to Nobel Prize winner John Forbes Nash by his psychiatrist: 'how could you, how could *you* believe that messages were being sent to you from outer space'? 'Because', replied Nash, those messages came from exactly the same place as my mathematical equations'. Thus speaks, perhaps, the ultimate reductionist, but it is sobering nonetheless – and perhaps reassuring to others – especially socialists – that we seem, all of us, to be psychologically vulnerable and, when the chips are down, to be curiously holistic! My feelings at this point are indistinguishable from my thoughts: my feelings are also not too removed from my physiology, a point not overly emphasised enough, I feel, by cognitivists. Finding the paracetemol instead of the passport reminds us of the momentous part that life plays in our lives: the self just happens to be going along nicely and then 'shit happens': events, dear boy, events are what matter, as an ageing Prime Minster once said. It is a point well dealt with, for example, in the novels of Ian McEwen. We, in the psychotherapies, however, possibly pay too little attention to this: I do not mean that we neglect the idea of it: I'm sure that finding ways of helping others to deal with events is important. Will the experiences of Alec and Nigel deepen their relevance to their own clients? Is the event of their (and others) mental distress now an irrevocable part of their helping armoury? I have a sense of irony too that both Alec and Nigel, trained CBT therapists and authors, welcomed, found relief, within the portals of the mental hospitals. No, I do not mean that either of them can be characterised by their work: they have other strings to their bows: ironic and surprising (where they found relief) nevertheless though. As one myself, I had always thought that being a good Catholic is about having permission to serially be a bad person. However, this is point scoring, as well as *being* the point where I am becoming aware of being a functionary in the service of what? Why am I actually writing this? I am, of course, only too aware of my capacity to 'purify' (another onetime religious concept) my involvement with this autoethnography by the dropping of names and the provision of examples. This paper is intended for a journal and, naturally, one seeks to keep one's intellectual end up in a context which at times seems positively anti-academic and fully experiential: this is my problem: that the intellectual is almost always verbal, articulated, propositionally set out: emotion yes, but distilled in the service of dignity and human advancement. Tempted to respond this but do not want to: except that rhetoric has always seemed to me to be essentially quarrelsome and arrogant. Or: did not want to respond but did.
	Jane: My thoughts about seeing you before arriving were that I was really pleased that you were safe but as an 'old socialist', wondering whether you could have, and should have been on an NHS unit, obviously in another district. I was aware of oscillating between a professional view of what was happening (i.e. thinking in terms of signs, symptoms, treatment etc) and a personal one of wondering how a man who I admire so much, (professionally as a clinical supervisor, and personally as the man who introduced me to Graham) and of such education and intelligence, could get himself into such a position. When did the insight and self knowledge end? Despite all this, I somehow thought that 'good old' Alec would greet us at the unit doors. I suppose my emotions then were concern and curiosity with perhaps an iota of irritation. (Non-NHS bed and us professionals should some how never get ill?!?!). On seeing you I felt shocked to the core. I hardly recognised you. You were stooped, shuffling and had put on a lot of weight. It appeared that your hair had become much whiter and you were clearly quite heavily medicated. You were also talking about feeling safe in your room and feeling paranoid when you were out of it. I felt near to tears initially but tried to focus on the rather banal conversation that was going on. I have no memory of the content of the conversation but the feeling that we were all just being polite. (Was there a round of joke telling?!?!) Having seen many people in an equal and often worse mental state I was shocked at how upset I felt seeing you so ill. (I have thought afterwards that my feelings must have been similar to many family/friends who see a loved one ill for the first time. I naively thought that my training would prepare me for this.) I remember feeling relieved when you said you were tired and we could leave. (Are you sure you want this much truth?). My behaviour at the time felt rather strained and ill at ease. I was not 'myself' but trying to be supportive and also concealing my shock. It felt like going through the motions.I was feeling very worried at how Graham would be feeling and wondering if he would be up to going to the fiftieth birthday we were going to that evening. I was pretty sure I would be too upset to attend. I felt very concerned about Mary thinking if I felt this bad, how on earth must she be feeling? When we left I felt quite stunned. I also wanted a damn good drink! I perked up during the afternoon but could not really enjoy the party as I felt so sad.	
Nigel: I had deteriorated over several months leading up to the admission to a hospital in London. I had moved out of the family home and had been living in a bed-sit. My diet had reduced to soup and lots of alcohol. I was drinking each evening. Curiously I was managing to keep work going and clients were continuing to benefit from psychotherapy sessions. I got drunk one evening and had an idea that travelling abroad would resolve all my difficulties. I began looking for my passport and found several boxes of paracetamol. I popped some out of their silver foil wrapper. I do not know how many. It was an experiment. I wanted to see what it was like. Ideas of going to	**Mike H**: January 2007 Hi Nigel Happy New Year! How good to see you as always, thank you for the Morrissey card I shall use it like the Book of Kells card you sent me as a book mark and think of you when I use it, this is a very romantic start to a letter! I have been thinking about your research project and have tried to recall as much as I can which I feel at this point in writing is rather hazy but I am hoping that as I write more memories will come to the fore. My first and overriding memory was walking through the corridors of St Thomas's to a darkened staircase, my thoughts as I climbed those stairs was one of fear for you, not fear of any physical harm you might come to but psychological harm from your experience of being exposed to in patient psychiatric care. Of course this statement is loaded with prejudice and pre conceived ideas about the unit you were on but it was based upon my own experience of working on such units, I suppose I have always veered towards a fairly negative view of admission wards as I see them as symbols of medical control. I think I had been reading too many social construction theories of psychiatry + a good dose of Szasz and Lang. Of course I have worked with and known some of the most caring and sensitive people (I include you in this group) on these types of units but I have also come across some pretty dismal nurses whom could hardly be called therapeutic. I just hoped at the time you	

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France evaporated. I fell asleep. When I woke up I found the punctured strips of thin tin. I got scared and rang a friend. They threatened me. 'If you do anything like that again I will call the police'. I went off to work. I decided that day to drive to beachy head. I cancelled all my appointments for the day. I was travelling through Bexhill towards Eastbourne and I got a phone call. A family difficulty had come up and I needed to turn round and travel back to Hastings. When I got back to work I was met by my manager and a couple of psychiatrists. They questioned me and then we all agreed that a short stay in hospital might be helpful.	would only come across the former. I knew in happier times you would judge the latter people with your usual insightful and fair-minded understanding of why people behave they do, but you were vulnerable and exposed I felt at the time. Being a good catholic my journey would not have been the same without a good dose of guilt! I was aware that I had meant to visit you earlier and was also aware I only visited you once, while I knew other friends were visiting regularly. My life is littered with such patterns of behaviour and feelings of not doing as much as I should be doing, I guess I feel a little helpless at these crisis points in other people's lives, it is always difficult to judge how much someone wants you around or whether they need space and time for reflection. I cannot at this point even remember what year you were in hospital, you are probably going to say 30 years ago or something like that !!! Anyhow on with my memories. I remember meeting you and getting our permission to leave the ward for a walk! I was quite relieved when I saw you and chatted with you for the first time again, I had apprehensions about what you might be like, god knows what I was expecting, and I cannot remember really, I should have known better considering my experience. There was sadness about you but it was so good to see you were ok, although I knew you were suffering deeply inside. You, G and the kids had been through so much heartache and of course I was deeply saddened by all the events that happened at the time. I thought about your family a great deal, wondering how they were, I knew, without doubt, in the long term both you and G would help them understand and get them through ok. Now that we have the benefit of time past I believe I was right on that judgement, they are a credit to both of you, two very fine young people who exhibit many, of both your qualities. The Ministry of Defence sticks in my mind for some bizarre reason from my memories of the walk, I know we walked and chatted freely past it along the Embankment. I was probably yacking on about some Northern Ireland story which I was prone to in those days (that reminds me I met someone the other day who vehemently hates Mrs Thatcher and has a bottle of champagne on ice in preparation for her death! I referred him to two songs he might listen to Stamp on her grave, Mr Costello and Margaret on the guillotine, Mr Morrissey, both fine records), I guess we will know when we have self actualized when we have forgiven her! I digress. I also remember when I ran the London Marathon at about mile 24/25 thinking me and Nige walked along here! It got me through some very painful final miles!!! I'm struggling to remember much else, I think I knew you would be ok in the long run but emotional scars cut deep. So overall there was sadness, fear, guilt, relief, I guess some shame that I belonged to a group of people who might do harm to you, empathy, I began to really understand how one might feel in this situation, and I know it helped me become more sensitive and patient in my approach to people. I guess at times, even with the best will in the world, we can become de-sensitised to some degree or other. Finally, hope for the future. You will always be a trusted and dear friend, someone with beautiful human qualities and someone I have only ever felt, very privileged to know. I hope this has been some help to you Nigel and not too eleventh hour !! Story of my life eh!! Love Mike x	
Alec: The mental health user involvement movement in Britain, which we contribute to, continues to be very much about involving the other, qua *other*, thus reifying and confirming her or his supposed 'otherness'. I suppose what we're attempting to do is enter into and share the space with the other, to undermine 'otherness'. Our hope is that by using an autoethnography approach in this context we will contribute to the project of destroying the boundaries/ borders/walls between self-other, professional-layperson, sane-mad,	**P-N**: With respect, Alec, I think one has to be careful about the motive for discussing one's own mental health difficulties these days, as it seems sometimes to be somewhat fashionable, like it is a badge of honour and a validation of why one can legitimately support other people with mental health difficulties.	My apprehension that this project was less about lessening dividing lines as much as about abolishing them altogether has proved true. Clearly the correspondent in column two has missed the point of this: further, why something that is fashionable must, perforce, be suspect fails me. The important point is the apparently honourable desire to deal with problems of self and others in their various contexts. Although there is a nobility to this imperative it can still be asked if this is a right thing to do from other perspectives. If, for instance, one allows for the introduction of an objective force, say a discrete therapy, into a relationship between two people does one allow this because it is necessary for a positive, healing, outcome? Or is it possible to proceed without an actual therapy on the basis of the vitality and centralism of the relationship alone? If the issue is one of severe phobic disorder, on the part of one of those in the relationship, can the other ('therapist') proceed simply on the basis of human regard?

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worker-user, teacher-learner, professional knowledge-experiential knowledge.		
Nigel: 29 September 2006: Alec and I are presenting autoethnography to the Professional Doctorate group I am in. We divide group into groups of three and fours – They read our proposal and Alec's account God and planes . . . The group are quiet and then start talking. I am feeling a little nervous. I am feeling a little odd-I am part of the group and yet not part of the group. What will people think of me now I have 'outed' myself? Sat with Alec. We then ask the group for feedback. Following themes start emerging: Brave and yet powerful. Will Alec regret writing the paper? How is autoethnography different for an autobiography? What are we going to do with the data? Is it generalisable? Is this approach Self indulgent? Exhibitionist How do we intend protecting ourselves and participants? What new knowledge will emerge? Who is your audience? Who do you want it to be? Society or culture? who are you representing? Where will you publish? Sense of discomfort. What has changed and how do you know or how will you know?	**Marian**: I consider you were both extremely brave in undertaking the presentation in the first place – and in doing it so honestly. I enjoyed the presentation, and felt quite aggrieved at having to leave early – not often a feeling I have on those Friday afternoons, it must be said! You have left me with waves of conflicting emotions which have come to the fore since the presentation. It is difficult to describe them here. I guess some would consider putting thoughts to paper easier than doing it face to face, and indeed it is often a method I am familiar and happy with – but occasionally, the words become evasive – and I'm not too sure why yet. But I find it intriguing that this is so, and is reflecting on it. I found your approach refreshing, Alec – in a mad sort of a way that was entertaining, yet poignant. For me, the important message was that as 'health care professionals' we need to seriously consider how we perceive the 'care' we give, and accept that it is often falling below par. There is also the stigma. When you commenced, I was unsure as to what could be gained by being so forthright. However, the more I listened, the more I thought about how we (or I) present to colleagues/friends /family, in terms of my judgements and produces. You forced the issue of social construction to the forefront of my mind – and I am left wondering how (or why) I am perceived as the champion of the 'underdog' or 'undesirables' within the family, and yet a fellow student confided having to attend 'therapy' a couple of hours prior to your presentation, explaining that it has to be 'totally confidential, and you do not need to worry, I'm not psychotic or anything like that'. Having worked for years in mental health, and loved working with adults with challenging presentations, I found this perception of my values a new experience. My only suggestion for further presentations would be that had I not been privileged to have read Nigel's assignments prior to the presentation, I would have no prior information as to the origin/theory, and value of autoethnography. Perhaps you could introduce a bit about this? Or maybe, this will contaminate your presentation? Trying to force it into a conforming pattern? I do not know – the decision is yours. What I do know is that is was a stimulating and thought provoking presentation. Thanks for sharing. Marian **Nigel to Alec**: Its interesting-when you were admitted to the NHS hospital I got a call from Adrian the next day telling me that you had gone in and how astonished he was that this had happened and made noises to get you transferred to the private facility. Why hadn't I done that? I still feel a . . . about that. I was fooled by my adherence to collaboration. I wanted you to discover what might have been good for you. I had missed some important clues I think. A few weeks earlier you had rung me very early in the morning. It was 7.15 am. You told me that you had already drunk a couple of pints of cider. You were very happy and telling me about some of your experiences at work. They were experiences that sounded like they had given you pleasure at the time but you were now regretting some conversations you had had with some colleagues. It reminded me of the character in the Monty Python show who was playing the piano naked. People need to retain their dignity. This earlier conversation was then followed by numerous phone calls from you seeking re-assurance for earlier conversations **Alec to Nigel**: I remember feeling a mixture of compassion, revulsion and guilt when you went in as an acute in-patient. I bought you a card. It felt like a lame thing to do. I should have gone to see you. I convinced myself at the time that this was a wrong thing to do for both of us. I had and have revulsion for acute in-patient wards - part based on the (negative) evidence base and part on my experiences as a psychiatric nurse in the past. But I was guilty at not visiting you. I also remember waiting for you to invite me since I think that I rationalised all me feelings into 'it will be intrusive to visit Nigel unless he wants me to'. I remember talking on the 'phone with Ronan. I said 'I'm waiting for Nigel to ask me to visit'. He said that that would never happen and that I should just go to see you. So, we kept in touch over the 'phone and you got my card. I still feel guilty, years later.	Discomfort provokes action: some of the questions – data/generalisability – are defensive no doubt but then, what is the difference between autoethnography and autobiography? There are similarities, for example both can be brave and powerful. Both can be necessary: right now, in our culture and in mental health, we could do with writing that is charged, human, challenging and opinionated. But there are also differences as the comments by Alec and Nigel at this point show. The autobiography deals, usually, with the full life of the person and its cast of characters will be many. Its audience, presumably, will be all potential readers who can read. The autoethnography, while perhaps redolent of universal significance, will be of interest to those involved somehow in its content, in this particular instance, psychiatry, breakdown, recovery and its communication as experience. Disregarding ghost-written memoirs of comedy duos and such like – 'Posh and Becks: The Story So Far' – they will have a single author and who by no means be expected to be telling the truth: the late politician Alan Clark (1993) referred to his *Diaries* as 'a work of art' and the late Amis (1992) cheerfully announced that much of what was in *his* memoirs was 'contrived'. The student in column two seems fully aware of the dangers of form over content: the contrast between the written word – and its particular designation as fiction etc – and the presence of the persons involved. It has long been a hobby horse of mine Clarke (1995) that the best qualitative studies possess fictional elements and that ultimately the true home of the ethnographic study, whatever its hue, is the novel. Is the autoethnography a step in this direction? The role of the 'Greek Chorus' is to comment and enlarge upon the drama taking place before it: or, if you like, Alec and Nigel are 'the soloists' while I provide some of the background noise: while I initially saw myself in this guise I have come to recognise that there is an element of pretentiousness about it, and I am being pulled now constantly to see myself as posturing, waxing lyrical. I have no way of finding my way into the 'bee box' that is the mind of either Alec or Nigel: how to fathom the depth of their guilt and/or the extent to which these depths are imagined as a product of memory. The academic psychologists advise us that memory is a construct at best while the Freudians insist that what is more interesting are the bits we 'make ourselves' forget and why. How do I know that my responses to Nigel and Alec's testimonies is not coloured by what I know – and have known - of them generally or that my comments do not stem from needing to 'see' that to which I may call significance to. I feel that I have

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		to prove myself as some kind of seer and I am actually not good at that at all. Or perhaps, like us all, too good at it. 'We see things not as they are but as we are' (Kant 1724–1804) and, reflecting back on my comments here – for example, my take on Mary's comments [see below] – I may have been too quick to interpret in the sense of demonstrating intuitive skills at the expense of what actually may have been meant.
Nigel: I remember thinking in the 'hospital transport car' taking me up to London 'Try and take in all the experiences you are about to have'. The bloke driving the car had his own brick making company. We spoke for a while and then I was unable to concentrate and I faked being asleep. We arrived at St Thomas. The driver opened his window when we were parallel with the reception box in the middle of the car park. 'Where is the medical ward' he asks.		
Nigel: The staff often used to sit next to people when they were making private phone calls. I developed an idea. I was reminded of the work of Michael Argyle, *The Psychology of Interpersonal Behaviour* (Penguin 1967). If I wanted to let Ian know that there was a member of staff near me I would say Michael Argyle.		
	Mark H: Several key things. Phone call from M. Nigel had gone missing, car had gone and a length of hose pipe was missing. It did not feel real. I was anxious and strangely excited. Maybe that was anxiety. We thought you might have gone to Beachy Head. I went out in my car looking for you in what turned out to be the wrong place.	I am struck all the time by the way in which things are picked up, dusted off and let go: 'I was strangely excited but maybe it was anxiety'. I never knew anyone get excited at the prospect or commencement of anxiety before: of course you would have to get inside the 'bee box' to find out what being 'excited' feels like: can you, for example, think straight when excited: when neurotransmitters are charging around in your body? 'Why don't you think straight' someone once said to a friend of mine who was diagnosed as schizophrenic: 'but what do you do when you *can't* think', he replied.
Nigel: I had found a crag of cliff on the South Downs. I intended to drive there. The idea of Beach Head never entered my mind.	**Mark H**: Met you once at little Common Hotel on the seafront. Trying very hard not to be a therapist. Offered you much reassurance. Remember our conversations were very circular and I could not reassure you. First time I noticed that your physical appearance had deteriorated. This observation mirrored other peoples concerns about you. When I was told you had gone to hospital this I felt that this was for the best as you had been suffering for many months by this time. Visited a few times in hospital. Brought R (daughter) on one occasion. We did not say much on the train there or back about you specifically but we chatted. We all sat in the family room of the hospital. Remember J (son) not wanting to come up to hospital I think he was worried about being emotional, possibly.	
Nigel: I remember you wearing a new style of bag. One where the strap went from your right shoulder across your front and finished just above your hip. I had not seen one of these before and it gave me a sense of the outside world.	**Mark H**: I was confident that once you were in hospital then the panic was all over. You were going to recover. There was certain un-realness about the whole situation. I was not worried that you would kill yourself. Worried that you were in crisis but somehow knew that you would not kill yourself. I did not expect bad things to happen. **Mary**: I screamed a thousand inner screams during Alec's tortuous journey. I had no choice but to join Alec stumbling in the darkness, knowing my life, as well as his, had come to a virtual standstill. At the beginning I thought Alec's depression was no more than just 'feeling low'. It irritated me, as most people get the latter. They work with it, not crumple to a heap. Looking back, it is hard to separate the drink dependency from the depression. It was however the alcohol I dreaded the most. It changed Alec from a calm, gentle person, into a verbally abusive, angry and irrational	My immediate response is to not violate Mary's story, to leave it alone, between her and Alec. And yet it has seemed to me to be a heartfelt and terribly relieved account and extremely close, perhaps dangerously so, to the actualite: of the various accounts, it's the one that seems viscerally edgy and working its way, in its actual expression, towards something. Obviously things were not easy and the drinking especially, unsurprisingly, was going to be explosive: there is a clear implication that any re-occurrence of the alcohol may not be welcome. I showed this comment to someone whose opinion I trust overwhelmingly and who responded that *she* could see no evidence for it in Mary's testimony. Why hasn't Alec commented on this part? Or: why does Mary's account appear in a vacuum with nothing to the left of her and me to the right? Is Alec using me as some kind of alter ego? What in sanity's name am *I* doing talking back to his wife? I keep thinking what the Freudians would make of this: worse! What will *she* make of it? If anything. Wilfred Bion (1961) tells us that much of our manifest

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.	personality. During the alcoholic phase I saw the person I loved curled up into a ball, rocking back and forth crying. I saw him defecating on floors and vomiting day and night. I heard him repeatedly say self-damaging phrases: 'I want to die'; 'I want to kill myself, commit suicide'; no-one likes me'; 'I'm no good'. 'Self indulgent', my inner response at first. At the beginning of this nightmare I felt love, empathy and sadness. I felt helpless. As the nightmare progressed, I had emotions of irritation, dislike and remoteness towards Alec. Looking back now my safety valve I felt could not respond to someone who, as then I thought, was deliberately drunk, even after requests from me not to drink. I remember so many times I came home tired from work to find Alec sitting drunk on the settee, head lolling. More than once I made slapping actions near Alec's head. I wanted to hit him. I felt rage and close to hating him. I wanted to shake Alec out of his apathy and self-destruction. Why was this person so unhappy when he had so many positive influences in his life? It perplexed me. My changing emotions confused me. I should be constantly showing warmth, support and love at all times. Instead, I was harder, colder and almost uncaring. Looking back, I feel guilty about my approaches to Alec at times, and cruel. I always had love for him, but at that time it was veiled in mist. Because of Alec's bizarre behaviour, I grew tense. He shaved his head repeatedly, leaving little hair. In his coherent times, he watched the same video repeatedly. I hid alcohol, tipped a lot away. I took bottles in my car to work. At the end I was keeping his wallet, credit cards and spare cash. I did not like doing it, but it was imperative. I raided study drawers, bags, anything, in a frantic effort to find concealed bottles of vodka and gin, and still Alec's denial of drinking made me angry. At one time I wanted to leave the situation. I wanted some peace, some semblance of normality. In reality, I could not have gone. I could not leave Alec on his own, in his need, even though he had left me to live, eat and sleep on my own. I pushed Alec to go to his GP in time; he needed professional help. He went to the doctor with me drunk – a good thing as the severity of the problem was shown. I remember feeling embarrassment however in the waiting room. Help came for Alec just before his mental and physical state slipped further into the abyss. I wish I could have stayed more supportive throughout Alec's ordeal time, but I felt my own strength failing. If the weight had not been lifted I would have fallen myself. Eight months on, Alec is back, as 'my Alec' – a good, kind, caring man. He has done amazingly well and I am very proud of him. I'm calmer and at peace. He made it through and I know will go on from strength to strength.	behaviour is but a camouflage albeit a sometimes terrifically plausible one: even the emotional 'work', he says, hides the real stuff, the elusive, defensive, primitive motives. The idea I am working towards here is simply an 'arty' way of asking if all of the reasoning about the drinking and its genesis is in the ownership of one or more persons.
	Neil: I met Nigel when I was training to be a Cognitive-Behavioural Psychotherapist in 1997. I met him at the BABCP Canterbury Conference that year. My initial impressions of him, were that he reminded me very much of Billy Connelly, although had a right cockney accent, he was very warm, and I immediately felt a connection with him because of this. I did not see much of him over the next year or so of our training, which we were both doing at the time, until I left the UK to go to Australia to live in Melbourne. While I was away I had email contact with him, which was surprising really as we had not had a great deal of contact before that. I remember emailing Nigel perhaps more regularly than some of my other friends due to his ability to keep in touch and show a genuine interest. While I was coming to the end of my eight or nine months in Australia and actually travelling around, two months before I came home, his emails stopped with the title *madness* only in the header, and no text. I replied to the email but did not hear anything back for a week or two, and was emailed back by his partner, who informed me that Nigel had been admitted to an acute psychiatric ward in London. I remembered feeling very shocked at this, and immediately contacted our mutual friend to inform him, and to check that he knew, and I wanted him to make contact with Nigel. I arrived home to the UK about six weeks later, and as soon as I was able, took a train to London. I remembered walking into this large London Hospital, near the London Eye on the Thames, and finding his ward. The staff led me to Nigel's single bedroom where he was laying in bed at the time. It was quite a large room, although fairly dark. Nigel was pleased to see me, and we soon made out way of the ward for a stroll down the Thames. I was shocked by Nigel's demeanour really as he was obviously mentally unwell at the time. His usual brightness was rather flat and blunt, and there was evidence of some	Most of the rest is recollecting the events surrounding Nigel's distress and it echoes the not inconsiderable shock, guilt and dismay that attended Alec's distress as well. All told – and leaving aside Mary's account – it has been a narrative of perceptions tied into recollections of what happened, Some emotions have flowed, true but almost, perilously, as statements of the fact of their having happened. There seems a palpable absence of wanting to go inside one's head and ask why *this* feeling, *this* reaction, *this* belief. Had the participants not been schooled – as most of them seem to have been – in CBT – and I am being mischievous here – would the nature, the depth, the style of responses have been much different? I am satisfied to have been asked to contribute to this and admire the moral and psychological efforts involved both for Nigel and Alec. I have not found the process of this easy and have probably omitted a great deal that might be considered pertinent to the task. With that in mind, I have one final name to drop: Pinter (1981) has said: 'We have heard many times that tired grimy phrase: 'failure of communication' and this phrase has been fixed to my work quite consistently. I believe the contrary. I think that we communicate only too well, in our silence, in what is unsaid, and what takes place is continual evasion, desperate rearguard attempts to keep ourselves to ourselves. Communication is too alarming. To enter into someone else's life is too frightening. To disclose to others the poverty within us is to fearsome a possibility'

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	self-harm to his hands, which he readily showed me and explained what his cognitive process had been at the time of self-harming. I guess this is one of the first times that I have encountered a friend/ colleague who has become acutely unwell and required inpatient admission. I guess it is a reminder to all of us that we are all fragile and susceptible to mental ill health as much as we are physical illness. My impression of the psychiatric unit he was in, was a busy one where staff were lacking in time to form any long term attachments to patients, I guess due to the shortness of their stay and busy work load. I got a sense that they were not particularly interest, in who I was, or what I did, or my relationship with Nigel, and certainly did not encourage me to impart in information to them before I left, which may have assisted them in their care of Nigel. The experience of seeing him there, has I think affected our relationship in as much as I have a third ear when talking to Nigel, and am mindful that if he is under the same stressors again he could have a set back or relapse into ill health, and require professional care and support again. Due to the distance I live from him I find it very difficult to provide as much meaningful support, apart from email, telephone and occasional visits as possible. On a positive note, Nigel speaks from a position of authority when talking about problems, which many of us do not have at present, and I am sure this has helped him to become a more compassionate and empathetic therapist with his own patients. I know he speaks regularly at workshops on his experience, and receives very good feed back on the contents in helping staff adapt their own assumptions and beliefs about patients. I have also taken Nigel's experience into workshops, and invited my own patient to attend to give a perspective of their experience of therapy, which was very powerful. Hope this helps mate, cheers.	
	Ian Reflections on the time Nigel was in the 'bin' (2000). How time moves on!! I am aware that the 'now 'part of me has had to work hard at conjuring up thoughts, feeling etc about what was happening then. This immediately gives me an insight in to how time truly changes our reflective capability. I clearly remember M explaining to me over the phone that Nigel had been admitted to an acute in-patient ward (St Georges??) following an incident whereby Nigel had contemplated taking 'his life'. I was in complete shock and obviously deeply distressed by this. I contacted the ward who informed me that Nigel was on the ward and under constant supervision. I asked if I could talk to him but received the response that he did not at this time want to talk. I guess I wanted to hear from Nigel to be reassured by him. This could be interpreted that at that time I wanted my needs meet but I was seriously concerned. I remember phoning mark to gather more information about what had happened and how Nigel was. He like me was uncertain. I rang M again and related that I had spoken to the unit and Nigel had not been able to speak to me. We spent some time talking about Nigel and ourselves in relation to what was going on. Unknown to me M related that Nigel had become increasingly preoccupied with certain 'unhealthy' thoughts and as a result had been isolating himself and his mood had deteriorated. I rang the ward a couple of days later and this time Nigel was able to talk to me. I did not recognise the person on the other end of the phone. Nigel was (for once!!) very quiet and vague. I felt tearful and distressed for him. We have shared my laughs and some difficult experiences but this was different. Nigel was in a very bad place. I wanted him to say he was 'okay' but he could not as he was not. I wanted to see him. This is the difficult bit of the story for me. I guess you may not know this but whenever I meet up with you hidden within the joy of seeing you is a pang of guilt. This guilt is down to the fact that I had arranged to meet you in London but called to cancel on the morning. I did this as I had been playing rugby and gone out on the piss and was in no fit state to travel. As I write this I feel terribly upset especially in seeing these words typed out. I do not want reassurance about this because it happened as described and I know we are extremely close in spite of this. I would be interested in what your memory is in relation to this and I expect an honest view i.e. not watered down. I continued to make contact via the phone and we started to communicate in our 'style'. I remember you talking about how the staff would not give you any privacy when you where on the phone and how they had thought that Art work was the best	

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	treatment for someone in your condition. However as the phone calls continued I sensed that bits of what I knew about you returning. For example, telling me the same joke over and over again. As I feared upsetting you I just kept laughing at the same jokes over and over again!!! It is interesting how I was anxious not to say the wrong thing or try and be too CBT about things. I wanted to be natural as a friend but sometimes that is difficult due to the 'trying bit' We did meet in London and you looked bloody awful. You had lost weight (a good thing!!) but your eyes were soulless. I was taken aback by this. We had a few beers and tried to laugh about stuff. I say try as I was trying to hard to make you feel okay. You wanted to go into a gay bar which we did but I did wander what that was about for you at that time. I think I understand now. It was good to see you. (part two to follow). **Ian:** Nigel (part two) Hi Nigel. I have reflected on what I wrote in part one to you pre-xmas. I would change the word 'pang' of guilt as it weakens it true meaning. Following the trip to London I spoke with Cathy about how you were. While I was pleased to see you I realised how little I really knew about you. It is amazing what people can hide behind the eyes. Cathy also could not believe about what had happened. I saw you as the rock of the group. I remember Neil and I continually checking in with our thoughts about what was going on for you. That was helpful as I think we both knew different things about you and this helped give us a richer perspective. You and I continued to keep in touch regularly via phone and it was clear that you were on the road to recovery Since this time you have remained well (I think!!!) and I believe the combination of the PhD (helps the self-esteem!!) and stopping the alcohol (helps the skin!!) have contributed to a much more healthy sense of self. I guess you still battle with the demons but you control them rather than them you ?? I know you went through an awful experience but I believe you have become richer for it. You truly understand and thus can connect in many more ways to your clients, family and friends. Also from your experiences and Mark's it gives hope that people do recover.	

Coda

Right: that is that then; the stories have been told: only, they have not; ethnography is a 'never-ending story' and the beauty of the thing, the 'terrible beauty', is that nobody knows the Endgame. Based on what you have read so far, some of you might confidently predict how things will materialise for our two protagonists: 'leopards don't change their spots' – 'show me the child and I will give you the man' and so forth. But then – and their tales have, arguably, been existentially driven – hell is never 'the self': 'hell is other people', and their effects. But this introduces paradox: if the heartland of existentialism is a self that grapples with its *own* place in the world, then – morally – this only works by somehow 'including oneself out' from the community of others, to assert one's place as an essential to overall truth. Put it this way: when Foucaultians tell you there *aren't* any hard and fast truths, do not believe them: if you do, you will be signing up to the hardest and fastest 'truth' alive. Thus is the existentialist ambition – in the real terms it denies – a cop out from the (sometimes justifiable) demands and needs of others.

Actually, we are ethically required to respond to Alec and Nigel's stories. Even if, these days, we are a generation defined by the therapeutic mantra of 'to thine own self be true', I perch on the conundrum of how to appreciate the auto-ethnography. Is it, phoenix-like, ascension into existence on its own terms, in these particular cases self-evidently (courageous) manifestations of psychiatric distress? Or: as well, should one's response be to fit these narratives into something of theoretical or practical usefulness to mental health practice? One minor point I overlooked is the weight of constraint which inhibit the production of auto-ethnographies of mental distress. It is actually quite difficult nowadays to keep one's affairs secreted so that 'coming out' is a question of degree rather than an absolute. That said, too much is made – for and against – this aspect of the issue.

Are Alec and Nigel's narratives dependant on their status as practitioners and academics? This raises the question of the relevance of self-disclosure in respect of context: these disclosures, by any other name, carry a veneer of the academy; for example, they are presented as 'autoethnography', a respectable sounding intellectual departure. Reader's questions may pick up on this aspect since, if autoethnography brings qualitative research to its full possibilities, and I think it does, then the only step beyond that is reflective analysis and evaluation of what autoethnography does or does not achieve. For myself, I look forward to future Commentary sections of this journal with eagerness and not a little trembling!

Of course, the objectivists, in addition to squirms of embarrassment, will want to know the *outcomes* of all this. I mean, where is the randomization for God's sake? How can a researcher be his or her own best instrument, the arbitrator of his or her own sensations? Introspection be damned! said the early behaviourists: bring on your evidence base! Here, a lot will rest on the width of your perception of outcome: ironically, both Alec and Nigel's stories (unavoidably/surprisingly) implicate the role (and importance) of orthodox psychiatry in what happened to them, even if they highlight the poverty of the conditions and nature of its delivery. But there will be many, nevertheless, who will question the practicality of autoethnography as a *method* of carrying this forward and such like exercises in general.

Importantly, I think, these narratives *do* lessen the ages old configuration of mental health patients as 'other'; the may even diminish the psychiatric apartheid incipient in 'service user' designations. Psychiatric (medical) power operates partly via assimilation, 'me too' approaches nullify criticism by persuading us that the latest 'outsider' is now inside the tent or, if outside it, is such by virtue of 'delegation': the end point being invariably a 'first amongst equals' domain that remains essentially medical.

What is achieved here muddying of the waters where the natural owners of 'the tent' are redefined as qualitatively un-different to 'the other'. Some readers may feel that this is as far as these two autoethnographers have gone: but I think that the lack of a thoroughgoing and systematic sociological analysis of the relational aspects of their positions would be too much to demand at this point. In respect of the long and distasteful history of stigma in psychiatry, theirs is an important additive to the customs and debates by which we normally regard our professional selves in relation.

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