An exploration of constructions of meanings narrated by a cohort of older people in relation to their mental illness, its connection to and impact on ageing and familial relationships

Joanne Challis Smith

A thesis submitted in fulfilment of the
requirements of the University of East London
for the degree of Professional Doctorate in Systemic Psychotherapy

August 2013

ABSTRACT

The genesis of this study came from a wish to contribute to the evidence base of systemic and narrative therapies with the cohort with whom I work clinically, that is elders suffering with mental health difficulties. Its subject matter and methodology were influenced by recognition of the paucity in the literature of both subjective experiences and narrative research studies with this client group. In this study nine elders with mental health problems narrated experience of mental health, their family relationships and ageing. Identification of themes around these three areas of interest were made and analysis of narrative variables such as influence of past, present, local and wider cultural narratives, narratives of time, coherence, performance of preferred narrative selves and influence of audience were made. Service implications for Narrative and Systemic therapy with elders and wider service planning were considered in light of findings. Throughout, reflexive consideration was made by the researcher and this is included, particularly in the conclusion, in the write up.

Dedication

I dedicate this thesis to my dad, who died during its completion, and whose narratives of, and pride in, my academic ability contributed to this work.

Acknowledgements

Many people have helped me over the years that I have worked over this doctorate.

I would like to particular acknowledge the help of Dr Charlotte Burck my long suffering academic tutor. Dr Karen Partridge and Dr Reenee Singh for reading and their helpful comment on drafts of this thesis. I also gratefully acknowledge the material and financial support of the Derbyshire Healthcare NHS Foundation Trust and their Research committee for awarding additional financial support. Last, but not least, my family and particularly Keith for his belief throughout in my ability to complete this doctorate.

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1 INTRODUCTION

1.1 INTRODUCTION

I am a systemic practitioner and clinical psychologist working in elderly services in the NHS. Since qualifying as a family therapist ten years ago I have sought to promote family therapy services in this discipline. This has been hampered by the lack of evidence base to justify development, since there has been little research on benefits of Systemic Practice with elders. Whilst clinicians working with elders have recognised the potential of this approach, lack of opportunities to engage in research activities in clinical settings has led to a paucity of published work other than case studies (Smith 2003; Anderson 2001; Martin and Milton 2005).

Whilst training as a systemic psychotherapist I recognised the relevance of Narrative Therapy as a therapeutic approach for elders. It was common for me to witness life span narratives in therapeutic work and I recognised the value of these in relation to contextualisation of present problems and accessing different selves of clients.

Throughout my clinical experience I have witnessed clients evidencing impacts of ageist and stigmatising wider narratives and the impacts of previous silencing of potentially traumatising life events, by both medical and wider systems. Consequently, much of my therapeutic work has involved working to facilitate elders in their attempts to express, explore, grieve for and somehow integrate narrative selves as they face the latter part of their lives. I have recognised the value of different forms of narrative expression, use of additional family or care givers as witnesses and presenting ideas to wider audience. Furthermore, I have learnt from insights gained from this client group, their rich and complex lives, which have been lived beyond my own experience.

Learning of the emergence within qualitative methodologies of Narrative research methods, and in particular Narrative Analysis, was perceived by me as an exciting opportunity to combine clinical knowledge, awareness of the usefulness of Narrative Therapy with elders and my opportunity to conduct a research study (which could potentially contribute to research base of systemic approaches with elders). In particular I felt it could offer insight into the following areas, observed through my clinical work:

- How older people with mental health (MH) difficulties choose to create narratives of their experience
- How family relationships and the experience of ageing are included within these narratives
- How narrative content and construction reflects past and present wider cultural and familial narratives and how these were integrated into lifelong narratives by older people
- How the impact of negative cultural narratives e.g. stigmatisation of those with mental health problems and ageism has impacted upon the development of preferred narrative selves

I felt insights in these areas would allow theory/practice links to be created specifically in relation to Narrative Therapy and more widely development of systemic services through research which could give voice to the narrative constructions of experiences of this client group. Further it offered possibilities of highlighting how specific wider cultural narratives have impacted on this cohort and what challenges are faced by ageing in our present British political and social culture,

With these aims in mind the following research question was developed:

How can exploration of constructions of meanings narrated by a cohort of older people offer insight into their:

- Experience of suffering mental health problems?
- Familial experiences?
- Experience of ageing?

How might these be influenced by:

- Interrelation with each other?
- Past and Present narratives of local and wider systems?
- Need to create lifelong narrative selves?

And:

- Be related back to the clinical field?

2 LITERATURE REVIEW

2.1 INTRODUCTION

This research aims to focus upon narrative meanings elders create of their MH difficulties, ageing experience and family life and the interrelation between them. It would not be possible in this literature review to cover all areas which may be of relevance to this study. Decisions have therefore been made to focus on themes perceived as relating most closely to areas I aim to explore and enable identification of gaps in literature and research which this study may go some way in addressing. This literature review will therefore include past and present theoretical, cultural and political narratives relating to elders and a review of literature related to family relationships and mental illness. Clearly these areas are extensive and attempts at discerning which might be most relevant to this study have been made.

2.2 THEORETICAL IDEAS OF ELDERS AND FAMILIES

Life cycle theories present generalised patterns of life course, often using norms to make the case for predicted life cycle changes related to specific life stages and transitions (Nelson and Dannefer 1992). Examples of life cycle ideas applied to later life include; focus on loss e.g. “empty nest” syndrome, perception of elders’ familial relationships as less significant (Kuypers and Bengston 1983) and a lack of reconnection and adaptation within family systems (Matthew and Sprey 1989).

Life cycle theories have been criticised for minimisation of individual difference and presentation of simplistic, unrepresentative ideas of later life (Nelson 1992). Their portrayal of “normal family life”, against which alternatives are judged, (Scanzoni et al 1989 quoted in Allen et al 2000) has been felt to result in marginalisation of groups not complying with norms. Those with mental health problems being one example. They may also potentially overlook unique and individual experiences of family life across the life span (Matthews and Sprey 1989) with the result of families (and individuals within in them) experiencing “off timedness” when unable to fit with norms, resulting in fears of cultural judgment (Cohler, Pickett and Cook 1996).

Developmental theories also propose normative individual and family developments. Marriage, child rearing, children leaving home and spousal bereavement are proposed

as normative developmental paths, all presupposing ideals e.g. heterosexual marriage, conception of children, lifelong relationships. This again leading to marginalisation of those not able to fit these life experiences. Lack of consideration of later life in most developmental theories has contributed to common cultural ideas that later life is associated with cessation of positive change. One of the most quoted lifelong developmental theories extending to later life is Erikson's (1950). He identified four later life states: Integrity, foreclosure, dissonance and despair. He proposed integrity essential to acceptance of one's life as death approached and that this involved successful completion of "tasks" of individuation through life review. Critics argue that integrity can never be total and highlight lack of clarity regarding how resolution of such tasks should occur (Hyer and Sohnle 2001). Further, these tasks involve processes of separation rather than relatedness (Midlarsky and Kahana 1994) and focus on individuality rather than collective relationships in later life (Kopito Motenko and Greenberg 1995). The connection between Erikson's theory, interpretation of it in professional narratives and recent political ideas of non-dependency, self-reliance and responsibility for elders has not been difficult to recognise (Midlarsky and Kahana 1994).

Dismissal or neglect of active psychological and emotional roles is now recognised as a flaw in development and life course theories. Additionally, acknowledgment has been made of potentially negative influences such theories have upon wider cultural and political discourses of elders. Attempts will be made to highlight these further throughout this review.

The 1990s saw emergence of more positive and relational aspects of later life being focused upon in research. For example, Ryff (1989 quoted in Mack et al 1997) found elders' perceived continued growth and connection to their community as an important part of their ageing identity and Hyer and Sohnle (2001) noted coping and resiliency in elders' ability to adapt to changes of later life. Kopito Motenko and Greenberg (1995) suggested such research illustrated need to move from burden theories of elders to views of their possessing maturity in adapting to changing needs. They proposed systemic perspectives as useful in this regard. Around this time shifts were also occurring (partly related to increased life expectancy) in methodological approaches with longitudinal and life span studies replacing cross sectional ones.

These alongside different methodologies, allowed more complex and interrelated ideas (Allen et al 2000), inclusive of cultural and relational variables over time to emerge.

These changes (Bengston and Allen 1993) occurred around the same time as emerging interest in family care giving (Silverstein and Angelelli 1998) and resulted in life course perspectives taking on a more social constructionist approach. This allowed elders to be positioned as more actively engaged in dynamic processes of change, where multiple variables and social factors were seen as influential (Cohler et al 1996). Life course perspectives acknowledged the importance of relationship, reciprocity and change. For example, Lee and Shehan (1989) and Cicirelli (1983) suggested relationships between elders and offspring be viewed as reciprocal, with differing balances of dependency over time. Similarly, Glass and Dunham (1989) suggested parent child relationships in families should be viewed as dynamic, mutually influenced and increasing in knowledge of the other throughout life. Quinn (1989) found transitions between generations were achieved through adult children and parents rethinking differing responsibilities alongside long term loyalties. Fingerman (2001, 2003) researching relationships between older mothers and daughters proposed that despite life stage transitions, relationships remained uniquely intimate but dependent upon mutual adaptation, change, and release from previous roles.

Cohler et al (1996) studying family relationships of elders with MH problems found social changes also contributed to relational complexity. They wrote, “Psychiatric illness represents an important arena in which to apply the significance of the social timetable across the life course” (p.431) but noted a lack of research in this respect. Research in the study of later life (gerontology) has begun to view elders as active participants in ongoing developments, skilled in analytically reviewing past experiences, familial and social systems and using these to adapt to individual ageing experiences. Research exploring subjective experience and meanings created of growing older and familial relationship would add to a field open to new ways of understanding.

2.3 NARRATIVE THEORIES

Given epistemological shifts in theoretical thinking and the acknowledged connection between oral history and later life, Narrative theories of later life have begun to emerge. Narrative theories hold that all ideas of later life development, and research data contributing to them, are socially constructed narratives and, as such, need to be considered in relation to the particular professional and research cultures from which they emerged (Alheit 1995 in Kenyon and Randall 2001).

Detailed consideration of narrative theory in relation to this study will be made in the Methodology chapter, so focus will be given here to relevance of narrative in understanding ageing experiences. Kenyon and Randall (2001) suggested narrative gerontology built upon previous theories "to provide a conceptual framework for expanding the dialogue concerning important topics" (p.5) of ageing. They proposed that it did not contradict previous theories or offer new truth but rather socially evolving, co-constructions to the field. For example, Omer (1997) relating to Erikson's ideas suggested lifelong processes of creating narrative selves resulted in elders "more or less" achieving integration through pulling these together and argued that constant change of contexts, relationships and personal narratives created need for continual restorying which change as a result of life stages.

It has been proposed that we become better at narrative meaning making as we age through increased autobiographical memory processing, higher order meaning making, developmental changes (Elder and Caspi 1990) and wisdom (Baltes 2000). Narrating is viewed culturally as a natural, necessary and evolving process for elders and holds advantage in recovering meanings, unquestioned stories of self, grief processes and restorying (Kenyon and Randall 2001). Kenyon and Randall (2001) described the process of narrative processing in later life as "existential" and the reinterpretation of narratives by professionals as a retelling through their efforts to understand.

Clark (2002) suggested narrative gerontology allowed possibilities for more meaningful communication and potential healing through its ability to facilitate professionals addressing elders' needs more meaningfully. However, this necessitates researchers changing personal and professional narratives of ageing, as well as their

approaches to research. In this way they become part of the retelling of developments in the field (Kenyon and Randall 1997 quoted in Kenyon and Randall 2000).

2.4 IDEAS OF FOUCAULT AND DERRIDA

It would be impossible to consider the relevance of powerful discourses upon individual narrative formation without considering influences of Foucault (1988) and Derrida (1985) to the field.

Flaskas and Humphrey (1993) wrote how Foucault's work has widely influenced the field of humanities in the last 15 years through his focus of power and discourse in the creation of meaning of experiences and self-conceptualisation, both central to narrative understanding.

Foucault highlighted how influences of scientific neutrality in treatment of madness by medical systems, resulted in particular social constructions and control of difference by powerful systems. In doing so he offered new perspectives on cultural politics of marginalisation. Foucault viewed power as connected with interactions and contexts, positing that control in hierarchical societies is created through normalising social constructions, which create marginalisation of difference. He argued such processes could be seen to be reflected in medical, psychological and developmental theories. In later work he conceptualised power dynamics in relation to subjective selves as complex, hermeneutic "net like" systems within which self identities are influenced by powerful systems and these in turn inform future social practices. Derrida (1985) highlighted how deconstruction of political and powerful discourses in our society allows identification of hidden, underlying assumptions.

Derrida and Foucault's theories began a questioning process regarding how powerful systems contribute to marginalisation and highlighted how awareness and critical analysis of them can lead to questioning and change. Yudice (1989) suggests their ideas led to marginalisation being seen in the field of social science as a potentially positive because it allowed for resistance. Furthermore, Foucault and Derrida were also advocates of theories not being seen as "truths" but "merely laid down for you to pursue…. …to extend upon or redesign as the case may be" (Foucault 1988 p.78-79).

Their theories have therefore been extremely important in the development of discursive and critical approaches in the field of social science.

It is not difficult to identify how Foucault and Derrida's ideas relate to narrative theory and it is suggested they were used by Michael White in development of Narrative Therapy (Flaskas and Hymphrey 1993). The connection is seen in the recognition of societal discourses influencing individuals' meaning making, are internalised and result in invisible, on going self-monitoring and formation in reference to them. His ideas also connect to narrative theories through acknowledgment of how representation of ideas given us by wider society can be continued through the living out of them, or changed through individual and/or collective resistance. They connect in belief that we become both the product and the producers of history and societal discourse.

Derrida (1985) wrote that meaningful deconstruction of discourse only took place in consideration of those contexts in which they were created and previously influenced by and that discourses changed in relation to those of our societies. Similarly, Foucault (1988) proposed all historical periods possess particular, underlying truths constitutive of cultural discourses, which change over time creating need for their consideration. These ideas have been further developed in narrative theory (considered in Methodology chapter) and are of particular relevance where life span narratives are considered. Foucault also notes how in western society achievement is an important aspect of societal acceptability leading to marginalisation of those not meeting this standard. Clearly, those with physical or mental illness are more likely to fall into this category.

Elders constitute a marginalised group and many cultural narratives exist which influence formation of elder identities (Coles 1992 quoted in Adams and Blieszner 1995). Taylor (1989 quoted in Biggs 2001) suggested political policies shape cultural and social narratives, then, through their existence, produce evidence which creates, maintains and provides backgrounds for "moral judgments, intuitions and responses" of others. Political narratives offer descriptions prescribing how elders should "Legitimately live" (Jolanki 2004), perform "publically acceptable identities" (p305 Biggs 2001) and create acceptable selves (Holstein and Gubrium 2000). Consideration

of present political and cultural ideas of ageing and their potential impact of narrative formation will be made here.

2.5 WIDER CULTURAL NARRATIVES OF OLDER ADULTS

2.5.1 Negative stereotypes of older adults

Moves away from the welfare state and increasing ageing populations have led to elders being viewed politically as presenting a potential financial dilemma. Brubaker and Brubaker (1995) suggested early research focusing on familial care of elders added to these ideas of elders being burdensome (Brubaker and Brubaker 1995), ideas which Biggs (2001) feels have led to unquestioned negative theoretical and cultural narratives being internalised by elders, and to professionals failing to see the impacts of such negative narratives on service provision.

2.5.2 Positive ageing

In the 1990s movement of research to positive aspects of ageing (Johnson 2002) resulted in present political and professional narratives of "ageing well" or "active ageing". These theories present elders as responsible for their own physical and emotional health and able to make meaningful contributions to society. Although these ideas on the surface offer more positive views of ageing, deconstructed they might be viewed as political attempts make elders themselves feel responsible for lowering possibilities of imposing a burden through need of care from family and wider society. Simply put, one political advantage in replacing decline and burden narratives with successful ageing has been the potential it offers for "balancing the books nicely" (Biggs 2001, p. 312). However, this cultural view of ageing is now commonplace and "The association of activity with well-being in old age (now) seems so obvious and indisputable that questioning it within gerontological circles would be considered unprofessional if not heretical" (Katz 2000 p.135).

However, moves from negative views of decline as synonymous with age to ideas of agency in relation to one's health and positive ageing experiences (Featherstone and Hepworth (1991) quoted in Sanders Donovan and Dieppe 2002) only legitimises one form of ageing and necessitates viewing elders as having no different needs to

younger adults (Biggs 2001). This theory minimises issues of relevance in later life such as increased possibilities of illness and ageist prejudices. Jolanki (2004) felt the result was creation of "complex and contradictory" stories which elders feel pressured to live by without visible signs of old age" (p.484) and which lead to fear that departure from this accepted societal norm through unavoidable circumstance will be judged as personal failure.

The potential harm of this present cultural and political ideology lies in its perception of elders as an homogenous group, rather than acknowledging that, "Some age in good health some in ill, some are unremarkable either way" (Johnson 2002 p.125). The necessity of more individual and context related narratives of ageing (Baltes and Baltes 1990) if elders are to "construct a reality for themselves in all of its uniqueness rather than to react to role" (Jolanki 2004 p.127) has been noted. Professionals and researchers will need to explore further the experience of elders and their families from subjective perspectives if we are to understand their wide ranging needs sufficiently to create meaningful service provision (Adams and Blieszner 1995; Jolanki 2004).

2.6 LATER LIFE FAMILIES

The ageing experience in the light of mental illness and their relation to familial relationships is of interest in this study. Consideration will therefore be made of literature relating to elders in relation to their families to highlight findings which may be of relevance and identify any gaps in this research field.

2.6.1 Family as Carers: Burden Literature

Research in the 1970s focused on care of elders particularly with dementia and its cost to middle generations (Kramer 1997). This focus was criticized for bias toward carers (Kasl-Godly and Gatz 2000) and its contributory influence on negative views of elders. Kuypers and Bengston (1983) suggest consequences included later life families being influenced by negative ideas and consequently finding exploration of more complex relationship transitions difficult. This in turn restricted research interests further.

Family care literature is vast, with much focus on spousal or adult offspring (mostly daughters) caregivers. Demographic, social and burdening factors have been identified using empirical approaches to identify normative patterns. Contradictions in results are believed to be due to methodological limitations and narrow views of variables involved (Kramer 1997). Research which did focus more on negotiation and transition of relationships between elders receiving care and family, included consideration of levels of decline when care begins (Albert, Moss and Lawton 1996; Walker and Pratt 1991 quoted in Merrill 1997) and different stages of caring careers. Strawbridge, Wallhagen, Shema and Kaplan (1997) carried out longitudinal research of possible negative caring outcomes for adult children, spouses and grandparents looking after grandchildren. They found impacts of caring over a prolonged period more psychologically than physically difficult and that recovery from this occurred when care ended and initial grief passed. Brubaker and Brubaker 1995) found a higher percentage of women compared to men cared, but that there was little difference in impact between genders, except where female carers were younger in which case subjective burden was experienced as greater.

Merrill's (1997) narrative study identified characteristics such as class (working class expect to care for elders), gender (women more than men), personality type (carers tend to be nurturers), and parents' expectations (working class families believed parents chose particular offspring as carers) as influential to caring. They acknowledged interrelatedness of family systems by considering impacts on members indirectly affected (e.g. son in laws, etc.). A factor also considered in Schoonover and Hoffman's research of effects of caring upon marital relationships of offspring carers (Brody et al 1989). They found women perceived their marriages as negatively affected, whereas husbands reported their wives caring roles as not directly affect their marriage.

In relation to gender, Brubaker and Brubaker 1995) highlighted how younger carers tend to be daughters, resulting in women often caring for children and elders simultaneously. They quote Stoller's (1983) research which identified paid employment as more likely to be a reason for males' inability to care than for females. Matthew and Rosner's (1988) qualitative study also found adult sons played narrowly defined care roles whereas daughters offered routine, regular care.

Robeiro, Paul and Nogueira (2007) using semi structured interviews, focused on older male spouses experience and found perceptions of obligation, marital duty as motivators with positive rewards found in control and social approval. Although almost all these studies focused on carers of those with dementia the findings may be of relevance in considering impacts on later life families coping with issues of MH and physical illness.

2.6.2 Views of the person cared for

By the 1990s criticism of research due to its lack of consideration of the subjective experience of elders and its focus on carers was being made (Allen et al 1999). In addition, greater acknowledgment was made of the erroneous assumptions of elders' voices being invalid and the influence large empirically based studies (Bengston, Rosenthal and Burton 1996) and normative ideas (Kasl-Godley and Gatz 2000) had in influencing these. Agreement seemed to be reached that gerontological research had "assumed too much and documented too little" (Lee and Shehan 1989 p27) about adaptations of ageing and negotiations of change between elders and their families.

Shifts then occurred in the research field as greater attempts were made to elicit views of elders. Lee and Shehan (1989) for example, in a questionnaire study, found a difference between elders who expected their family to care and those who did not in relation to subjectively experienced quality of contact. The former experienced lower levels of satisfaction in comparison to the latter. Walker Pratt, Shin and Jones (1989) using structured interviews with carers and elders found daughters reported caring for parents from a sense of obligation, contrasting elders' view that their daughters were under no obligation to care and that the relationship between them was of more value. Brody et al (1983 quoted in Quinn 1989) researched three female family generations and found the oldest least likely to feel care should be provided by family and more likely to provide care than receive it. Similarly, Cicirelli (1983) found elders preferred to remain independent, however when care was required they preferenced this from offspring rather than formal care systems.

Mack, Salmoni, Viverais_Dressler, Porter and Garg (1997) researching elders' perceptions with open ended questions found continued self-care and independent living as important to this group, with housework and driving evidenced as proof of

this. They also found elders believed inner strength, determination, and desire not to be dependent directly affected their ability to continue coping.

Allen et al (2000) identified how focus on dyad relationships in the research field has led to neglect in considering interrelations of care in whole family systems (Bengston and Landry 1983). Brubaker (1995) proposes use of longitudinal designs could allow family dynamics to be observed, and like Allen et al (2000) feels qualitative methodologies necessary to better understanding of patterns of family relationships. Fingerman (2003) found marital status and number of siblings influential to mother daughter relationships and suggested consideration of complex family systems requires theoretical shifts in research approaches, which should include subjective perspectives of how family issues have been dealt with over time. (Fingerman 2003). As arguments for research methodologies which encompass complex and reciprocal relationships between elders and families have emerged (Walker, Pratt, Shin and Jones 1989), alternative narratives to elders being burdensome have begun to be witnessed.

2.7 COHORT AND GENERATIONAL DIFFERENCES IN FAMILY RELATIONSHIPS

A cohort is defined as individuals born into and aging through, specific time frames (Miller 1996). Cohorts are more likely to create similar narrative constructions of their present lives because they share understandings based on understandings formed through particular time contexts (Pelligrini and Sarbin 2002). Although distinct, each cohort's collective consciousness (Miller 1996) will have influence upon those who came before and those who follow (Uhlenberg and Milner 1996). This is particularly true in relation to views, expectations and lived out family stories. Kopito Motenko and Greenberg (1995) suggested barriers to intergenerational intimacy usually result from misunderstandings created through cohort difference. Allen et al (1999) suggested that ideas of what constitutes differences between generations and indeed the social constructions of what "family" means have in themselves changed. They argue familial relationships between generations have more recently involved increased choice, as previously unquestioned ideals have been able to be rejected. These changes have necessitated research capable of eliciting complex and differing

ideas of family life. The possibility of using a narrative approaches to explore a present elderly cohort's constructions of family relationships offers hope in this regard.

2.7.1 Understanding past relationships

Brubaker (1990) suggests that when researching family relationships they need contextualising within historical backgrounds, and in relation to the changing roles and responsibilities family members take over time. Pelligrini and Sarbin (2002) note how despite the realisation elders' present family narratives can only be understood in relation to past ones, most studies do not consider family history (Pearlin et al 1996). Fingerman (2001) points out all family problems are transitory, not reflective of overall familial relationships and so should not be considered in isolation. Some carer literature has considered past family relationships. For example, in relation to offsprings' willingness to care (Field 1989, Fingerman 1997, Webster and Hertzog 1995 quoted in Fingerman 2001), effectiveness of care (Suitor and Pullemer (1987) quoted in Pearlin et al 1996) and current later life parent/child relationships (Fingerman 2001). One enduring professional narrative in literature relates to unresolved family issues re-emerging at times of family transitions (Kuypers and Bengston 1983) given that they require a revisiting of past family scripts (Quinn 1989) and "historically reinforced expectations" (Kuypers and Bengston 1983 p225). On a more positive note some have suggested different generations share positive familial memories (Berman 1987) which can be utilised when agreement in the present is difficult (Fingerman 2001). These findings highlight the need for research into the significance and complexity of family relationships across the life span to encapsulate their changing and reciprocal nature. Variables such as illness, cultural views and the processes of ageing are clearly important considerations.

2.8 IMPORTANCE OF FAMILIAL RELATIONSHIPS

Bengston and Roberts (1991) used a three generational, longitudinal study to identify six components elders considered important in family life namely: Contact, Affection, Consensus, Support, Obligation and Structures for interaction. Allen et al (2000)

building upon these ideas proposed family relationships are multi-layered (e.g. shifts in caring roles affect relationships indirectly and directly in families) multidimensional (various forms of assistance are given to and by elders) life stage dependent (changes in care roles creates different issues and dynamics at different ages) and with relationships between grown up children and spouses of particular significance for elders.

Brubaker (1990) wrote how "Family interactions especially the interpersonal liaisons are meaningful to men and women in their later years" (p.960). Elders have been found to gain particular enjoyment from shared narratives with other family members (Hildreth et al 1980). In particular past and present narratives of self as parent (Pelligrini and Sarbin 2002) or grandparent were cited, which are felt to increase confidence in family relationships and/or (Cook, Cohler, Pickett and Beeler 1997) provide remembrance of personal resources and agency. Given family relationships are of interest here, consideration will be made of research around particular family relationships with elders.

2.8.1 Elders and grown up children

Mancini and Bliesnet (1989) noted the mutual support existing between elders and grown up children which was reported by elders as acting as a buffer, despite other stressors it may bring. However, they found the need of support from elderly parents by grown offspring (resulting from unexpected life events) threatened this relationship. Such changes were perceived as more significant to relationship change between elders and grown up children than increased parental care needs (Logan and Spitze 1996 quoted in Allen et al 2000) in these studies. Similarly, Pillemer and Suitor (1991 quoted in Koropeckyj-Cox 2002) found elders whose offspring experienced mental, physical, stress or drug problems suffered more frequently with depression themselves and that poor quality relationship caused by distance or prolonged dependency by grown up children created distress for elders. Connidis and McMullin (2002) suggest a sense of failure and/or blame regarding outcome of offspring's lives is a risk factor for the emotional wellbeing of elders, most probably as they perceive it as reflective of their parenting success or failure.

Bornat, Dimmock et al (2000) found elders' narratives of their children's divorce resulted in creation of private and public narratives which allowed them to maintain preferred moral narratives whilst expressing support to their children. In my clinical experience divorce often results in elders offering increased practical support, be this financial, childcare or accommodation, creating unanticipated changes to their own narratives of later life and retirement and this is an under researched area of familial change in later life families.

Fingerman (1997 quoted in Fingerman 2001, 2003) explored conflictual issues between daughters and mothers and found close relationship, awareness of each others faults and wisdom in avoiding known differences, as preventative of conflict. She also posited that difficulties in this relationship result from inabilities to adapt to changes in relationship at this time (particularly by offspring) rather than generational differences per se. Barusch (1987) highlights how power dynamics between elders and offspring partly depend "upon the interpersonal, physical and financial resources of the parent" (p.45) and a decline in any one of these results in changed relationship. They suggest negotiations of power, care, coercion, bargaining and deference may all be involved in change of family dynamics with elders. Such findings illustrated elders do not suddenly become irreversibly dependent on offspring (Motenko and Greenberg (1995) and highlight the reciprocity and complexity of these relationships. They offer alternative descriptions of fluid continuums of give and take, dependency and independency through life (Cohler 1983).

Some research exists to suggest elders may be more comfortable giving familial support than receiving it in relation to their grown up children (Brody et al 1983) and (given increased life expectancies) their own elderly parents. Further, elders have been shown to suffer lowered morale when they do receive care from their children (Scott and Roberto, Stoller 1983 quoted in Lee and Shehan 1989) and gain greater self-esteem from reciprocal support and interactions. These authors felt their findings resulted in part from elders' internalisation of negative stereotypes and consequent fears of being considered burdensome. Eggebeen and Hogan (1990) considering four sources of relationship exchange (monetary, material, child care and assistance) found advice and companionship were given and received in equal amounts between elders and offspring, but that offspring who had children were in receipt of most care from

their elderly parents. In addition they also found that, "Once established, patterns of exchange tend to persist through time" (p.229) and that this was regardless of age of parent.

Good quality relationships with offspring have been reported as providing mutual emotional and practical support. They are perceived as a source of pride for elders, a provision of emotional closeness and a protection from depression and loneliness. However, difficult relationships with grown up children are a potential source of stress and may have serious impacts upon the emotional wellbeing of elders (Koropeckyj –Cox 2002). A factor I commonly find in my clinical work with elders.

Given increased awareness of the complexity of relationships between elders and offspring and their potential negative impacts, it is interesting that ideas of childlessness in later life being disadvantageous remain seemingly unquestioned. Evidence in fact suggests that although on measures of social contact childless couples are more isolated, subjective reports of happiness and life satisfaction are equal between elders with and without children (Glenn and McLanahan 1982 quoted in Koropeckyj-Cox 1998). No evidence existed of childlessness increasing loneliness or depression in later life (Koropeckyj-Cox 1998). In fact, some evidence exists that childlessness contributes to life satisfaction (Veevers (1980) quoted in Koropeckyj-Cox 2002) because of the choice it affords to create reciprocal and satisfying peer support networks (Dykstra 1990 quoted in Koropeckyj-Cox 2002). However, impacts of childlessness may be related to whether it was a voluntary choice or a source of grief (Alexander et al 1992) and whether being childless creates dissonance with hoped for later life experience (Koropeckyj-Cox 2002).

2.8.2 Later life spousal relationships

Brubaker (1985) notes how, "spouses provide extraordinary companionship and support throughout the later years" (p.962) and that later life is perceived as a time when marital satisfaction has the potential to increase. However, fitting with my own clinical experience, Peterson (1990 quoted in Allen et al 1999) suggested this negotiation involves each feeling there is fairness in reward for roles and responsibilities each have taken earlier in the relationship. Lang, Staudinger and Cartensen 1998, Cartensen, Gottman and Levenson 1995 (quoted in Allen et al 1999)

found elders in unsatisfactory marriages suffered more physical and mental problems. However, women appear to suffer these effects more, since men generally report marital relationships more satisfying in later life (Zarit et al 1986 quoted in Brubaker and Brubaker 1995). These findings make an argument for research studies which can consider the longitudinal and reciprocal nature over time of later life, long term relationships.

Although not synonymous with later life, the probability of illness at this time does increase and although, "couples care for each other throughout their lives, when one member of the couple becomes ill the nature of the relationship changes" (Greenberg, Stacy and Penzo 2002 p.71). These researchers noted the gradual nature of physical changes mean resulting shifts in relationship dynamic are subtle. It is felt that some older partners who shift into carer roles can experience increased sense of self-worth and satisfaction (Huston 1990; Seltzer and Wailing Li 1996; Kramer and Lambert 1999 quoted in Greenberg et al 2002). However, care of ill spouse also increases potential for emotional distress given illness and change to caring roles can negatively affect intimacy (Skaff and Pearlin 1992). Gender differences have been found in relation to spousal caring, with males often finding purpose in retirement years (Skaff and Pearlin 1992). Allen et al (1999) reviewing research on impacts of different illnesses on marital relationship in later years found little difference. The specific impact of depression in later life marriage was researched by Sandberg and Harper (1999) who found marital distress occurred when one spouse became depressed. Greenberg et al (2002) considering systemic interventions with such couples found opportunities for spouses to create meaning of the illness in relation to their shared life and history helped buffer negative consequences for the relationship. Further insight into experiences of older couples who experience MH difficulties in their relationship and how the elder with MH problems perceives their relationship would be of value to the field.

On the whole research on divorce in later life suggests such elders are less happy financially (Uhlberg and Meyers 1981), socially (Amato and Keith 1991), emotionally (Chiriboga 1982) and experience more health problems (Zick and Smith 1988 quoted in Brubaker and Brubaker 1995). Growing recognition of the importance of social

networks for elders as sources of reciprocal, emotional and practical support (Skaff and Pearlin 1992) have been noted.

Death of spouse in later life is quoted as the greatest predictor of suicide in older men (Tweedy and Guarnaccia 2007) putting this client group at greatest risk. However, Brubaker and Brubaker 1995) found little gender difference in relation to grief responses, impact being profound for both. Widowhood is connected with loneliness and depression, regardless of support from offspring (Koropeckyj-Cox 1998) and can lead to financial and emotional losses. Renewed closeness to offspring and other family can counteract loss (Shanas 1979 quoted in Barusch 1987). How such shifts in connection between family members are negotiated, who they are with and how these mitigate the effects of acute grief are little understood. The ending of developmental and life course theories at the point of loss of life long spouse has been identified as being obstructive to such research interests in the past.

Creation of new relationships, co-habitation and remarriage are common in later life. Bulcroft and O'Connor (1986 quoted in Brubaker and Brubaker 1995) for example found that elders looked for monogamous, longer term relationships when pursuing new ones. Success of new relationships in later life is believed to be connected to having dealt with previous relationship endings and nature of these losses. In recent decades with increase in divorce, women's increased independence, greater social acceptability of gay relationships and cohabitation, patterns of later life relationships are emerging which challenge previous set developmental theories. Research which allows insight into the meanings elders create in relation to relationship choices in later life is needed if we are to meaningfully work systemically with this age group.

2.8.3 Relationship with Grandchildren

Seventy five per cent of elders are grandparents and fifty per cent great grandparents (Shanas 1980). Becoming a grandparent, although generally thought as a joyful experience, is connected to social constructions of ageing, carrying with it particular negative cultural narratives. Burton (1986) found elders who perceived they became grandparents too soon resented the role for defining them as old. Likewise, grandparenting can be a disappointment if contact with grandchildren is not perceived

positively and contrary to expectations of this being a fulfilling role (Kivinick 1982 in Brubaker 1995).

Barusch (1987) discussed how grandparents familial support in upbringing of grandchildren is a powerful source of giving for elders. One Shanas (1980) identified as a hugely unacknowledged and financially unrewarded resource in our present society. Minkler and Roe (1983) (quoted in Strawbridge Wallhagen Shema and Kaplan 1997) found grandparents who become main carers for grandchildren were at high risk of health problems and financial disadvantage. However, they note this may be connected to circumstances leading to need for full time care by grandparents since these events were usually traumatic.

Where grandparents took active and supportive roles, the quality of relationship was determined by adult children (Dellmann-Jenkins Papalia and Lopez 1987) and roles depend upon cultural or racial expectations (Kivett 1996 quoted in Allen et al 2000) or requests from adult children (Fuller Thomson Minkler and Priver 1997 quoted in Allen et al 2000). Regardless of roles taken by grandparents, the relationship was usually reported as being valued by both parties (Sprey and Matthews 1982)

2.8.4 Sibling Relationships

One of the more recently acknowledged significant familial ties for elders are sibling relationships. Cicirelli (1982) describes these as, “the longest most durable and egalitarian family relationship” which provides unique bonds and support, invaluable when peers or spouse are lost.

White (2001) noted sibling closeness, which often declines in middle years, becomes more significant in later in life due to mutual needs which allow former resentments to be given up (Goetting 1986). Cicirelli (1985) found reconnection between siblings allowed discussion of past family narratives, and Brubaker and Brubaker (1995) that shared childhood experiences created enduring bonds. Gold (1989 quoted in Brubaker and Brubaker and Brubaker 1995) noted that siblings report experiencing greater acceptance in these relationships. O’Bryant (1988 quoted in Brubaker and Brubaker 1995) found sister/sister sibling relationships usually strongest followed by

brother/brother and that where sister/brother sibling relationships were maintained this was often initiated by sisters.

Sibling relationships can involve care giving, particularly when siblings are unmarried (Brubaker and Brubaker 1995) or lack care from offspring. Siblings are often active in visiting brothers or sisters in care homes and tend to make efforts to ensure siblings in formal care are included in family events (Cook et al 1997). In relation to mental illness Meeks et al (1990 quoted in Cook et al 1997) again found that it was sisters in particular who continued to offer most support into old age.

However, despite recognition of this important family bond in later life, little research has been carried out from a life course or wider family perspective, particularly into a life span view of this relationship when MH problems are present.

2.9 PHYSICAL AND MENTAL ILLNESS

2.9.1 Physical Illness

Like the gerontological research field, recognition of the influence the dominant presence empirical research methods had upon the ideas of illness led to narrative methodologies becoming more popular from the 1990s allowing insight into individual and subjective constructions of illness previously silenced (Jewson 1976 in Bury 2001). Increases in life expectancy and better medical care have resulted in those with chronic illness living longer, also resulting in sufferers and their families becoming less marginalised (Bury 2001). Kelly (1994) described how opportunities narrative research brings are not only resources for understanding how sufferers create meaning of illness, but a resource for sufferers themselves to voice their experiences (Kleinman 1988 quoted in Hydén1997) and to recreate narrative selves.

Research has led to identification of genres of illness narratives. For example, liberation narratives (involving movement from illness to new narrative selves) Charmaz 1995) and tragedy narratives (involving being oppressed by illness). Hydén (1997) taking a different slant, considered genre in terms of thematic purpose of narrative, “namely the relationship between narrator, narrative and illness”. He

suggests narratives of illness be considered in relation to whether they present illness *as* narrative (illness is expressed through the narrative and narrator and illness are one), narrative *as* illness (narrative or lack of narrative becomes constitutive of illness) or narrative *about* illness (narrative offers knowledge and insights about the illness and may reflect adopted medical narratives).

Studies have identified how wider cultural narratives influence individual narrative formation both through their descriptions of illness and their prescriptions of how to be acceptably ill. In relation to the former, Hydén (1997) noted how cultural, causal narratives of illness become integrated into personal narratives. Reissman (1990) felt that this could be seen in narratives through the moral positioning of self to audience those who are ill feel bound to make. Influence of strong medical narratives have also been identified as being so influential in creation of narratives of causation and diagnosis, that they create difficulties for sufferers to discern their own understanding of such experience (Bury 2001). Hydén (1997) posited that consideration of context is essential to understanding narrative formation and expression around illness since narratives *about* illness often occur in medical settings. From clinical experience I would add that power dynamics of these particular narrative interchanges of past illness narratives are also worthy of consideration (Smith 2004).

Illness narrative studies have been influential in highlighting importance of pivotal events in life narratives (Reissman 1990). Hydén (1997) writes how illness becomes a pivotal, contextualising event, "an epiphany, around which all change revolves and where cause is situated" (p.57). It has been hypothesised that one reason for this is "biographical disruption" (Bury 2001) caused by illness, which necessitates re-evaluation of narrative self, relationships and life. Narrative activity allows illness events to be transformed, reconstructed into life histories, understood, explained to others and connected into wider narratives (Hydén 1997). Such processes create new integration whereby illness narratives are integrated into personal identities (Bury 2001).

Hydén (1997) noted lack of research given to differing "cultural patterns of illness narratives" (p.64) and illness over time, creating argument for narrative studies

considering impacts of past and present wider cultural narratives of illness and the significance of different and co-morbid illnesses (e.g. mental and physical).

2.9.2 Physical Illness in Later Life

It is believed elders experience heightened narrative disruption when facing pain and illness (Becker and Kaufman 1995; Holstein and Cole 1996 quoted in Sanders, Donovan and Dieppe 2002) due to double jeopardy of negative cultural narratives related to illness and ageing. Bury (2001) suggested awareness of societal disapprovals around potentially being a burden on others influential to participants and evidenced by their inclusion of examples of their independence in what he perceived were attempts at presenting morally acceptable selves to audience. Freeman (2004) suggested prevalent wider narratives of decline and death in later life are so damaging they create "premature foreclosure" in narrative content and "loss of narrative itself" (p. 88) for elders. He warns of impacts on elders of societal narratives that suggest "the only story to be told is one that is over" (p.89).

Becker (2001) found elders narrated illness as "ordinary" because they internalised common cultural narratives and constructed it as part of the ageing process. They write, "Ordinary pain does not require a story since stories are not generally told about the normal which remains invisible" (p.106). This finding both supported Freeman's "premature foreclosure" theory and illustrates the hermeneutic relationship between stories told and stories lived for elders struggling with illness. Becker (2001) highlighted resulting contradictions in elders' narratives between inevitability of illness and need to hold to a belief of wellness and activity. So a difference is noted in the illness narratives of younger and older adults. Adults' illness is constructed as a disruptive influence in an otherwise linear life story whereas for elders, "to disrupt this dominant story (of decline and illness) the narrator has to disrupt the linear story mode". Becker (2001) suggested the result will be more chaotic illness narrative formation if cultural narratives of illness are resisted. There is clearly much scope for considering impacts of wider cultural narratives upon form, content and contradictions in elders' illness narratives and how this might make them unique in form.

2.9.3 Mental Illness

For many sufferers of chronic mental illness onset occurred in early or mid-adulthood and where illness persisted, results in need for its integration into life narratives (Jones 2002). Cook, Cohler, Pickett and Beeler (1997) note importance of particular life stage at point of onset when studying narratives of mental illness, because delay and disruption to life plans are created from that point as sufferer loses agency. If these ideas are considered alongside recognition that cultural expectations of life course transitions also change over time (Cook, Cohler et al 1997) a clear dilemma for the formation of integrated life span narratives is created. Research is therefore needed which considers impacts of changing cultural and professional narratives on personal meaning, for both sufferers and their families over time.

Adame and Hornstein (2006) highlight lack of first person accounts in research of MH and Cook, Pickett and Cohler (1997) highlight lack of focus on familial constructions. Early family therapy literature offered some insights, but was criticised for potentially blaming families and focusing on relapse prevention rather than subjective experiences of family systems (Adame and Hornstein 2006). Jones (2002) used unstructured interviews to consider emotional experiences of families where MH was present. He identified relatives experiencing loss and anger at the arrival of mental illness but feeling unable to openly express these due to shame and guilt for having such feelings. Finding meanings for the illness was important and breakdown of relationships often quoted as pivotal to onset. Adame and Hornstein (2006) reviewing literature in this area found high distress levels in families in relation to their relative's MH problems and poor relationships with professionals

Objectification of (Kinsella, Anderson and Anderson 1996) and finding external cause for illness (Robinson 1996 in Jones 2002) are both believed beneficial to family relationships. The grieving processes necessary to allow acceptance (Jones 2002) are felt to have been overlooked by professionals, leading to difficulties in longer term familial adaptation (Adame and Hornstein 2006). Sufferers' views of impacts of MH upon family relationships appear to have received little attention in the research field. Further research which considered sufferers narrative constructions of how their MH relates to family relationships would therefore be valuable.

2.9.4 Mental illness and the parenting process

Bassett, Lampe and Lloyd (1999) describing past medical views of those with MH difficulties noted how in previous decades sufferers were discouraged from having children or if they did, children were removed due to presuppositions they would parent badly. Nicholson and Biebel (2002) noted how research focused upon negative impacts of MH on parenting have skewed research and allowed such ideas to persist. In addition, research has focused almost entirely upon mothers (not fathers) and suggested that they may be less emotionally available (Mowbray et al 2001) which leads to their experiencing emotional difficulties (Stott et al 1983 quoted in Nicholson and Biebel 2002). It is now acknowledged that little attention has been given to areas such as the subjective experiences of these mothers, the outcomes for grown up children, impacts of fathers having MH problems or the nature or quality of these particular parent/child relationship through time and/or when the parent is elderly. This is clearly an area desperately needing a more life span approach.

In one study which did attempt to consider subjective views of mothers with MH problems, focus group and interviews were used and identified that they feared losing custody of their children and the impacts stigma may have upon their children (Nicholson and Biebel 2002). Akerman (2003) studied mothers' social constructions of parenting with a MH problem and found misdiagnosis, single parenthood and difficult interpersonal relationships perceived as having significant impacts. However, these and other studies highlighted parents' desire to provide normal upbringings, prioritise maintenance of this relationship (Nicholson and Biebel 2002) and closeness to their children (Akerman 2003). In addition, they highlighted the extent to which self-esteem and pride was gained from this role. (Akerman 2003). The resilience of parents' struggling with MH difficulties is just beginning to be appreciated. It is posited here that consideration of this relationship over the life span would offer more meaningful insights given recognition earlier of changed reciprocity of care in familial relationships.

One of the rare studies considering longer term impacts of the presence of MH in parent/child relationships is Williams (1998). This evaluated a group for grown up daughters of women with MH problems. It found the experience of stigmatisation as a result of MH being in their family, lack of explanation earlier in their lives of their

mother's behaviour and why she was absent (when in hospital) were significant. Perceived consequences as grown ups included difficulties with social skills due to reduced opportunities for socialisation in childhood and desire for their own children to be parented differently. All had taken caring roles as adults and struggled with female friendships.

Cook et al (1997) studying life span family interactions found when MH problems extend to later life, family tensions tended to decrease. They quote a study by Solomon et al (1997) which found a "natural process of maturation over time improved families confidence in understanding and coping with psychiatric disability" (p.432). They call for more research focused on familial adaptation to MH over time to identify positive familial adaptations. The importance of research considering narratives elders create of parenting experiences, the impact of MH upon these and the impact on later life families is clear.

2.9.5 Mental Illness and elders

Impacts of ageing upon MH are identified as related to loss of roles, physical restrictions and illness, all of which exacerbate emotional distress (Larivière et al 2002). It is not feasible to cover all types of MH problems here, so focus is made on the most commonly experienced and researched; depression (Sandberg and Harper 1999). Potential co-morbidity between physical and MH can result in later depression being complex. Anxiety, pain and chronic medical conditions are known to increase potential for depression (Tweedy, Morrison, DeMichele, Gelbach 2002) as does care giving (Livingston, Manela and Katona 1996 in Tweedy et al 2002). Additionally, and increasingly in my clinical experience, co-morbid risks of alcohol and in some cases substance abuse are significant (Blow 2000 et al quoted in Tweedy et al 2002).

First and preferred treatment option for depression in elders is often medication, despite this contradicting research evidence. Psychotherapeutic approaches have been shown as an effective treatment for elders with depression (Thompson, Gallagher, Breckenbridge 1987). Landreville, Landry, Baillargeon, Gurette and Matteau (2001) in a comparative study of cognitive therapy, antidepressants, and cognitive bibliography with elders, found all rated as acceptable but preference given to cognitive therapy and cognitive bibliotherapy over medication. They argue treatments

for depression do not currently reflect elders' preferences and further research and education of professionals is needed. Research allowing insight of elders' views of treatment throughout the course of their MH may evidence changed medical approaches and subjective comparison of treatments experiences.

Although researched with regard to aetiology and epidemiology little attention has been given to relational and familial contexts (Tower and Kasl 1995) for elders with depression. Sandberg and Harper (1999) write how, "Ironically depression in later life, the most common psychological problem of the fastest growing segment of the population, has been largely ignored in the marriage and family therapy literature" (p. 393). In an attempt to redress this imbalance they studied depression and mature marital relationships and found clear connections between perceived marital quality and depression, with abilities to endure difficulties in relationship acting as buffer. Tweedy et al (2002) pointed out how grief related depression in elders is often overlooked as a result of ageist ideas that bereavement is inevitable to ageing, resulting in risk issues being overlooked. They found half of all widowers suffered significant depressive symptoms a year after loss of their wives (Tweedy et al 2002). Gaps in the research field of treatment, diagnosis, wider familial issues and impacts of professional and societal discourses regarding causes of depression in elders is clear. Just one example of what is believed to be the most common MH problem for elders has been considered here and future research would also need to consider issues related to differing types of MH problems.

2.10 SUMMARY

This literature review aimed to outline researched areas which may be of relevance to this study and identify existing gaps. Past development and life stage theories felt to impact upon present life course perspectives through potential creation of "off timedness" for those with MH problems were identified. Recent emergence in the older adult field of narrative gerontology was contextualised within the theoretical shifts which have occurred in the social sciences, and acknowledged for its potential in offering alternative, more subjective and lifelong perspectives, which until recently were lacking in the literature. Present political and societal narratives of ageing were considered in relation to impacts these can have upon elders' constructions of

preferred personal narratives. My introduction outlined connections between narrative perspectives and my own clinical and theoretical preferences. The focus of this study will be of narrative constructions of elders living with MH problems and their familial relationships over the life course. This being the case, particular consideration of physical and mental illness in relation to later life, narrative constructions and family relationships was made here.

The paucity of subjectively focused research around functional MH problems in later life and in relation to elders' views of familial change has been noted. It is perhaps not surprising then, that the complex interrelations of each of these are little understood. This study will focus upon narratives of elders with MH difficulties and their familial relationships. It is hoped this will go someway to addressing areas neglected in the research and clinical fields through insights gained from elders' constructions of such experience. Given the cohort of participants it has potential to elicit life span narratives. These in turn may allow contextualised views of family dynamics and illness narratives within the changing wider narratives which may have influenced them. It is acknowledged the research and theories outlined in this chapter will have influenced my approach to the study and that this will carry over into interviews, analysis and choice of write up formats given the new knowledge and interests I have gained.

3 METHODOLOGY

3.1 CHOICE OF METHODOLOGICAL APPROACH

Narrative analysis (NA) is chosen as the methodological approach of this study; the rationale for this choice is explored below.

Recent growth in narrative studies has been viewed (Kenyon, Clark and de Vries 2002) as part of a larger, paradigmatic shift away from positivist thinking (presupposing an objective and measurable reality) to epistemologies including social constructionism, constructivism and critical theory. Generally speaking social constructionism advocates language based realities, made through social and intersubjective constructions (Ray 1999-2000). Constructivism includes recognition of cognitive processes involved in individuals' construction of knowledge (Gehart, Ratliffe and Lyle 2001) and critical theory emphasises how cultural institutions and powerful systems shape identities and values (Guba and Lincoln 1994). All perceive reality as subjective and influenced by contexts at local and wider levels.

This paradigm shift resulted in movement from large, empirically based quantitative studies (Elliot, Fischer and Rennie 1999) to qualitative methodologies, allowing greater focus on detail, meaning and individual knowledge (Gubrium 1992). Qualitative methodologies have been recognised as more congruent and applicable than quantitative to systemic theories (Sells, Smith and Sprenkle 1995). The identified gap in later life research of subjective and meaning focused studies and the focus upon systemic approaches in this study has led to qualitative methods being chosen.

Qualitative approaches encompass a wide range of methodologies fitting particular research questions. Many current qualitative methodologies favour verbal data, given its openness to participants' views. Of these, some methodologies such as Grounded Theory (a constant comparative deductive method) and Interpretative Phenomenological Analysis (IPA: an ethnographic inductive analysis), have been described as more realist (Miller 2000). This is because, although they presuppose no definitive truth they both assume some reality "out there" (Smith, Jarman and Osborne 1999) from which approximation toward concepts or theory (either by building it or providing evidence for it) can be made. IPA attempts to gain insight into individuals' worldview and perspective (Crossley 2000) whereas Grounded Theory,

through process of induction, moves toward abstract concepts (Miller 2000). Given this study does not aim to create theory or concepts, but rather explore variable meanings, IPA and Grounded Theory are not considered appropriate.

Other methodologies which use verbal data and pay close attention to language include Conversation Analysis (CA), Discourse Analysis (DA) and Narrative Analysis (NA). These focus more on language content and assume analytical interpretations as partial. Given this study aims to consider in detail meanings created by elders and the influence of time, cohort and systems upon these, the most obvious choice of methodologies seems to be between discourse analysis and narrative analysis.

3.1.1 Consideration of difference between Discourse and Narrative Analysis

DA views language as performative of social practice (Crossley 2000) in that it is used to describe and legitimate action (Potter 1997) structure experience and make sense of self. It posits that social and subjective constructions of self (Wetherell, Taylor and Yates 2001) can be understood through analysis (Gill 1997) of available and utilised language resources (Potter and Wetherell 1987 quoted in Gill 1997). It analyses text in detail to identify "interpretative repertoires" (Wetherell Taylor and Yates 2001, p.198) and the linguistic structures considered as "building blocks of conversation". Then, uses these to consider how they relate to particular and wider cultures, illustrating how participants both use and are used by language and conversational forms (Wetherell, Taylor and Yates 2001).

Although viewing analysed text as potentially representative, DA differs from IPA and Grounded Theory by not viewing language as a medium to understanding a person's experience (Potter and Wetherell 1987). Rather, it views language as a means of constructing realities from different language options performed within differing contexts. DA's connection to NA lies in its movement away from attempts to represent reality and attempt at some objectivity, to viewing researcher and their personal contexts as interconnected to interpretations made (Gill 1997). Both view language as a function for construction of self, which is connected to other individuals and influenced by wider systems (Roberts 2000). DA highlights influence of systems

through closely analysing discourse, whereas NA examines hidden ideas of culture reflected in narrative content and construction.

Although aiming to give voice against powerful wider systems, DA's detailed focus on text, to discover self "theorised in discourse" (Potter and Wetherell 1987 p.102 quoted in Crossley 2000) has resulted in criticism of negating the experience and agency of interviewees leading to their depersonalisation (Crossley 2000; Roberts 2002) and negating experiences of interviewees (Crossley 2000). Its leaning toward Critical Theory gives it a political edge and researchers (more than interviewees) the role of "transformative intellectuals" (Giroux 1988 quoted in Guba and Lincoln 1994).

NA considers whole narrative texts as main data (Androutspoulou, Thanopoulou, Economou and Bafiti 2004) and gives importance to language because of its ability to create and re-create meaning of experience (Hinchman and Hinchman 1997 quoted in Reissman 2001). Rather, using language to assume meanings through close analytical inspection (Holstein and Gubrium 2000) NA views interviewees (Reissman 2001 p. 32) as active editors of storyline (Holstein and Gubrium 2000) "on centre stage" and with researcher positioned as "passionate participant" (Guba and Lincoln 1994 p.115). It focuses on ways individuals create meanings of experiences in on going and constantly changing ways which are seen to relate to contexts and relationships.

Given a main aim of this study is to focus on voices of elders with mental health (MH) problems in order to enrich professional and theoretical knowledge and make connections back to the clinical field, NA seems more fitting than DA.

3.1.2 Narrative Analysis

NA then, involves shifts in viewing phenomenon we are interested in and consequent investigation of them as story rather than truth (Kenyon, Clark and de Vries 2001). It assumes subjectivity (Reissman 2001) so does not aim for verification or definition (Chase 1996). Rather, it focuses on stories (Burck and Frosh 1994) as "meaning making units of discourse" (Reissman 2001 p 705). Given their personal, complex, co-constructed and context dependent nature, narratives generated using this

methodology become viewed as much more than "data" (Kenyon, Clark and de Vries 2001).

NA does not focus only on "what" is said but the "how" of self-construction (Holstein Gubrium 2000). It can "reflect and respect participant's ways of organising meaning in their lives" (Reissman 2001 p.696) consider why experience is conveyed in particular ways (Ray 2002) what self-representations individuals create and how they are realised in particular contexts (Holstein and Gubrium 2000; Chase 1996). NA also allows insight into meanings attributed to life changes (Reissman 2001) and cultural or familial stories which can embed or restrain narrative formation (Chase 1996).

Narrative researchers have advocated preference for different analytic foci and varying ideas of NA might be seen to be separated into three main areas (Squire 2005):

1. Structure and syntax
2. Content and meaning making
3. Interrelational

Ideas of structure in narrative originate from Labov's (1967,1972) early sociolinguistic approach to narrative structure and organisation. His ideas originate in linguistics and present a model of narrative structure with component parts used to construct accounts of experience in particular ways and present self to audience. By identifying sequences and analysing their structure researchers using this method identify what is of importance to the narrator. Labov views narratives as residing in the person, and narrative research as a form of encouraging them to come forth. His focus on structure creates a linear view of narrative form (Becker 2001) and allows judgment of what constitutes a "good" narrative, particularly in relation to orientating and holding audience. Labov's early model influenced the field of NA greatly.

Lieblich et al (1998) pulling from earlier ideas of Gergen and Gergen (1984) also focus on structure of whole narratives to distinguish between holistic and categorical organisation. However, they propose analysis of structure allows insight into subjective ideas and values of narrator as well as how they engage the audience and

storytell. They suggest considering structural categories of genre, development of plot (progressive, regressive, steady) and cohesion as ways to understand the identity formations of narrators.

An example of content and meaning making NA comes from Riceour (1983, 1984, 1985) who perceived narratives as co-constructions of the narrators' experience made with them. He saw plot as fluid rather than static, and categorisable on the basis of reception by audience as well as telling by narrator. He suggested narratives be perceived and analysed as subjective, emotive and reflected accounts of events, made in a time plot, rather than structured accounts of events (Andrews et al 2000). This approach suggests time itself is narrative and makes the contexts within which meaning are constructed a focus of analysis. Riceour moved NA from ideas of guidelines to that of researchers being hermeneutically immersed in processes of meaning making.

Mishler (2000) also took a meaning making and inter relational approach to NA. He perceived his research as ongoing conversation between himself and participants over several interviews to create a co-evolving narrative. He focused on narrative as central to identity formation and an expression of cultural norms. He analysed coherence of narrative selves and paid close attention to structure in relation to representation of significant characteristics. His approach to NA was more socio-linguistic and employed comparison between narrative interviews to highlight difference and similarities.

More recent theoretical writings have highlighted the importance of attending to wider and local cultural contexts within which narratives are produced (Chase 1996). It was felt this allowed identification of the significance of dominant discourses to the creation of personal narratives (Holstein and Gubrium 2000). In analysis this may involve focus on inclusion and exclusion of particular episodes in narrative construction (Lieblich, Tuval-Mashiac and Zilber 1998) and/or consideration of evidence for internalised dominant narratives through language use.

Some NA studies also encompassed other foci such as hidden, unconscious or internalised dimensions (Holloway and Jefferson 2000 quoted in Roberts 2002)

connections across time (Clandinin and Connelly 1994 quoted in Roberts 2002) coherence (Crossley 2000, Androusopoulou et al 2004) and use of narrative to solve dilemmas (Reissman 2001).

Although some researchers have tried to create more standardised methods of NA (see Fiese and Sameroff 1999, Wengraff 2001) no agreed guidelines exist. This results from the "very nature of such research work" (Lieblich et al 1998 p.170) being multidimensional (Fiese and Sameroff 1999) and therefore requiring engagement in on going debates regarding the pros and cons of analysing from differing viewpoints. Since this approach is analytical and inductive, questions will emerge from each study and change the nature of analysis (Reissman 1993).

Analysis decisions are therefore led by text and become "almost intuitive using terms defined by the analyst" (Manning and Caullum-Swan 1994 p.465 quoted in Roberts 2002) through engagement in an "interpretative relationship" with transcripts (Smith 1996 p.18 quoted in Crossley 2000). As a result Reissman (1993) warns against setting hypotheses at the beginning of narrative studies and identifies its inherent uncertainty as a methodology. Kenyon and Randall (1997 quoted in Ray 2002) describe this uncertainty as an anguish for researchers, whereas others feel it offers the potential of new and rich understandings (Kenyon, Clark and de Vries 2001).

So, although still relatively new as a methodological approach, the application of NA has varied, depending upon different narrative "genres" adopted by the researcher, focus of research endeavour and interpretations by the researcher of what narrative "is" (Reissman 2008). Focus based on aforementioned structural theories of Labov (1972) would consider how narratives are organised to achieve the strategic aims for narrator (Resissman 2008) holding as central "how" narratives are told rather than content of telling. The focus could be on overall structure and construction of narrative to identify storyline (which might be seen as representing individuals' values and beliefs) (Mills 2003) or upon structure of parts of narrative embedded within the whole. Either way, it allows perception of how narrators make sense of experience and create self-identities through narrative construction (Reissman 2008). It is an approach criticised for its specificity which can result in the self of the narrator being lost. Lieblich et al (1998), building on earlier ideas of Gergen and Gergen (1984),

suggested an approach focused on whole narratives to distinguish between holistic and categorical organisation. They proposed structure allowed insight into narrators' values and ideas. This method involves focus upon narrative form to induce coding categories (see Androutsopoulou et al, 2004 for an example of this approach in practice).

Thematic approaches to analysis differ by focusing upon content rather than form of narratives. Reissman (2008) feels all NAs are concerned with content of the narrative but that thematic analysis makes this the "exclusive focus" (p53). Thematic, or event focused analysis has been described as one of the most straightforward approaches. It involves categorising and ordering episodes of experience narrated (for example, all narrative excerpts relating to ageing) to identify main themes or stories told by the narrator. The approach has been criticised for not considering conditions of telling, for example relationship with audience, wider discourses and historical processes (Laslett 1999 in Reissman 2001). Researchers who applied this approach include Mishler (1990) who interpreted patterns of structure believed to represent significant characteristics of text. Close attention can be paid to excerpts of narrative but consideration of the co-construction of narrative between interviewer and narrator, and comparison between narratives (allowing interpretations of similarities and differences across narratives) are more common. Kenyon and Randall (1997 quoted in Ray 2002) feel this method necessitates consideration of gains and losses inherent in working within whole individual, or across different narratives.

In her early work Reissman (1993) combined structural and thematic approaches, beginning her NA with broad structural foci, then moving to detailed attention of content to analyse use of language, cultural narratives and archetypes. In the latter stage long narrative stretches were reduced into lines and stanzas to examine "organising metaphors" (p.50). She believed deconstructing language structure to be essential to interpretation in NA.

Squire (2010) writes how "search for a valid interpretative frame is perhaps the research stage that causes most argument and concern" (p.50). In my decision making regarding which approach to use, reference back to the study aims and my own understanding of narrative was facilitative (Riessman 2008). This study aims to gain

insight into how a specific, marginalised, group offer narratives in relation to their MH, ageing and how these relate to their family life. The hope this holds is that understanding how these experiences are narrated could offer insights for clinical practice. Given my wish to take a reflective and reflexive position as researcher, issues of interview content and audience relationship to narrative telling were felt to be important to the analysis. Further, given my work with elders and appreciation of the potential impact of past and present dominant discourses upon this cohort's narratives I was keen to use an approach which could encompass these.

Perhaps not surprisingly then I was pulled toward recently advocated interactional and interrelational approaches to NA in my decision making process. These have emphasised the need to understand how narratives are negotiated between teller and audience (Reissman 2001) and the influence of wider narrative discourses upon them. They have acknowledged the social and political aspect of NA given in their view that personal, collective and wider social narratives are inextricably linked and mutually influential (Reissman 2001). These approaches have also attempted to integrate and assess influences of historical, cultural and immediate contexts of telling. Therefore, allowing insight into links between individuals' past, present and future narrative selves, how these change through time to maintain coherence between self and cultural narratives (Reissman 2001) and the relevance of immediate and wider audience.

These developments can be seen in approaches to NA such as "Experienced Centred" (Squire 2010) and "Dialogical/Performance" (Reissman 2008). Both fit with the above noted aims of this study, are therefore of particular interest and will be considered in more detail.

The "Dialogic/Performance" approach is inclusive of both "thematic and structural methods of analysis, whilst also displaying a different way of working with data which is more hidden" (Reissman 2008 p.115). It achieves this through viewing meaning as emerging from the readers/researchers interpretations as well as narrative content. Reissman noted how analysis "includes the voice of the investigator…as there is a dialogue between the researched and the researcher" (Reissman 2008, p. 137) and views this as a strength of the approach. Awareness that any narrative

offered is “performed” for particular audiences at particular times is also of importance as are “broader contexts beyond the interview” (Reissman 2008, p.139). This leads to need for analysis of variables such as past and present cultural contexts to identify the aforementioned “hidden” aspects of narrative tellings.

Squire (2010) advocated an Experience Centred approach to NA, where narratives are viewed not as constructions of events but rather “Stories of experience”. This interpretative approach advocates exploration of both the “what” of the narrative and “who” of narrator. It considers why participants choose to tell narratives in a certain way and how this telling has been influenced by context, audience and cultural systems. She feels these can be found in both form of narrative and language use.

Both approaches perceive NA as moving beyond the narratives being analysed by including the influence of researcher. As a result they are approaches which necessitate reflexivity from the researcher around issues such as how narratives were experienced by researcher, why parts of narratives might be difficult to transcribe and how they personally interact with given stories and become important. Strategies for reflexivity such as the checking of evolving interpretations back to narrative transcripts are advocated since as “we are always powerfully limited in story understanding” (Reissman 2008, p. 53) we need to account for our findings. NA is perceived as a reflective as well as analytical process which inevitably results in change for the researcher as part of the analytical process. These ideas fit closely with my professional and personally preferred view of narrative thinking and the responsibility I feel it affords us. In addition, Reissman (2008) suggested it is an approach particularly suited to life story analysis, making its applicability to this study stronger.

Risks, of course, exist in focusing on one approach to NA and those considered here are not exhaustive. For example, consideration has not been made of narrative forms, such as video, dance, and writing nor of approaches designed to offer insight into performative and embodied aspects of narrative tellings (Hydén2013). Given the, inclusion criteria and aims of this study consideration has been restricted here to those approaches which it is felt are most applicable to the choice of approach being made and have contextualised its development. Each form of NA considered here can be

viewed as a narrative of the analysis itself. It is anticipated that the particular approaches used and my learning process in their application will add further to these ideas and debate, rather than replicate any particular form of them.

In this analysis I aim to consider:

- Content of narratives as a means of gaining subjective and lifelong perspectives into the difficulties and familial issues faced by participants and their experiences of ageing self
- Constructions of self and experiences made in narrative form and language
- The influence of wider past and present discourses upon these narratives
- The interrelation between teller and audiences in narrative construction
- Influence of researcher to overall research process

I will be applying ideas from Squire (2010) and Reissman's (2008) ideas of analysis and taking a reflective and reflexive stance. My analysis will be led by narratives in an inductive manner.

Having considered previous approaches to NA then, it is planned that in this study analysis will include the following. Narrative structure will analysed by consideration of overall form or creation of core narratives and the sequencing of sub narratives within these. The development of plot or themes will also add to ideas regarding structure. Consideration of content will attended to in detail given the life span nature of these narratives. This will include consideration of what episodes and events are included, how they are described and what significance they may have to narrator. Further focus will be made of what details are included and excluded and potential influences of wider past and present wider discourses and interview context upon these findings. How participants interact with their narrative in terms of positioning selves in relation to other characters and events will be noted. As will their recruiting of immediate, and wider audiences into this co-constructive process. These analyses will be made in relation to unique historical and political contexts of this studied cohort and attention paid to content, language and narrative form in this respect.

Comparative analysis between interviewees' narratives will be undertaken in analysis to facilitate identification of themes. Narratives will be analysed inductively, with initial whole text analysis allowing for identification of within narrative themes, with across narrative theme clusters being gradually identified as analysis progresses. It is envisaged these cross narratives will then inform direction of further analysis and will be taken back into whole texts to allow contextualisation and honouring of participants' whole narrative tellings. Reissman (2008) notes how such an approach allows "test theories" to be developed which lead to predictions for researcher with a resultant "moving back and forth between the interviews themselves and generally….. in a classic hermeneutic circle" (p.50).

3.2 SPECIFIC AREAS OF INTEREST, APPROACH AND RELATION TO THIS STUDY

As noted above, analysis in this study is planned to be inductive resulting in themes and ideas emerging and evolving throughout the research process. However, this approach also requires a reflexive positioning by researcher. In the earlier chapters I have overviewed areas of research I feel are of relevance to this study and my own motivations and insights gained from clinical work. Clearly these will, in part, steer my thinking. In addition, I have read in detail the narrative theories influential to the field of Narrative Analysis. I therefore feel it fitting to give outline to these below so as to make transparent the narrative interests I will inevitably be pull toward in my analysis.

3.2.1 Narrative constructions of self

Fundamental to narrative theory are ideas that we make meanings of our life through the stories we tell of it (Andrews 2004). Narrative theory holds that we create ourselves through narrative (McAdams 1993 quoted in Crossley 2000) and hermeneutic relationships exist between life and narrative as we interlink our experiences with stories of them. It is proposed that when asked to give account of ourselves we turn to narratives for reference and in this way make ourselves known to self and others. Furthermore, as we create and re-create self in these tellings we become "a story forever being rewritten" (Bruner 1994 p.53 quoted in Andrews 2004). Choosing which parts of narrative self we remember and narrate results in

creation of particular narrative identities (Widdershoven 1993 p.7 quoted in Andrews 2004).

Consideration will be given in this analysis to how "individuals make identity claims on the basis of their social positions" (Mishler 1999 p.112). In particular how participants present self with a mental health problem and/or elderly will be of interest. What parts of self identity are included e.g. moral self, parent, etc. will be of interest as will the location of self in relation to other characters and life experiences e.g. saviour, victim. Any self presentations will be considered in relation to immediate audience.

3.2.2 Coherence in Narrative

It is argued that in order to create meaning we must generate coherent narratives which make sense of our existence (McAdams 1993 in Crossley 2000). Linde (1993) proposed this can result from our inner experiences creating raw, conflicting emotions. In a world where we only observe others experiences as externally organised such awareness results in vulnerability; the "remedy is to narrate" (p.121).

Labov (1972) pioneered ideas of structural coherence as necessary to narrative, highlighting how beginnings, action, ends and usually some evaluative function were needed to create coherence. Freeman (2004) pointed out how translation of events into narratives creates ideas of beginnings and ends to our experiences as there is "no story without an ending and no ending without a story" (p.88). Coherence in narrative can be seen as created in the telling and partly dependent upon audiences' feedback to narrator regarding necessary coherence for on going engagement.

Coherence is often viewed temporally or chronologically and time itself, it is argued, is biographical through narrative themes of past, present and future in narrative tellings (Roberts 2002). Whether listening to or telling narratives, elements of "what happens next" influences telling and listening.

Disruption of self-narratives can necessitate visiting the past to "inform our present" (Freeman 2004, p.114) in attempts to hold narrative integrity. Bornat et al (2000) suggest opportunities to narrate and processes of narration constitutive of coherent

self-narratives, and particularly so for elders since narrative self is created by "re imaging our pasts from the position of the present" (Reissman 2004 p.26).

Self-narrative creation also influences future narrative selves, since present narrative formation opens up new ideas of self not previously anticipated (Reissman 2002). In this way our narrative selves are always being rewritten (Andrews 2004) and influence our future through its living.

Coherence in personal narratives involves creation of themes across time (McAdams 1993) and requires reflexivity from narrators as they choose what they remember and share (Holstein and Gubrium 2000). Labov (1972) made early reference to developmental processes inherent to narrative formation, proposing narrative abilities changed over the life course. Andrews (2005) suggested life stories not only convey life stage but are told in relation to them. Further, expectations exist in our culture of narratives needing to fit particular forms for particular life stages. Bornat el al (2000) for example found different narrative forms were expected by those listening to elders' narratives.

Bornat et al (2000) criticised focus on coherence in study of elders' narratives, arguing it is based on developmental theories and may inhibit elders' explorations. Mishler (1999) suggested tendency to focus on coherence originates from psychoanalytical theories, internalised by professionals despite their ambiguity, and that we should focus more on how narratives are relational and used to manage conflicting ideas.

These ideas from narrative theory regarding coherence and time will be of particular interest in relation to how participants in this study create narrative selves across the life course. Coherence will focus upon which parts of life experience are included, how they are organised and presented to audience. Relevance of how past, present and future selves are connected or disconnected in narrative telling will be of particularly interest.

Gubrium and Holstein (1998) described the difference between dominant ideas of narrative form and coherence and those offered by narrators as "narrative slippage"

(p167). It is expected narratives offered by participants will be unique and my intention is not to analyse them with a particular coherent framework in mind e.g. chronological sequencing. However, despite my attempts at neutrality in this regard, my subjective influence in the creation of participants' coherent form (through interview format, audience engagement and disengagement) my interpretation (Polyanyi 1985, Elliot 2005) of it (in need to understand narratives read and analysed) and my choice of format in conveying will clearly affect it (Reissman 2002).

3.2.3 Narratives and Wider Discourses

Narrative theory acknowledges narratives are "not merely one's own but a social phenomenon" (Gergen and Gergen 1984 p.174) always to some extent influenced by "cultural organisations and narrative conditions" (Gubrium 1992 p.581). Cultural expectations (Riceour 1985) influence ideas of "the nature of proper lives, proper events and proper reasons for…choices" (Linde 1993:128) thus providing stories of how we should live. Linde (1993) wrote how one reason for offering narratives is to illustrate "the narrator knows what the norms are and agrees with them" (p.123). They suggested acceptability of our personal narratives lies in their presentation as well as content. Dominant cultural narratives are believed to become saturated in our culture and taken for granted in our thinking, resulting in unquestioned compliance (Daniels and Thompson 1986).

It is proposed by narrative theorists that personal and cultural narratives interrelate and adequate matching between them is crucial to the maintenance of integrated self-narratives (Webster 2001). The result being possibilities of preferred narratives are constrained (Holstein and Gubrium 2000) a sense of "off timedness " where goals are not achieved, or even narrative foreclosure (Freeman 2004) when cultural narratives fitting particular experience or life stage do not exist (Kenyon and Randall 2001). For example, Mishler (1999), analysing narrative of an ageing craftsman, described how he found his own self narrative unacceptable because it was not in keeping with perceived cultural ones of strong male provider. In addition, since wider cultural narratives are set against historical ones they only remain relevant within certain time frames (Mishler 1999). Bornat et al (2000) found that older women in their study exemplified this theory by recognising changes in cultural ideas of gender and family

over time and creating bridges between their own past moral and preferred narratives and current social ones to remain acceptable to younger family.

Attempts to integrate personal with wider cultural narratives may not always be possible and where it they are not, the misalignments created can offer insight into the problems dominant cultural ideas create for individuals (Andrews, Day Sclater, Squire and Treacher 2004). This in turn can then open possibilities for questioning dominant discourses and their restricting influence. If, as narrative theory proposes, culturally dominant narratives only exist whilst repeated by enough individuals to become collectively lived out (Andrews et al 2004) it follows that voices raised against them create possibilities for wider cultural change. Reissman (2002) noted how this process enables narratives of marginalized groups to change over time in the "mobilization of these actors in collective movement" (p. 697). Narrative theory has more recently recognised that this interrelation between individuals and wider culture requires a "relational conception" of NA, one which allows not only study of "culture and the individual but of their relationship" (Andrews et al 2004 p.9) if meaningful understanding (Mishler 1997 p.696) through research is to be achieved.

Signs and rules of cultural norms can be identified in narratives (Elliot 2005) through NA allowing views of wider cultural discourses (Chase 1996) and social processes (Holstein and Gubrium 2000). Some narrative analysts used formats of understanding cultural stories or contexts to situate those offered by participants (Andrews 2004). For example, Wengraf's (2001) approach of triangulation includes comparing narratives to historical and political accounts and Freeman (2004) includes literary genre to illustrate genre and archetypal characterisation.

In this study consideration of inclusion by participants of dominant cultural ideas, particularly in relation to MH, family life and ageing will be made. Consideration will be given to how these may have shaped or restricted participants' narratives, been internalised, or outwardly observed by participants. In particular I will be interested in the extent to which dominant cultural narratives may have, or be, hindering participants' creation of "satisfactory enough alignment between individual experience" (McCloed 1997 p.27) and the bigger story within which they play a part

Evidence of wider cultural discourses within participants' narratives will be viewed as the result of interrelation between the individual and their changing cultural contexts. It will not reflect an historical or cultural "truth" but the participant's interpretation and integration of them into their own lives (Craib 2004). This highlights the importance of contextualising such findings back into whole narrative texts and the lives lived of participants to appreciate their significance.

On a more strategic level, NA provides opportunity to illustrate how the connection between individuals' meaning making in the face of wider constraints can "have implications for social policy debates and practice development across a wide range of settings" (Bornat (2002 p.131). It is hoped that in the longer term this research can be circulated in ways which may contribute to shifts in unhelpful wider discourses.

3.2.4 Narrative and Audience

Narrative theory holds that narratives need audience to exist and that changed audiences result in changed narratives. For example, Fingerman (2001) observed narratives of the same events told differently by daughters in presence and absence of mothers. Narrative theorists acknowledge narrators work to engage audience through their telling, offering what they believe an audience will find acceptable or of interest. Narrators then, choose to present or perform particular selves to particular audiences at particular times (Reissman 2002). Narratives presented to particular audiences also change in relation to feedback, creating necessity to be both "watcher and a narrator" (Linde 1993 p.121) in the narrative process. Narrators are not only influenced by audience, but also use it to witness, confirm (Linde 1993) and help co-create their narratives. Bornat et al (2000) for example found elders used immediate audience of researcher for reflection to create an interpretative process in narrative creation.

Although narratives are told in relation to particular audience how these are received and used by that audience may or may not fit narrator's original intent. Narratives are received and understood in relation to the audiences own preferences and understandings. Once told then, narrators' stories become "entwined with the life stories of other individuals" (Kenyon and Randall 2001 p. 7).

This analysis takes the position that narratives will be both contextually and relationally specific (Reissman 2002). Findings will be viewed as specific to interview context (Andrews 2005), influenced by narrators perception of what I as interviewer and a wider audience might expect and know (Elliot 2005).

Verbal cues to audience (for example, requests for agreement or opinion) and non-verbal cues and reactions (sighing, crying, holding gaze) to and with immediate audience will be considered as significant contributors and some attempt made to record these will be made. Additionally, since a probable motivating factor for participation in this study is its wider professional audience, presentation to imagined audience will also be considered. Given the life span nature of these narratives, past ghost audiences may also be related to (Andrews 2005) at different points of narrative telling. Attention will therefore be made to whom narratives may be aimed and how narration to audience is being utilised.

Consideration of the influence of audience upon narrative formation requires reflexivity by researcher. How I am perceived, my status, role, gender, age, reactions to narrative content and forms of telling will all be influential (Andrews 2005) and considered for their significance.

3.2.5 Narrative Truth or Lies?

Narratives are means of understanding as well as expressing experience and as such involve "going beyond" factual events (Freeman 2003) through reflection and interpretation. The question can therefore be posed as to what extent narratives should be viewed as reflections of subjective experience or how they might "lie" (Andrews 2004).

Consideration of this question will be made in relation to two areas of narrative theory outlined above. Firstly, coherence. Craib (2004) noted that one purpose of narrative telling is to make lives feel manageable. This can result in creation of stories or causality, where there previously there was none, through ordering contradictions. Linde (1993) also noted how narrating experiences can result in "discontinuity between inner experience and the presented self" and Reissman (2002) that selves we present are those presumed as preferable socially. If then personal narratives

potentially conceal aspects of self, or are in part reflections of wider cultural views, (Andrews 2004) we must question whether "true selves" are represented through narrative. Adding to this debate Craib (2004) posits that when narratives are embedded within wider social contexts, and/or influenced by emotion and fantasy, they can become "non-truths" and that this should be an aspect of analysis.

Secondly, in relation to audience, it was noted how we create preferred selves in awareness of others scrutiny; narrative forms can be skilfully used to "get what we want from others" (Josselson and Lieblich 1993). It could therefore be argued that narratives are means of concealing, as much as revealing self to others, (Andrews et al 2004) through purposeful use of contexts and audience, and not a true reflection of self.

My stance on this debate is that narratives (unless more disturbed) begin from some personally or vicariously experienced event, since one can only "imagine from the vantage point of the life which has been lived" (Linde 1993 p.113). Wengraff, Holloway and Jefferson (2004) termed these events as "first order" narratives which, when narrated following personal reflection become "second order". They suggest these are not truly reflective of events but interpretations of them. Similarly, Craib (2004) noted how narratives reveal experience "not as it was" but how it is retold. He warns researchers against analysing any narrative as "sacred" but rather, "more or less true or false, more or less self-serving and more or less other things" (p.65). Following his advice these narratives will be considered only as "truths" for the narrator in that they will be attentively witnessed and validated by audience, but analysed as products of individuals' interaction with audience, context, emotion, time, experience and the whole narratives within which they are embedded.

3.3 AREAS OF INTEREST

In addition to factors and issues highlighted by narrative theory, the areas of interest of this study, their connection to narrative theory, and how these ideas will be related to planned analysis will be discussed, since these will clearly create some bias in focus during analysis.

3.3.1 Mental Health

Illness often necessitates narrative revisiting to create maps of meaning for self and others and "repair the damage that illness has done to a person's sense of who she is in life and where she may be going" (Frank 1995 p.53). Reissman (2002) felt narratives of illness given by sufferers contrasted those of medical professionals who tend to offer narratives of hope, resulting in ambiguous endings (Good 1994). Reissman (2002) suggested narratives given at onset of illness involve positioning self differently in relation to present contexts and consequently a revisiting of past narratives given new perspectives.

Creation of narratives around illness is of particular interest in this study. Mental illness is more stigmatised than physical illness and the social constructions created of it have dramatically changed over the past 50 years. It is envisaged participants may have been subject to and possibly internalised many and changing past medical and cultural narratives in this respect. Therefore, evidence for internalisation, and/or ways meaningful self narrative construction may have been constrained, will be of interest in analysis. Participants will also have experienced MH difficulties and potentially their onset and treatments within different medical systems and beliefs. How these have influenced current personally preferred narratives of MH difficulties, and are or are not integrated in relation to present difficulties and treatments, will be considered. The potential of stigmatisation and fear of judgement in the past, present and future will also be of interest.

3.3.2 Family Life

Familial stories are acknowledged as closely entwined with wider cultural narratives and as, such changeable over time. Barthes as early as 1973 wrote how familial narratives in our society have become "so culturally embedded and obvious ……..they are not questioned" (p.5). The life span narratives that are envisaged as possible from this study may allow a view of familial issues such as reciprocity, obligation, loyalty, support and their significance over time. Consideration of how past familial relationships have influenced issues of MH, and the relationship between family and ageing will be of particular interest. Focus was given in the literature review to studies and theories related to familial relationships and their impact on MH

and ageing experiences. Narratives which reflect such findings are therefore more likely to be identified if present in this study given this previous focus.

It is felt NA will allow insight into roles participants have perceived themselves and others taking within their families at different life stages. The interrelations between wider cultural, familial and personal narratives will also be of interest.

3.3.3 Ageing

How and whether narratives of ageing are interrelated with family life and MH issues will be of particular interest in this study given my clinical role and focus on contributing to the field of systemic work with elders. De Vries (et al 2001) noted how elders learn. I am aware from clinical practice of the difficulties in finding narrative templates in later life, given the present negative stereotypes of ageing, the greater longevity of this generation in comparison to those previously, increased opportunities for continued work and (for many) increased financial resources. Use of previous generations' experience of ageing as a resource may be lacking and how elders find alternatives more fitting to their cohort will be of interest. Whether participants are aware of these cultural changes and present political and cultural stereotypes of ageing will also be focused upon.

Our culture currently views ageing as a generally negative experience and ageism is not difficult to observe. Freeman (2004) noted how elders often struggle to create narratives about their later lives because dominant cultural narratives communicate that their lives are in decline and ending. The result of which can be lack of available future narrative scripts and leading to elders needing to "reconcile themselves to their narrative fate" (Freeman 2004 p.81). It is therefore possible that this area of interest is receives little attention from participants due to lack of narrative formation.

Reissman (2002) noted how personal lives are embedded within particular time frames, reflecting as much about social and historical worlds as individual themselves. For example, De Vries et al (2001) found older women's narratives could be distinguished in analysis as they were the only gender and cohort not referring to their adolescence as turbulent. They felt this reflected cultural expectations for women who were teenagers at that time and their need to comply with wider discourses.

Participants in this study will be of a particular cohort and attention will need to be given to the corresponding cultural morals and ideas for each gender in the more formative years. This in turn will be considered in relation to the whole narratives being analysed.

Given life span perspectives of this study, the way in which this marginalised group have integrated change over time into their narrative form (Reissman 2002; Bornat et al 2000) will be of interest.

It was noted above how forms of narrative are felt to change with age and life stage. Specifically, elders are felt to be more skilled in linguistic techniques used to evaluate experiences and show ability to imaginatively move back and forth in narrations (Labov quoted in Elliot 2005). Kastenbaum (1983) found elders' narratives to be more past orientated with future narratives given more loss focused, reflecting Freeman's (2004) findings that elders' future narratives were mainly of illness, loss and death. The idea that elders are particularly skilled in narrative telling is one reflected for me in my clinical work and clearly a motivator for advocating the use of narrative therapeutic approaches with this client group. How elders' constructions might be seen as skilled in comparative techniques, and the integration of past and present wider cultural discourses across the life span, will be of interest.

Bornat et al (2000) found elders in their study used opportunity to narrate in research interviews as an opportunity to map and create new meaning. It will be interesting to see if participants here do likewise.

3.4 EPISTOMOLOGICAL STANCE

The difference between constructionism, constructivism and critical theory was noted earlier in the methodology and their influence to NA noted. Attempts to identify which of these epistemologies NA falls within would feel false and potentially limit understanding (Hammersley 1996). Instead an attempt to consider how ideas of each might be seen to be influential to NA will be made.

Critical theory connects to the use of NA in this study in its perception of individual meanings being inextricably related to "historical and subjugated knowledges" (Burns 1978 p.213 quoted in Guba and Lincoln 1994) which change through time given their dependency upon values attributed by narrators and others. Constructivism encompasses ideas of critical theory, but connects to hermeneutic ideas fundamental to NA, that "individual constructions can only be elicited …through interaction between and among investigator and respondents" (Guba and Lincoln 1994 p111). Accepted importance of memory formation and cognition in the field of narrative research also relates constructivist understanding to NA. Defining features of constructionism (Potter 1997) can easily be identified in narrative theories since it holds central the belief that thoughts and behaviour are interrelated to culture, language (Potter 1997 p127) and constantly changing understandings of reality.

Denzin and Lincoln (1998) refer to narrative methodologies as falling within the "fifth moment" described as a place where "narratives replace theories, or theories read as narratives." (Flick 2002 p.10). Having considered the ideas around these different epistemological stances in relation to NA, I would describe the position of this study as postmodern, from an ontological perspective and one of "storytellers and story listeners" (Kenyon, Clark and de Vries 2001 p.4). My preferred connection to particular epistemological, theoretical and therapeutic stances adopted for this study are related to the above noted understandings, informed by and informing my narratives of self, others and the world. These preferences are inherently influential in planning this research and I predict they will be challenged as a result.

3.5 NARRATIVE INTERVIEWS

Narrative interviews aim to approach interviewees' experiential world as structured by and of itself (Flick 2002) and therefore do not elicit information in particular ways. Through offering freedom for creation of narrative (Paget 1983 in Reissman 1993) interviewers are considered as bridging gaps between conversation and research in areas of research interest (Flick 2002).

Purist narrative researchers advocate open ended, uninterrupted narratives (Flick 2002, Reissman 2001). Others suggest revisiting particular parts of narrative for

clarification by interviewer (Flick 2002). Holstein and Gubrium (2000) feel, given the amount of text gained, that focus upon areas of research interest are essential at interview start. As an example of this being Reissman (2001) who when researching identity change, invited interviewees to focus upon turning points in life course, a method also used by Pelligrini and Sarbin (2002) to obtain narrative accounts of relationships between sons and fathers. Some propose eliciting narratives through more structured methods. For example, Androutsopoulou (2001) suggest using Kelly's (1969) self-characterisation to create directed, written accounts of self and family relationships, and Flick (2002), describing episodic interviews, interestingly attempted to create a compromise by combining narrative with semi-structured interviews to elicit situational narrative accounts.

Given this research is interested in how narrative constructions are created and offered around the areas of interest semi-structured interviews, which may predetermine form or genre, do not seem applicable. Instead, interviewees will be invited to narrate on issues of their mental health problems, family life and ageing using a "generative narrative question" (Flick 2002 p.97). Its wording will be adapted from ideas proposed by researchers such as Pelligrini and Sarbin (2002), Flick (2002) and Crossley (2000). Once the areas of interest have been noted participants will be left to narrate freely with appropriate engaging responses from interviewer. Questions may be asked at the end of narratives offered, particularly if there are any concerns regarding risk or ethics, and to create more contextual understanding of some parts of narrative. No particular time limit will be set for interviews.

A pilot interview will be carried out to identify practical limitations of this proposed interview format. However, there is no aim to make the interview "ideal", rather it is accepted that focus on maintaining a collaborative and evolutionary position makes this a practical impossibility (Holstein and Gubrium 2000). It is hoped the pilot interview will highlight potential advantages and losses of this particular format, which can be used to identify improvements and increase awareness of how interview format and contexts may influence interview processes and elicited narratives.

A position of empathy, respect and integrity toward interviewees and neutrality regarding interview content (Grafanaki 1996) will be taken. It is envisaged my clinical

psychology and psychotherapeutic trainings will be facilitative in achieving these and the reflexive stance necessary after each interview. See Appendix 1 for details of the process of interviewing with the participants recruited.

3.6 SAMPLING

The aim will be to recruit participants who are between 65 and 85 years of age (born between 1920-40), currently receiving services from mental health services (excluding dementia or psychosis) and who have previously experienced at least one episode of mental illness whilst an adult resulting in some form of psychiatric care.

A decision to use a particular age cohort was made since this will offer a "unique consciousness" (Miller 1996) give shared historical, social and political trends and it is felt could give greater potential for identifying local and wider cultural influences on narrative content and form. For example, inclusion of elders who were children during the war or early post war may give insight into impacts upon childhood experiences in these circumstances and be a subject included in narratives.

Criteria of MH status are based on the aim of specifically understanding experiences of elders with MH difficulties from a life span perspective and in relation to their current difficulties. The sample will be recruited from my own working environment and it is hoped this will facilitate links between findings and clinical practice locally. Participants will be recruited through mental health professionals working with this client group who will offer details of the study in the form of information sheets (Appendix 2) and pass on details where agreement to take part is received. A decision has been made however, not to try to recruit participants from within my service area so as to avoid the possibility of my having already seen clients for therapy, or their participation in the study potentially influencing their choice to accept therapy from me in the future. Those suffering from dementia and/or psychosis are excluded on an ethical premise that cognitive impairment and/or lack of insight may potentially create difficulties for informed consent and heighten potential for traumatisation through the research interview (Grafanaki 1996). In addition, this study aims to explore the narratives of elders with functional and not organic MH difficulties.

Although equal gender mix would be preferable it is envisaged that there will be more female than male participants given the longevity of women is greater, the ratio of women in comparison to men in receipt of MH services is higher and they may be more willing to offer confidential narratives. Between eight and twelve participants will be recruited for interview.

The ethnicity and past cultural background of participants will be considered as relevant to the findings in this study. Details of the demographics of the sample recruited can be found in Appendix 3. Further details of the recruitment process can be found in Appendix 4.

3.7 LIMITATIONS OF NARRATIVE INTERVIEWS AND ANALYSIS

Two main limitations exist in the consideration of narrative studies. Firstly, narratives are constrained in their understanding by particular contexts and times of telling (Bruner 1986 quoted in Roberts 2002). As a result outcomes can only be understood as stories and not stated as predictable in form or pattern (Saatkamp 1995 quoted in Holstein and Gubrium 2000). This inherently prohibits generalisation to other populations and raises questions of reliability. Secondly, given assumed impacts of researchers' own subjectivity, upon design, analysis and narrative account of the results (Clandinin and Connelly 1994 quoted in Roberts 2002) findings will be inherently biased and cannot be considered as valid. Both these limitations and how they can be considered within the research are considered in more detail below.

3.8 VALIDITY

Validity based on positivist paradigms and standardised methodologies (Reissman 1993) is impossible in narrative studies since they contradict its very nature (Lieblich, Tuval-Mashiach and Zilber 1998 p. 171). Alternative, less rigid but explicit views of validity are therefore necessary (Elliot, Fischer and Rennie 1999). These involve focus upon trustworthiness as opposed to "truth" of interpretation (Reissman 1993).

A narrative study moves toward being trustworthy if it provides good explanation of how interpretations were made, with traceable paths of evidence rooted in text (Lieblich, Tuval-Mashiach and Zilber 1998). This requires openness regarding assumptions and values of the researcher (Agger 1991 quoted in Reissman 1993, Elliot, Fischer and Rennie 1999) and acceptance of researchers' power and interest in the interpretations (Kreiger 1991 quoted in Ray 2002). A trustworthy study will be persuasive, reasonable and convincing (Reissman 1993) when considered in relation to its text. As such it can be considered as valid in making a contribution to the wider field (Lieblich, Tuval-Mashiach and Zilber 1998).

Trustworthiness and persuasiveness create coherence, not certainty, in reading (Elliot, Fischer and Rennie 1999) which allow meaningful understanding (Yardley 1997 quoted in Crossley 2000). Trustworthiness and persuasiveness are themselves value based judgments (Cronen 1992 in Reissman 1993) so choices regarding their achievement and judgments of success by readers will depend upon context, academic culture and writer's skill (Reissman 1993). This can create ongoing discourse and debate of interpretative processes (Reissman 1993) which, in turn, inform the narrative field (Lieblich, Tuval-Mashiac and Zilber 1998).

In this study interpretations will be situated back to text, considered in relation to peer generated (Elliot, Fischer and Rennie 1999) ideas through research seminars, academic supervision (Smith, Jarman and Osborn 1999) and feedback from presentations. A reflexive journal (see Appendix 5 for example excerpts) will be kept to allow understanding of developments of thought (Smith, Jarman and Osborn 1999) and create links between ideas generated and my own reactions, emotions and life circumstances.

The extent to which interviewees are included in interpretative processes in NA is difficult. Josseslson (1996) concluded that since NA does not aim to represent interviewees "truth", inclusion of interviewees in analysis maybe more problematic than meaningful for narrator as well as researcher. Given analysis here will be comparative across as well as considering each whole narrative, it would be difficult to consider feedback regarding written findings as contributory of trustworthiness. It is envisaged that improvement of trustworthiness will be an evolving process and one

considered further in Clinical Implications and Reflexivity Chapters and hopefully a contributor to the field of NA (Elliot, Fischer and Rennie 1999).

3.9 ETHICS

Narrative studies view as ethical those outcomes created through meaningful dialogue between researchers and participants regarding issues of ethical boundaries and potential dilemmas (Miller 2000). It follows that until engagement with interviewees, their narratives and the research process begins ethical dilemmas cannot be fully be predicted (Grafanaki 1996).

In planning, the first ethical question must be whether the study's usefulness justifies inviting participants to share personal narratives (Miller 1996). One rationale for this study lies in my conviction, gained through therapeutic work and literature, of need for subjective voices of elders with MH to be heard to a greater extent by professionals working with them. Another is the belief that greater understanding of how elders with MH construct meaning of their experience will offer new insights into the influence of past and present cultural, medical and familial systems on their narrative selves. This could allow greater understandings for our therapeutic work. Thirdly, use of qualitative and particularly narrative methodologies in such enquiries may create more enthusiasm and confidence for others to carry out research and therapeutic work which will serve to contribute to this field, whilst keeping the elders' voice central. I feel these justify asking participants to offer personal narratives and the completion of this study.

All research utilising in depth interviews as data raise particular ethical issues. NA is no exception. For example, attention to interviewees' vulnerability and potential power of researcher has been noted as necessary (Chase 1996). My openness to personal narrative change through positions of curiosity and non-expert positioning will, I hope, work to minimise this particular issue. Narrative interviews are described as potentially taking us to the "soul of a person" (Ray 2002) and such intimate disclosures need honouring with genuine attention. Narrative interviews are given little direction from interviewers however, appropriate emotional engagement (verbally and non-verbally) with interviewees when disclosing vulnerable aspects of

self is essential. Previous training in psychotherapeutic techniques has been acknowledged as beneficial in this regard (Miller 1996) and is hoped to facilitate my success in this endeavour.

Narration by interviewees will inevitably lead to revisiting difficult issues for participants and potentially reflection of them. Opportunity to discuss experience of narrating for the purpose of the interview will be available following its completion if needed. Boundaries, limitations of role of interviewer and confidentiality will be explained at the beginning of the interview, as will provision for after support should this be necessary.

Interviewees will have been given written description of the purpose of the study previously (see Appendix 1) and these will be reinforced verbally at interview. They will be required to sign consent forms for recording of interviews and inclusion in the study (see Appendix 6). At this point a letter will be sent to participants' GP informing them of their patients intent to participate in the study (see Appendix 7). Given the close reference to original narratives which will be made in write up through quotes and contextualisation there is a possibility interviewees may easily recognise themselves (Chase 1996) once write up is competed. Particular attention will be made to ensure participants understand this at the point of consent.

3.10 RESEARCHER REFLEXIVITY

It is argued that full participation by researchers in narrative studies necessitates intellectual and personal change (Ray 2002 p135). Miller (1996) described how personal experiences and their processing resulting from his narrative interviewing as a noteworthy finding, resulting in deeper self-understanding and necessitating staying with difficult issues.

Researchers' prejudices, cultural discourses (Ray 2002) and personal blind spots (Miller 1996) will all affect final outcome of analysis since narrative studies do not create "neutral data" (Crossley 2000 p.103). Possibilities for exploring professional and personal prejudices (Ray 2002) are therefore necessary throughout the research

process if we are to account for their influence on the research study and trace whose voice (interviewer or interviewees) represents the final product.

Issues in this regard needing particular attention are considered briefly. Firstly, although this study aims to offer some insights into the potential internalisation of cultural stereotypes, it is not beyond imagination that as researcher and clinician I may hold, as yet, unquestioned cultural ideas influential to the lives of participants, or that although I perceive this study as offering opportunities for empowerment, I might unwittingly support dominant social discourses (Roberts 2002).

Issues of coherence were noted above and having worked with many clients who have experienced a disconnection in their life span narratives due to trauma, particularly war trauma, childhood abuse and evacuation, there is risk I may bias toward such narratives as supportive and affirming of my previous professional ideas and/or insight to future therapeutic conversations.

In terms of personal narratives at the point of study onset I feel I should own that: I have no children (currently a feared grief), am the daughter of ageing parents who are currently negotiating role transitions in early retirement and initiating a divorce. I am aware that listening to elders' narratives will inevitably involve confronting issues connected to my own familial situations and that narratives offered may not fit with my own personal choices or preference. I am expectant that this study will lead to change in personal and professional ideas of ageing and add to my "journey to that place and space we hope to occupy someday" (Mills 2003 p.20). Throughout, I anticipate exploration of personal feelings "about aging and elderly parents" (McFadden 2000 p.630) and even as I consider these issues become aware of a previously hidden motivation for this research of learning how to meaningfully connect with my parents as they age.

In terms of the impact of physical characteristics on interview dynamics the most obvious will be age difference, gender and nationality and all the cultural narratives these carry with them. Particular care will be given to use of language in conveying important information to this particular age group, without creating caricatures of the generational differences (McFadden 2000). As a younger female (in relation to

participants) I have been offered opportunities in terms of education and career which were probably denied some in this study and may not fit past cultural ideas of women's roles. These factors will need to be attended to in terms of sensitivity to participants and also in relation to the difficulties I may experience in hearing stories not fitting to my own personal and moral decisions.

I envisage my experience of working with elders clinically and my clinical training as engendering of sensitivity, neutrality in language, awareness of difference and openness in learning from interviewee feedback. I view it as my responsibility to use these skills in interview contexts and call them to mind in analysis and write up.

Research supervision, tutorials, peer support and if necessary personal therapy, will be organised during the interview and analysis stages, to facilitate exploration of personal and professional issues which may arise (Clandinin and Connolley 2000).

3.11 SUMMARY

In this chapter consideration was given to differing qualitative, language based methodological approaches and argument made for the choice of NA in this study. Exploration was made of the different approaches to NA and decisions for choice of approach in this study based on the Dialogical/Performative (Reissman 2008) and Experience Centred (Squire 2010) approaches explained. Consideration has been given to aspects of narrative theory and subject matter which are perceived as being of particular focus, in the hope this highlights possible bias in analysis. Details of the proposed research were outlined.

4 FINDINGS

4.1 INTRODUCTION TO FINDINGS

The methodology chapter above outlined how issues of validity, my approach to NA and anticipation of particular areas of interest would all inevitably influence analysis. No patterns or insights of truth can be said to have been identified in this study (Saatkam 1995 in Holstein and Gubrium 2000) rather results themselves are perceived as narratives and could have taken many forms. Those which have emerged are the result of many variables, the potential influence of which have been described in the consideration of Narrative Theory above.

The process of analysis leading to the ideas outlined in the Findings chapters will be briefly described. Flow charts illustrating the analytical process can be found in Appendix 8. Description of the analytical processes leading to inclusion and exclusion of findings (including textual examples) can be found in Appendix 9. At the end of each recorded interview initial thoughts, emotional reactions and ideas generated by listening to the narrative were written down. At this initial stage it became clear that some narratives were emotionally more difficult to transcribe and analyse than others and this was reflected upon in tutorials and peer supervision. As each transcription was made emergent themes were noted. Transcribed texts were then each individually read and analysed to allow narrative data to emerge from text. It is acknowledged that reading of each whole narrative influenced interpretation of the next and that tentative identification of themes prompted focus on similar ones in subsequent transcript reading. This process was perceived as part of the inductive nature of Narrative Analysis. As sub narratives emerged within and across transcripts, consideration was given to why these themes were focused upon and potential others not. Themes identified across narratives were then taken back to individual whole texts, to allow contextualisation within and in respect of participants' whole life span narratives. Narrative variables inherent in analyses from Dialogical/Performative (Reissman 2008) and Experienced Centred (Squire 2010) approaches were considered in addition to content themes. These included positioning of self by narrator, influence and use of audience, presence of local and wider cultural narratives, interview context and particular narrative language constructions.

The decision to divide findings into the three areas of Mental Health (MH), Family Relationships and Ageing was made as attempts to organise findings for write up

progressed. Given these three areas were highlighted as of interest at interview, they were inevitably present throughout narratives offered. It was the interweaving and connection of these themes in whole narratives which led to a decision that, in order to write up findings in an adequately coherent fashion, these headings were necessary to section themes. This decision was felt to be honouring of participants' narratives and themes but clearly influenced interpretation of analysed ideas and will impact upon interpretation of readers. It is hoped efforts made to emphasise interrelations of the three areas in write up goes some way to illustrate efforts made to identify these connections.

It was also felt when writing up, that given the wish to connect findings back to narrative theory and the literature review, discussion of them would best fit as part of this chapter. However, further discussion is made in the following chapter on how findings relate to clinical implications.

The influence of my subjectivity as researcher is acknowledged as having affected my interpretation from design, interview, analysis and write up. The results of my reflexive thinking regarding findings are included at the end of each section. It is hoped this goes someway to illustrating influences I may have had upon particular analyses and their influence upon me. Further detailed consideration of reflexive issues related to the research process is made in the Reflexivity chapter.

5 MENTAL HEALTH

5.1 INTRODUCTION TO MENTAL HEALTH

Mental Health (MH) was chosen as the first of the three areas in this findings chapter as all participants organised narrative telling around this issue. This chapter will consider some of the narrative formats and constructions used by participants to describe the influence of MH on their lives, relationships and self. Followed by consideration of themes and ideas identified across narratives. Throughout, findings are connected back to previous literature, related to past and present cultural and professional narratives of MH and considered in relation to audiences.

5.2 THE START OF A MENTAL HEALTH NARRATIVE

Seven of nine participants began their narrative with reference to the start of their MH problem, the other two referenced family first then moved on to MH issues shortly afterward. Participants narrated openly about MH difficulties, contradicting ideas from some other studies_suggesting elders talked about MH issues "in a veiled and vague manner and qualified later on" (Jolanki 2004 p.498).

Sanders, Donovan and Dieppe (2002) note how, "experience of illness represents a dramatic break with the visual trajectory of a person's biography" (p.232). In this study the onset of MH difficulties were narrated by all participants as a pivotal event in their life span narrative. It also served as the core organising narrative theme fitting with Hýden's (1997) theory that "The illness is the vantage point from which all other events are viewed and to which all other events are related" (p.57).

Participant 9*: "Well it started with agrophobia and erm I think it started when the girls were about five years old you know, when I knew I'd got to take them to school".*

Participant 1*: "Would you like to know how far it went back? When it first started I was normal what I think was normal happy go lucky teenager and after I was married it sort of kicked in when I was twenty one this...erm...anxiety if you like …."*

Participant 7*: "I had a motorbike accident and that was the start I was always classed younger what they classed in them days as highly strung and anxious....."*

***Participant 3**: "Well it's more or less 1980 I was fine until I lost my husband ....twenty five years from today my husband was killed and erm I had a premonition..."*

Even participant 8 who had not previously struggled with MH problems and perceived himself as having grief rather than a MH problem began the narrative with the pivotal moment when his feelings changed

***Participant** 8:"Well my problem started when I lost my wife on....and I haven't been the same since"*

Sanders, Donovan and Dieppe (2002) note elders talk of chronic health illness by considering how present difficulties contribute to longer term effects on their lives. In this study opening narratives referring to MH were followed in six of the nine narratives by long explanations before I (as interviewer) was invited to contribute. In all narratives causality of MH was connected to life circumstances, reflecting Sanders, Donovan and Dieppe's (2002) finding in illness narratives of younger adults that following initial narration of impact exploration of causation followed.

The relevance of the interview context (within a clinical psychology department) and my known qualification as a clinician upon the choice by participants to narrate of MH is acknowledged and considered in more detail below.

5.3 CONTEXTUALISATION

Wider contextualisation following initial explanation of MH narratives occurred in majority of narratives and seemed based on assumption that this was necessary for audience to understand their experience. As participant 5 pointed out:

***Participant 5**: "It started with sort of anxiety ...I've got to start at the beginning because I had sold all my furniture..."*

Participant 2 began with a long uninterrupted life span narrative contextualising perceived pivotal and contributory life events and relationships which led to the start of their MH problems.

Participant 2*: "Anyway I was born in Essex on the (date of birth) erm my parents are about 32, 33 when they had me. I was an only one. Err I start school at the same time as* ***WWII*** *was* ***happening*** *and my schooling up until I was sixteen was done during the war and because of the location a lot of it was in shelters. Err although I can't say it didn't seem to me that either mi mother or father they probably loved me in their own way but I didn't feel very much that* ***I was*** *loved but on the other hand I had an extremely enjoyable childhood"*

Sanders et al (2002) note how ascribing multiple and interrelated reasons for illness can be important to narrative experience, but lead to conflicting narrative styles, ambiguities in the story and result in incoherence. This participant noted movements away from his main narrative by noting to audience the less important sub narratives thus offering explanation for incoherence and movement from the core illness narrative.

Participant 2*"..But one thing happened during that that upset me a* ***tremendous*** *amount and it never left me and it crops up fairly regularly although its nothing whatsoever to do with my problem I'll make* ***that*** *clear but it was.."*

The difficulty, but importance of holding coherence temporally whilst creating interrelation of life with illness narratives was identified by this participant.

"*: It's alright I am just trying to get things in the right order which is very difficult after all these years you know (coughs pause 10 secs) Oh yeah incidentally...."*

This participant created a preferred positioning of narrative self as someone at the mercy of others mistreatment and mistakes. This allowed both justification for his MH problems to audience and release from blame through preservation of attributes such as honesty. This fits with Hýden's (1997) view of illness narratives involving need to

ascertain who (or what) is responsible for the illness and present a moral self in this respect. Talking of difficult work experiences Participant 2 noted.

***Participant 2**: I said " ....I am not to discuss that ….. with anybody either on or off this job" ..... I thought he was going to bloody burst and from that day on he did his best to make my life a **bloody misery**.."*

*"...This is my big regret I should have gone off on a **medical pension** and not an ill health one it would have been worth a lot more to me but at least I have been **honest** about it"*

Andrews (2008) notes middle life can be a difficult time to, "have a perspective of where we have been and where we are going. But as we ascend the mountain and near the close of our life's journey the path or paths that we have taken become visible" (p. 87). In this study, age appeared to allow reflection and consideration of how MH narratives might have been different had different choices been made. Further, reflection itself allowed some reauthoring as "Health talk (became) intertwined with talk about past and present everyday life" (Jolanki 2004 p.489). For example, participant 5 noted how losing the home she shared with her sister whom she was caring for contributed to her MH problems.

***Participant 5**: And through all this time I thought "What am I going to do? What is going to become of me? And then after she died I had to face the problem of where I was going to live..."*

Later in the narrative

"I should have put the money into somewhere into a flat or anything."

Narrative reflection occurred largely in relation to how circumstances, others actions, and participants' decisions, might have created different outcomes regarding MH. Participant 4 reflected impacts of circumstances outside her control as having affected on her MH.

Participant 4: *"....I was brought up in a convent, they put me away in a convent from when I was born so that family.....I don't know anything about it ……..I think that's what started this mental health thing off with me I don't know? Could have done couldn't it? I wasn't jealous or nothing, well I was in a way jealous but it hurt I never knew what it was to have a mother and a father I always thought what it would be like (pause 1 sec)...."*

In this segment narrative reflection and understanding occurs for the participant through witnessing her own narrative telling. My opinion, as audience, is invited as potential contributor to new co constructions of narrative understanding and can be seen in questioning e.g. "could have done couldn't it?"

Narrative reflection of how things could have been different focused not only on others and life circumstances but also personal attributions. For some this led to "self" rather than "other" blame.

Participant 5: *"...If I hadn't been like I always am I always do everything in a rush erm if I had slowed down and taken them more slowly I would have I would have gone..."*

One insight gained from analysing these narratives was, that in order for reflection and creation of narrative change to occur, pre-existing causal narratives are needed to create comparison. Clearly, age is an advantage in this respect, as life span perspectives and experiences allow more opportunities for alternative ideas and stories. Although revisiting of choice is not always positive, Jolanki (2004) notes how, "By advocating the idea of choice it is possible to regain one's agency and construct oneself as agent rather than victim of fate. This means health becomes a matter of individual decision making and responsibility" (Jolanki 2004 p.499). It will be considered later how age and cultural narratives might have been restricting of possibilities to regain agency for these participants. However, undoubtedly the opportunity to narrate understanding of MH acted to allow reflection.

5.4 CONTACT WITH SERVICES AND TREATMENTS

An across narrative theme emergent regarding start of MH problems was contact with services. It was noteworthy that all narratives recalled how treatment offered when they first received input from MH services was medication regardless of age of onset.

Participant 1: *"I went to the doctor with these various head (pause) pains, in the end they sent me for an x-ray which was ok but it was around the time when purple hearts were on the market, you know being prescribed and I took those and various other things and they didn't seem to help ..."*

Participant 7: *"Four or five psychiatrists who were top at the time stuck me on more and more medication saying "You've got to take these" and then another would say "You need to come off it's bad for you".*

Participant 3*: "...I grieved but I was trying to be strong (pause 3 secs) and through (pause 3 secs) my sister in law and brother in law I was put on liquid valium. I'm not quite sure how long for (pause 2 secs) ..."*

These narratives in content and form reflect lack of agency with regard to medication at the start of MH problems. Participants did not narrate questioning doctors' past opinions at this time, which may reflect modernist cultural narratives of medical expertise in the 1950s and 60s. Participant 7's reflection in narrative of **why** he took medication, included past medical narratives, the need for relief from symptoms and the impact of his age.

Participant 7: *"I was taking barbiturates …… which I was told I was okay with them you know it's alright but when you are young it might come to when you are younger you want to enjoy life you don't see any problems when you are younger and if the tablets help you, you do it but having been through that experience I know just how bad it can be"*

Attitudes and choice regarding prescribed medications in the present were narrated differently to the past, possibly reflecting changes culturally and professionally and/or the insight gained from narrative constructions of their past experience.

Participant 4*: "Because they put me on those tablets called (pause 2 secs) no what's the name of those ...antidepressants put them on them but I was I said "No take me off them" I didn't want to go and now I'm on what are they? my memory! (pause 1 sec). Diazepam I'm on a small dose 5mg three times a day but it's not a strong dose but I can't see that it makes any difference (pause 5 secs) probably does but I can't see as it does".*

In this narrative construction personal agency is mixed. The narrator explains how she actively determined against medical opinion but then chose to take medication not perceived as useful. Qualification is used to emphasise to audience how only small amounts of medication are used, illustrating awareness of possible audience disapproval of use of diazepam. Participant 6, similarly notes her choice not to take medication.

Participant 6*: "and someone came out and gave me these Oh I can't remember the name of them now and said "would I take them? "Oxy something I can't remember the name of it now it doesn't matter anyway I recognised the name and they are habit forming so I have only ever taken two."*

But adds to the narrative her reluctance to dispose of the medication completely.

"I still have them I wouldn't take them but I don't know why I've kept them ..."

So, analysis here found that although participants experienced a sense of greater choice regarding use of medication in later life, there remained some internalisation of, past medical narratives that they may need medication to fend off symptoms of MH difficulties.

Participant 1:*".....whereas I don't know if they do any* ***good*** *(pause) but for* ***me*** *(2 secs) you know if there were those placebos they might do just the same I don't know*

but knowing that I've just got those in my bag and I tell my GP this that I just feel like they're my prop (3 secs) erm I'm not necessarily using them very often but I just (pause 2 secs) they help (pause 5 secs).

Interestingly, participant 8, who did not perceive himself as having MH problems, reframed purpose of medication in his narrative, and in doing avoided the medication having negative associations.

Participant 8*: "I am on power drugs at the moment do you want to know what drugs" (takes out packet)*

Cultural narratives regarding usefulness and types of medication used have changed. However, given powerful past medical systems and the trauma of initial onset personal narratives regarding their usefulness may be more difficult for this cohort. One participant narrated how support from her psychologist allowed her to choose different therapeutic options.

Participant 1*: "They (medication) made me feel so dreadful I thought I just can't do this ...so I phoned my psychologist and told her what I was going to do erm and with that I went to see the doctor again who had given me the tablets and she agreed that they weren't suiting me so then I carried on with my psychologist."*

Other participants narrated ability to negotiate with medical professions in later life.

Participant 3: *"I'm going back three four five months ago I had a very very bad panic attack where I couldn't control myself and I managed to get myself down to the doctors on my own and I err…….....and doctor my doctor said "It's depression" I said "No it's not depression I'm not depressed I'm not depressed" I says "I'm getting about in my way and my time and I'm doing things" I says "It's up there" So the doctor said she said "it is an illness and the sooner you accept that you are ill* ***with depression*** *she says "you will never get better"*

This participant narrated how she tried to illustrate to her GP that she was not depressed through evidencing her independence and active life. Radley and Billing

(1996 in Jolanki 2004) quote this as a common narrative inclusion for those who are ill and an attempt to regain social worth to audience. In this instance the attempt was overridden by the GP's more powerful medical narrative that acceptance of diagnosis was necessary for recovery. Hydén (1997) notes how narratives given by doctors are essential to patients in their endeavour to find meaning for their illness and play crucial roles in this respect. For this participant the threat that, unless she accepted an alternative narrative she would not heal, had a powerful effect upon her preferred self narrative.

When Participant 7 narrated his attempt to resist a similar medical argument he communicated to audience the emotional consequences of the medics response. This narrative was more disconcerting to witness.

***Participant 7**: "...He said "I'm going to get you right I'm going to get you admitted and we'll go the full course and I'll treat you" I said "Medication?" He said "Yes" I said "No thank you" I said "I don't want to be put on medication whether its good or bad for me" I says "I'm going to be one of (indiscernible) cases" "Oh you're not" He says, "I know people who have been put on antidepressants and they have reacted and it has upset them" and he said "Well I'm sorry I'm not going to treat you then you'll still get support" I said "Well won't you support me?" He said "No I'm here to do a job" He said "I'm not a policeman and I don't want to know about the units you are drinking or how many pints you are having "It was frightening and he was horrible. And I said "(indiscernible)" I got quite annoyed with him and (indiscernible) he wanted me to say "Yes" but I said "No I'm not going to say yes at all...."*

The speech form and detailed narrative here creates a powerful sense of audience re-enactment of this difficult encounter and the sense of powerlessness felt by the participant in the face of the doctor's reaction. Efraimsoon, Sandman, Hydén and Rasmussen (2004) found that when patients transgressed formalities of patient review meetings by challenging professional opinion feelings became "unsettled" in the room, revealing a truth that despite outward appearances, patients lack choice or influence in these encounters.

Embedded within this participant's whole narrative were other stories which highlighted why he felt need to resist hospitalisation. Had the psychiatrist these insights he may have considered different treatment options. The need for life span perspectives on elders' narratives is one of the considered important insights of this study, considered in more detail in the Clinical Implication chapter.

".....But you see I've got my doubts in the hospital my mum died there and they just sit round and I'm frightened "

"... they were going to move her (his daughter) to another hospital but I said "But that's a long way and she's not going to get better and I don't have a car so we couldn't we wanted to see her and as I say we were naïve and we didn't get a lot of help.....anyway this consultant wanted to send her and we talked to someone……So we said "No" and he kept saying "I'm sorry you can't stop me" and I said "I can stop you....." and he admitted that he but what we did we compromised..."

This participant possessed personal narratives of having successfully negotiated with doctors to protect his children. Although he had failed to win such arguments for himself, strong moral narratives remained and he narrated their contribution to his participation in this study.

"I felt passionate about how people with mental health problems can get trodden on and pushed around they are always the easy way to take on and there are a lot of people in the know with power let it happen ..."

5.5 USEFULNESS OF TALKING THERAPIES

A recurrent cross narrative theme was usefulness of "talking therapy" in later life. I use the term "talking therapy" as it is one which I feel encompasses the range of approaches they may have experienced. Clearly, awareness of immediate audience (myself as clinician) and wider audience (other psychotherapists) may well have influenced participants' wish to narrate this approach positively. For example Participant 6 appeared to speak directly to the ghost audience of her psychologist.

***Participant 6**: "I would like to say "thank you" to my psychologist (pause 2 secs) ...."*

"Talking therapy" was only referred to as having been available later in life and was compared to previous treatments received.

***Interviewer**: "So talking helped more than medication for you?"*

***Participant 4**: "Oh yes 'cos tablets couldn't"*

Comparing talking therapy to previous "flooding therapy" participant 9 noted,

Participant 9**: "It was helpful but I feel it wasn't **deep enough** for ...I've found more help with the psychologist sort of talking things over erm (pause) she's helped me **so much"

For some ideas that talking was helpful had surprised them.

***Participant 1**:" But I wouldn't have thought just talking to somebody like we talked that it can bring out these awful things that were in there somewhere"*

Although psychotherapeutic approaches are now available they were not offered when most participants first experienced difficulties.

Participant 3:** "...the psychologist knows all this (pause 2 secs) to me she's personal. I've taken the psychologist into my heart (pause 2 secs) I can tell I feel I can tell her **anything"

***Interviewer**: Does that help to talk to somebody like that?"*

***"Oh definate, Oh definate Yes** (pause 2 secs) and it's as the psychologist ha ha has said (pause) to me "Did I have any kind of help when I lost my husband?" And I said "No ...."*

One participant narrated awareness that being referred for therapy as an older person was unusual in our present culture, illustrating awareness of ageist professional ideas which have predominated services, that elders do not benefit from these approaches.

Participant 6*: "You see I think I have been lucky in having a GP who has sent me along here. How many GP's would have just passed it off?"*

This participant was the only one to compare therapeutic approaches having been offered counselling at her GP's surgery before being referred to a clinical psychologist.

Particpant 6*: ".....and I was sent I won't say where but I had to see the equivalent of the psychologist and I saw them for four sessions and then it was "That's it then you don't want to see me again? No?" So I had four sessions with him and that was it." "Well I was no better then than I was at the beginning and that to me in all this mental health bit that was negative"*

No participant narrated being offered family or couples therapy despite narrating extensively of connections between their family and MH difficulties. However, participant 9 did note how psychological therapy had led to consideration of systemic issues.

Participant 9 *"...yes erm the psychologist has made me see not actually what I was doing to my husband but that other people were concerned in the sort of with what I was doing erm..."*

Analysis of narratives of therapeutic work also highlighted what participants had specifically found useful.

Participant 7*: ".... I mean the psychologist to me she's brilliant because I think she cares about people herself. I know it's a job but it's a vocation you see and I trust in her immensely but I don't trust the doctor the psychiatrist..."*

Narratives participant 7 formed of her psychologist being genuinely caring were no doubt possible given her ability to compare this professional's relational approach to past medical practices. Importance of trust was also narrated by participant 6.

Participant 6: *" Well I can say anything to the psychologist no matter what it is if you like he is like a wall in so much as I can say things to him I can't say well I can't say* ***I wouldn't say*** *to my husband or any of my daughters I know it won't go any further"*

Although participants showed awareness in their narratives of having not received talking therapies earlier, they did not appear angry about this. Several, on the contrary, narrated feelings of guilt for currently receiving this input. It is my clinical experience that elders are often apologetic for needing input and very grateful for its receipt. I have understood this as related to the historical context in relation to the NHS coming into being in their childhoods. Sanders, Donovan and Dieppe (2002) also note that elders hold awareness of limited health resources and cultural narratives of their lowered legitimacy in competing for these, resulting in fear of judgment when in receipt of them. Offering another explanation for narrated feelings of guilt and gratefulness. The following narrative illustrates how for one participant this guilt influenced participation in the study.

Participant 1*: "Oh gosh I feel guilty taking her (psychologist's) time .....so that's why I decided to come and pass on my little bits of knowledge of what I'd gained because it might help somebody else. I feel it is sort of putting something back in the system because I must have taken pounds out of it"*

This fear was even experienced through participation in this study despite participants having chosen to give of their time and trust.

Participant 5*: "Am I holding you up?"*

Participant 6*:"I feel perhaps a bit guilty going on about me all the time (laughs) you know about* ***me****"*

This apologetic stance in relation to being heard was witnessed in narratives of both female and male participants.

Participant 7*:"...it worries me now because you are listening to me rather than doing what you want now"*

Interviewer: *"No no you are doing exactly what I am wanting"*

Later in the interview.

*": .....**but he's ever so brave braver than me,** I'm taking up your time"*

Interviewer: *No not at all I am smiling because you have to be very brave to deal with anxiety*

One gender difference noted across narratives regarding "talking therapies" was descriptions of relationship to therapist. Two of the three male participants referred to the relationship with the professionals they had confided in as reciprocal.

Participant 2*:"..he (the psychiatrist) told me all about you know when his own marriage was breaking up when I used to go and see him you know when we used to go and see him we used to talk about **that** together you know"*

Participant 8*:"...we don't always talk about my my he's not he doesn't always become a psychologist he sometimes becomes like a semi scientist ...I am interested in science and he is and we talk about different scientific actions err and events err I get on with him..."*

This narrative positioning might be understood as older males feeling more able to accept "talking therapies" if power dynamics are believed more equal, since receiving therapy may clash with cultural narratives of men being "tough" and not needing to talk about problems.

5.6 DESCRIPTION AND MEANING MAKING OF MENTAL HEALTH SYMPTOMOLOGY

Descriptions of the experience of MH were often narratively constructed as MH symptoms being beyond control of participants and unpredictable in nature. Participants positioned themselves passively in relation to MH difficulties and metaphors were used to achieve this.

Participant 1*: "But it is like sometimes I'm on a treadmill and you know I just can't get off but I'm coping with it a lot better"*

Participant 6: *"It's just it's just I wake up in a morning it's like a switch it just clicks and I can feel you know my pulse starts racing and it's like it* ***all day*** *"*

Some participants used more detailed descriptive narrative formats.

Participant 9*:"I would get so agitated I would be going round the house trying to do jobs but starting jobs and not finishing them just going from room to room"*

Participant 2: *"... I'm* ***depressed*** *every morning. If I'm not going out anywhere or I haven't got anywhere to go I sit on the toilet* ***with the lid down*** *and I find myself half an hour three quarters later I'm just staring at the carpet you know and that happens (pause 2 secs) ..."*

In all above narratives sense of helplessness in relation to MH is narrated and a sense of passivity communicated to audience through language such as "just".

Participant 4 created a greater sense of control in her narrative as she identified situations more likely to elicit symptoms.

Participant 4: *"Yes I get a lot of those palpitations things (pause 2 secs) that's when something upsets or something you know I suffer from them (pause 1 sec) or if I'm dreading going in somewhere you know"*

One cross narrative theme was difficulty in constructing meaning around symptoms of MH when at onset and the accompanying sense of fear. Some participants noted how, because of their symptoms, they initially constructed a narrative explanation of physical illness.

Participant 6: *"The anxiety started post op, yes post op and I didn't realise at the time.. but I was a fortnight in one hospital and a fortnight in another and came home and it started then I thought I was having a heart attack and my husband sent for the GP and then there was something else I don't know what was it? And he sent for the GP again and then I heard the GP say to my husband in the hall "Well if it carries on like this we will have to get her to see someone" (pause).....Yeah yeah (pause 1 sec) as I say I didn't realise at the time what was happening you know ..."*

This narrative construction conveys a sense of bewilderment created through the fast and detailed narrative content. This participant noted how the naming of her difficulties as mental rather than physical was a result of others constructions. Participant 8 also described the start of his problems as initially physical.

Participant 8*: "Well when my wife died in the August I was alright for a bit I was very sad but the next year I started laying in bed not getting up and not eating and things like that and err I was taken into hospital by the psychiatrist .....I was alright in the hospital and then I came out and about six months later I had a relapse and he took me in again since then I have been going to the day hospital I was going twice a week..."*

This narrative construction is simple and straightforwardly offers a physical description, sequenced clearly with no reference to personal uncertainty or confusion. This participant had created a narrative construction of their difficulties as related to his grief and in this way avoids adopting a construction of MH difficulties despite two admissions to a psychiatric hospital.

5.7 MENTAL HEALTH AND STIGMATISATION

Many negative wider cultural narratives of MH exist and it is within the awareness of these, and the possibility of being judged by immediate and wider audience, that narratives in this study were offered. Awareness of potential judgement by audience was evidenced in participants checking that what they were saying was being understood, or what reaction was being made by audience. Participant 9 seemed to become aware of her fear of being misunderstood as she witnessed her own narrative. Interestingly my response is one of reassurance.

***Participant 9**: "....I'd go out of the house and I'd have to (laughs) touch the kerb outside the house to check I was outside (laughs) it's a funny (laughs) I suppose it's funny to anyone who it's not happened to."*

***Interviewer**: "It makes sense to me but that can sometimes be the problem can't it because for people who can't understand it can be a bit embarrassing can't it?"*

Another participant seemed to respond to fear of judgment with a more defensive construction, making it more difficult to respond to as audience.

***Participant 2**: "...I know what depression is like and it is **bloody awful** and if you haven't been there I don't care who it is they **can't understand** if depression has been bad just **how bad that bad can be** its ahh.."*

Participant 3 chose to share her experience with awareness of potentially being misunderstood and narratively negotiates this by pre-warning audience not to misinterpret what she is saying. This created an obligation on my part to remain open to what she was conveying and hold onto my own professional bias and fears.

***Participant 3:** "Please don't take this the wrong road what I am going to say now. I still want to die..."*

This narrative also betrays possibilities of this lady having been misjudged by professionals in the past. The awareness of being judged by wider audiences with regard to MH issues was also witnessed in narratives of Participant 4 who narrated

how awareness of potential stigmatisation by others had led to her to become discerning with regards who she told of her MH problems.

Participant 4*: "……..cos I wouldn't go up to anybody and say I suffered with mental illness it's the way people take it now they'd think "Oh she's crazy her" (pause 2 secs) 'cos they don't understand mental health and they think it's craziness they don't understand there are so many parts to it mental health....."*

Participant 3 makes the same connection to the importance of judging context in relation to sharing with others.

Participant 3*:"It depends where you are and what it is in't it? But still if I was in the middle of town and there was all people around and they was talking I don't think I'd go you know and talk (pause 3 secs)"*

Fears of being misunderstood or judged connected to cross narrative themes of avoiding others. However, participants tended not to make a direct connection between fears of stigmatisation and avoidance but rather narrated the latter as social anxiety which was either perceived as a symptom of MH, as in the excerpt below.

Participant 4: *"Well it has not let me get on with my life as I would like to (pause 6 secs) because people come for a cup of tea and then* ***I don't want them anymore*** *do you get what I mean? They get on my nerves then. I don't tell them that, I'm not rude, but I pretend I'm not in or if I'm in town and I see them coming toward me I'll just nip in a shop way because I don't want to talk yet another time. I don't know what that is? It's not mental illness its more depression isn't it?"*

or as self-blame as was for Participant 6.

Participant 6: *"I'm very* ***shy*** *erm (pause 4 secs) I think erm not having much erm self-worth I think really I feel rubbish* ***most*** *of the time I mean what I do if I'm going into town I choose the time I am going to go. I go at dinner time and I think I might not see anyone I know.....So my husband can't understand why I do that but* ***I can't*** *go in a*

morning I just go around lunchtime when I think everybody's gone home for their dinner and I do things like that"

For participant 7 social anxiety and fear of others was perceived as having created secondary MH issues by contributing to his alcohol problem.

Participant 7*:"I daren't do things the only time I dare go out was when I had been drinking you know for some more drink"*

However, even this strategy had limited utility.

"....it scares me and even when I go to the pub ...I go in the corner away from people"

In this narrative description anxiety is again externalised through the word "it". This participant further narrated the impact MH problems had on his confidence to take up responsibilities.

Participant 7:" *I might let them down you know I couldn't say I could be there every day the way I am..."*

Here, MH is narrated as being the cause of not taking on responsibility, but at the same time the perceived consequence of this is further lowered confidence, creating a hermeneutic circle of negative past, present and future lived internalised narratives.

Participant 7*:"I won't make targets because there is always a chance of failure and so if you set a target you should do whatever you can if I do try and do something and still fail I feel down"*

Participant 8 did not create a narrative construction of his symptoms as a MH problem and as a result an interesting contrast was identified regarding attributions made for lack of social contacts.

***Interviewer**: "What do you think it is like growing older or **the grief** how has that affected your social life?"*

***Participant 8**: "(laughs) well I don't have a social life **I never have** actually except when I was in the forces of course you know you have a social life then but err no I've never had a **social life** it's just been me and my wife"*

Here, the past narrative of not having had a social life helps construct present social restrictions as a preference rather than problem, normalising this situation and avoiding self-blame.

5.8 COPING WITH MENTAL HEALTH PROBLEMS

Cross narrative themes of coping with MH problems were also noted. Of these the most common was to keep busy/active and stoical. It is hypothesised this may be a previous internalised post-war narrative of keeping a "stiff upper lip". Participant 3, was the eldest participant and a teenager during the war years.

***Participant 3:** ..."I thought I was going to be able to cope with something that had happened up here."*

***Interviewer**: "By keeping active?"*

***Participant 3**: "By keeping active, keeping going not think as much. Which I did (pause 1 sec) ...."*

The narrative meaning constructed by this participant was that keeping active would prevent brooding, which, it was presumed, would make MH worse. This participant's whole narrative conveyed someone who had taken this attitude in relation to her life following her husband's death. Participant 6 narrated inactivity being an anxiety in itself.

***Participant 6**: "I was sitting in my chair and of course I couldn't do very much because I was so weak I couldn't do a lot and I spent an awful lot of time sat in my*

*chair reading or whatever and I had this fear of being in this chair I want to do things.....**I go I make myself go places**..."*

As the narrative around this subject continued it developed into an idea that a necessity existed to be active even if they did not feel motivated.

" ....I have to make myself do it otherwise I wouldn't go anywhere"

***Interviewer**: "And does it help when you do things then?"*

"Well it means that I am getting, I'm doing something I'm not sitting in that chair Mmm you know"

The extent to which activity is believed to be helpful in dealing with MH problems by this participant is unclear, as ideas of activity appear intertwined with wider cultural narratives of "ageing well" and can be related back to findings in the literature review of these coping strategies being preferenced by elders (Mack, Salmoni, Viverais-Dressler, Porter and Garg 1997). It may be that for these participants the need to both remain active and present narrative self as taking responsibility for doing so is influenced by fear of stigmatisation for being ill and being older. A theme explored further in the Ageing chapter.

Not surprisingly then other participants described pushing themselves in order to prove they could do things.

***Participant 7**: "I go to the supermarket on the busiest day I can just to see if I can do it, it's that bad I'm that gone my legs are like jelly and my heads going round"*

***Interviewer**: "You push yourself?"*

"Well you see I've gone one more down than I have in the past and I don't know if I will succeed but if I don't try something (pause 2 secs)...."

This excerpt reveals the presence of a third potentially influencing wider narrative from past and present medical systems, which advocated activity as buffer to MH difficulties and possibly more behavioural approaches of “flooding” and “exposure”.

5.9 RESPONSIBILITIES AND ROLES

A clear cross narrative theme with regards to past coping with symptoms from MH difficulties was responsibilities earlier in life. For men this related to their working lives.

***Participant 7**: “....and then Monday morning you would go to work but you would still (pause 2 secs) have habits and routines when you are anxious or depressed I always stuck to my job and once you stop that routine you get out of the habit and I think that's my biggest problem but if I'd not if I had something **I'd got** to do it wouldn't be able to find an excuse to get around it”*

Past routines of work were constructed as having provided necessary structure and responsibility in the face of MH. The loss of this routine was constructed as having lowered resolve and led to self-blame. This fits with (Hodgetts and Chamberlain 2002) finding of the emergence of personally critical narratives when men are unable to overcome the impacts of illness on their lives.

Participant 2’s narrative regarding onset of MH difficulties and presentation of self had focused heavily around success, particularly in his career. Loss of career due to MH difficulties was narrated as a source of grief, and fears created regarding future self-defining narratives expressed.

***Participant 2**: “....And err since then I've had some bad bouts of depression erm. I was mainly alright whilst I was **working** I said to **the psychiatrist** “What am I going to do for the rest of my life.....”*

All female participants who had mothered small children narrated this time as one of alleviated symptoms, contrary to longstanding theories that this is a time of increased stress and vulnerability for women with MH difficulties (Brown and Harris 1978).

***Participant 4**: "..like I said I think it really started when I came out of convent **then** when I got married and had children it went off"*

***Interviewer**: "How come why do you think that happened?"*
"Because I'd got somebody hadn't I? I'd got somebody close to me then"

***Interviewer**: "But you said your husband wasn't very nice to you"*

" No he wasn't but the kids was there weren't they (pause 2 secs)...."

Participant 3 had lost her husband traumatically and narrated a culturally common idea that she coped following his death because her responsibility as a mother gave her no choice.

***Participant 3**: ...".and erm having two children two daughters I erm grieved but I was trying to be strong (pause 3 secs")*

Participant 1 offered another prevalent cultural narrative, that mothers need to overcome emotional difficulties to protect their children from potential harm their mother's MH might cause them.

***Participant 1**: ...." and I had a son just the one son and then I was what I think was a very good mother caring you know still am I think erm and then my husband and I loved our son he was a little miracle really and then I have always vaguely been anxious always wanted things nice and tidy as they should be erm and then I didn't work until our son was five and started school I got a job as the erm welfare assistant at school so that was okay because he really did not know that I was working you see because I was part time and then I was just a normal mum I suppose really. The odd time I would go to the doctor...."*

In this narrative the participant indicates that as audience I would "know" and accept that a cultural definition of a good mother is to be caring. It may well be that wider cultural narratives regarding the strength and responsibility required to mother have been enabling for some women with MH difficulties, findings which can be related

back to literature review where it was identified how past recollections of self as parent served to increase confidence in relation to later life family transitions (Pelligrini and Sarbin 2002). Certainly, participants in this study retrospectively narrated this period as an alleviation from MH symptoms (as will be discussed later in Family Relationships chapter). However, in this study motivations for being strong were identified as related to fear of societal judgment as well as positive remembering, and therefore, in some ways sad to witness. Furthermore, narrative confirmation was given of the strength of parental responsibility through stories of worsening MH symptoms once children became less dependent.

***Interviewer**: "I was wondering with you saying ….. it was more difficult when the children left home but when they went to school it was more difficult."*

***Participant 9**: "Oh yes well they didn't need me and I thought I was just abandoned I think that's what it amounted to in the first place. I seemed to be fine when they were babies…."*

For participant 5 taking on the role of caring for her elderly sibling was perceived as acting to buffer emotional impacts of her bereavement. Allowing her a similar narrative construction that her own emotional needs needed to be suppressed in the light of someone else's being greater.

***Interviewer**:."...and how do you think you survived that (death of husband and feeling anxious as a result) because you clearly managed to fight with it.."*

***Participant 5**: "Well there I think with my sister being as she was she appealed to me for help because her husband had died so I think that I couldn't think of myself I had someone else to think about and that sort of helped me but erm (pause 2 secs) ..."*

However the extended length of this care over time impacted upon the participant's emotional and physical wellbeing.

***Participant 5**: "I used to have to sort of drag myself out of bed and I would get her pills and help her to get up and wash and then it would be shopping to be done*

washing to be done all this sort of thing and it was a hard struggle it really was and I didn't think to go to the doctor and say you know "I can't I can't cope ....."

This narrative construction, of repetitive listing of menial tasks, conveys to audience a sense of burden and fatigue. Yet the strong narrative of needing to deny one's own needs for the sake of another prevailed and may have been included to ensure audience did not doubt her willingness to care.

However, for this participant and participant 8 the ending of the caring role , similarly to parenting, was narratively constructed as contributory to MH difficulties.

Interviewer: *"I mean it might seem a silly question but what are those differences what is it that has made life so much more difficult"*

Participant 8*: "well there was a deep love between us err as she got ill she was ill for a while you know with her chest I used to do all the housework* ***cook all the meals*** *I miss that"*

Responsibilities of work and care were clearly important in lives of these elders and narrated as associated with a time of respite from MH difficulties. However, loss of responsibility was narrated as having negative impacts on MH due to loss of roles, routine and for one participant (caring for a relative) fatigue following their death.

5.10 INTERACTIONS BETWEEN MENTAL AND PHYSICAL HEALTH PROBLEMS

Connection between physical health problems and their contribution to MH problems was a strong cross narrative theme in this study.

Participant 5*: "...but suddenly I seem to feel like I am going backwards again erm I don't know why there's no reason for it I've worked everything out and I started with this eczema and I've got that from head to foot and I think that's getting me down it* ***really is*** *terrible it wakes me up in the middle of the night and erm (pause) so I think*

I've got to be a bit careful otherwise I will find myself in a bit of and err ***a mess*** *another thing I had that has bothered me I had a black out at Easter..."*

For those participants (half of the sample) who had experienced life threatening illness particular connection was made between physical symptoms, feelings of anxiety and MH.

***Participant* 7**: "*every pain I get is cancer again "It's totally cleared up they said" "No treatment" ....he says "Get on with life" that's fine but like this tenderness now I think "No its cancer" it's not but it's all this I'm trying not to be mardy but I think all this what's happened to me and my wife (sharp intake of breath) ..."*

This participant identified the cue of physical pain as creating anxiety provoking narratives of feared future illness on the basis of his experience of past physical illness. He also narrated how these narrative fears were thickened by difficult past life events e.g. death of children and financial loss which he felt biased him toward fearing the worst. This again emphasises importance as clinicians of understanding how past narrative constructions influence those created in the present.

Further evidence of this need was seen in Participant 6's narrative of how both her past brain haemorrhage and experience as a nurse affected her narrative formulations which turn impacted upon her emotional wellbeing.

Participant 6: "*And I can only have to have anything to do with my head anything at all but if I do get an ache or a pain or something like that I have to try not to concentrate on it because again sub consciously there is "What if, perhaps" You know its this little bit of knowledge isn't it?"*

Interviewer*: "Of course you are bound to be much more sensitized to that now"*

"Well you are we nurses we immediately you know were taught I mean to think on the worst scenario and then you back tracked to get to where you might be and I think that you are taught to do that and you automatically go for the worst scenario ….."

Participant 2 had offered a long casual narrative for the start of his MH difficulties but also narrated how more recent illness impacted on his MH and challenged his preferred narrative self as independent and physically active. Smith, Braurack-Mayer, Witert and Warin (2007) found in semi-structured interviews that men try to create narratives which present them as adhering to cultural male stereotypes and that lack of possibility to meet these impacts upon self-esteem and emotional wellbeing.

Participant 2*:"....You should know instead of doing that (planned parachute jump) on my 60th birthday which was a Sunday I went into (pause 2 secs) the hospital for bowel cancer and err yeah (pause 2 secs) I sold my motorbikes I thought I've shot it now if I've got cancer I'm probably going to snuff it you know but all the build up toward that got me down, that got me down you know ....."*

For participant 3 more general physical decline was felt to be adding to her MH difficulties given her preferred coping strategy was physical exercise and activity.

Participant 3*: "**Yes yes yes** I mean like I said to you I put all my time and energy into, I love being outside I love walking now that's something I'm not very good at doing now but before I used to be up my **garden**. I used to be up my garden climb over my fence I used to wander **all the way down onto nearby villages** .....I've always been active"*

Interviewer*: "Mmm well that's difficult as well then"*

***"Very very hard** very hard it is something else that I haven't..."*

This narrative construction highlighted the impact of present physical self-narratives contrasting preferred self-narratives, an issue of relevance for elders. Narrative comparison to former, preferred selves was noted in awareness of loss of physical wellbeing, feared future illness narratives based on constructions of past illness and cultural narratives. Narratives of present illness and treatment all impacted upon MH of elders in this study and highlight the significant relationship between physical and mental illness for elders, an issue considered further in the discussion and clinical implication chapters.

5.11 DISTANCING FROM OTHERS WITH MENTAL HEALTH PROBLEMS

Through analysis it was identified that some participants compared narrative self with narratives of others who had more severe MH difficulties with the purpose of illustrating that they were not "too" ill.

Participant 7: *"I've seen.. I don't know how to say this I'm far better off than a lot of people with mental psychiatric problems and having done voluntary work of course and I feel for them because I'm not saying this in a horrible way I feel for these people because I can get out when I can but some of these people are never going to you know"*

In the above narrative construction the participant illustrated awareness of his need to reassure audience he was not prejudiced but creates a distancing between himself and those he perceives are affected by MH problems to a greater extent. However, this participant also illustrated the risk of comparison as a narrative strategy, since it also evoked images of a potential future self.

"…..and I think you know I think "Yes I am frightened that I am going to go like that" I don't mean nasty please..."

Participant 7 was not alone in narrating having taken a position of helper to others with MH problems in the past. Although this illustrates a compassion and ability to connect with others with MH difficulties there is also a sense of comparative reassurance, since the position offers affirmation that one's difficulties are not as bad as others.

Participant 5*:"I like to talk to some of these elderly people up there how they feel. Another lady I've been talking to....she's in a very bad way..."*

For Participant 1 comparison was narrated as having been forced upon her through shared service provision creating a more shocked realisation and a need to act a part.

Participant 1: *"...There was about twelve of us in the group I was referred to and I thought "Gosh" everybody there was crying and I was trying to ....I suppose I was acting really you know I didn't feel as bad as* ***any of them*** *and....."*

Participant 8, who did not term his difficulties as a MH problem, narrated a similar experience but chose to reject the service offered rather than try to fit with the group he found himself in.

Participant 8*: "I am not being snobbish (laughs) I find it a bit low level I will speak to them (other patients at the day hospital) and chat with them and stuff like that ...I find it* ***boring*** *and I was offered to go there and have dinner every day but no I make my own meals decide what to eat...you know* ***it was helpful*** *but I have gone past it now"*

Where Participant 1 positioned herself as part of the group by using the term "us" Participant 8 refers to others in the service as "them" making clear to audience that he is different and possibly reflecting a stronger need to protect his preferred self-narrative.

Older adult services often offer care through day hospital settings. However, the narrative accounts here justify thought being given to the possibility of collective care being unhelpful for some and need to carefully consider what is fitting to individual care. Implications of such findings for service provision are considered in more detail in the Clinical Implications chapter.

5.12 NARRATIVES OF SUICIDE

Inclusion of stories of suicide within narrative wholes was offered by almost all participants. Where suicide had been attempted the event was narrated as pivotal both in relation to life decisions and MH narrative. Participant 3 narrated a dramatic building of stress which led to her suicide attempt. The narrative form used pulled me (as audience) into her frightening experience of having been overwhelmed. The contrast of this particular narrative to this participant's previous narrated resilient self added to its powerfulness.

Participant 3*: ."...it came forward it was brought forward it came to the front and everything that we'd gone through everything all came forward I'd by that time when it came forward I'd heard the voice once but I heard the voice more often ...and I tried to push it back and I still tried to keep going and keep working but I couldn't .... "you are going to kill yourself now" the voice (pause 2 secs) I walked out of the nightclub (pause 2 secs) I went to my flat (sighs) I fed my cat (pause 2 secs) the money that I had I left it all out where they could see it ....And erm oh oh (pause 2 secs) "Not just yet, not just yet" .....I was still going to kill myself that voice was still there. I'd had enough I* ***just couldn't*** *stand it anymore .....and err I went up (pause 2 secs) got myself all undressed put my nightie on my dressing gown on took my tablets and my drink laid there just looking like that (indicates) looking all the way round my bedroom (pause 2 secs) "*

A quickened pace through use of short sentences and repetition created a dramatic narrative tension and inclusion of a "voice" an ominous presence of suicidal thoughts. A similar degree of detail and tight sequencing of events was also witnessed in the suicide narrative offered by participant 2.

Participant 2: *".....and err I remember I had my underpants on my dressing gown and I just kept walking from room to room putting one light off and another one on just building up to this it was you know all of a sudden that was it* ***I did it*** *I emptied them all out onto the working surface in the kitchen didn't drop any of them* ***on the floor*** *took every one of them kept washing them down with water and I went into the bedroom and I remember exactly how I was I had my dressing gown on and I put my legs on my bed and do you know I had the most* ***wonderful feeling of peace*** *Yeah (quietly) and I don't know how long I just drifted off ....."*

Participant 5's narrated events as becoming overwhelming leading to a sudden decision with detailed events sequenced chronologically.

Participant 5:*"****….****things got really on top of me so I took an overdose. I decided well that I'd go round to the chemist buy a whole load of aspirins and we had a cat that we were very fond of and I picked on a day when I would do it and I, I erm took her to be put down which was very hard and then I took these aspirins well it got very messy I*

was vomiting blood it was very un...well it wasn't working I mean I expected I took err sixty with about ten in liquid to take them down and erm (pause) Ohh I'd prepared everything I'd put plastic sheets on the bed and took a bucket expecting to be sick but blood (laughs whilst speaking) was coming from everywhere (laughs) and I thought "Well nothing's happening" you know "I should be becoming unconscious by now " but I was absolutely perfectly wide awake"

This upsetting event was narrated in a matter of fact fashion, more slowly than the others and in this way created incongruence on receipt between the distressing, emotional content and the rational narrative form. This may have resulted from previous rehearsal, or as a means of creating distance for narrator and/or her audience from the intense emotion of the event. For example, at one distressing detail she laughed. Perhaps this sense of emotional confusion was exacerbated by the participant also offering narrative presumption that I could empathise with her suicide experience through phrases such as "you know".

These suicide narratives, given their highly emotive content, appeared physically acted as well as verbally told. They included use of gesture and movement (standing up from sitting, beating the chest) and seemed to fit with ideas of narratives which are particularly difficult to articulate (in this case due to high emotive content) being "performed" as well as told through use of non verbal resources (Hydén 2013). The understanding of suicide narratives could have been enhanced through the collection of these particular data which would have enabled a more "performative analysis". This issue will be considered further in the Clinical Implications chapter.

Participants who had not attempted suicide still included this issue in their narrative. This may relate to previous narratives "about" (Hydén 1997) MH which participants will inevitably have had with doctors whose concern will be suicidal risk. Given participants were aware of their clinical audience this inclusion may reflect a presumption of required narrative content and/or previously rehearsed narrative telling in this respect.

Participant 9: *"No erm although I've been depressed I've never thought of doing any harm or anything like that it's not in my nature it was just something I'd got to put up*

with erm (pause 2 secs) in fact I took offence that people were asking me that question"

Participant 8: *"I think well you know suicide in the catholic faith is a mortal sin and err I think I may have done away with myself except for the fact that I am a catholic I mean I don't go to church every week you know although I might have done when I was quite young and I think it stays with you I was baptised and confirmed a catholic and err ..."*

For both the above participants faith had been a protective factor to suicidal thoughts. It had also been pivotal in the suicide narrative of participant 3. She narrated having sought spiritual forgiveness following her suicide attempt and making a pledge with God not to self harm again.

Participant 3: *"...I still want to die. I've still had enough but I should never ever as long as I live I shall never no matter how much pain I go through or I am in I shall* ***never ever take my life again. I made a promise*** *and erm ..."*

All participants who had attempted suicide narrated it leading to reflection and a decision to never repeat this act, a finding contradictory to common professional assumptions that suicide attempts inevitably create greater risk of a future one.

5.13 SUMMARY

Reviews of narrative research have acknowledged that all illness disrupts coherence of past, present and future selves and that, "depicting illness in the form of narratives is a way of contextualising illness events and illness symptoms by bringing them together within a biographical context" (Hydén 1997 p.52). In this study all participants' narratives of MH illness were identified as core to organisation of life story and coherence in relation to other life events.

Narratives of MH were interrelated throughout with life events and family relationships and this is reflected in the chapters on Family Relationships and Ageing which follow. Forms of overall narrative chosen by participants varied, some took a

temporal perspective leading to the start of MH difficulties, and others started their narrative from commencement of MH difficulties, defining self and experiences in relation to their MH problems from that point.

All participants created narrative constructions which sought to offer causal meaning and differences were noted in relation to positioning of self, issues of blame, responsibility and distancing from others with MH difficulties. For some the act of narrating and audience were used as a reflective resource for this purpose. Others appeared to have more rehearsed and set narratives which were less open to co-construction.

Significant themes identified included medical interventions and use of medication, which were felt to be a reflection of the cohort interviewed and subsequent shifts in medical knowledge and approach. Participants saw more recently offered psychotherapeutic approaches as helpful.

Themes identified in relation to participants' experiences of living with MH difficulties included, stigmatisation, coping strategies, past responsibilities (work, child rearing and caring) and interrelations with physical health problems.

Narratives of suicide were included by most participants and their narrative form, and performance felt to be distinctive. The potential relevance of these findings to therapeutic work and planning of services for elder will be discussed further in the Clinical Implications chapter. The impact these narratives had upon me personally and my reflection upon these is considered below.

5.14 MENTAL HEALTH NARRATIVES AND REFLEXIVITY

The organisation of narratives around a MH theme by participants in this study highlighted to me the deep impact MH had upon these elders' lives and identities. I found this upsetting to witness, and experienced mixed feelings of sadness and admiration for participants. Stories of justice and injustice witnessed particularly in relation to medical systems connected to my own preferred moral narratives and

experience, no doubt influencing my reactions, focus and representation of this particular area.

One identified past medical narrative I reacted against, was that MH difficulties could be helped by activity which serve to avoid thinking about problems. On reflection I felt this related to experience of silencing of contentious issues in my own family. A stance I have worked hard to repair in my life and has no doubt influenced my professional choices. For some participants however, these coping strategies had been used and allowed some sense of control. Observation and identification of my own narratives in this respect allowed me to consider this issue in relation to analysis and will hopefully facilitate respect in relation to future clients' choice of coping strategies and improved analysis of whether these are facilitative regardless of whether they originated from ideas I may not agree with professionally.

Hearing narratives relating to past medical systems also raised ethical issues. Some narratives revealed how psychiatrists, rather than being powerful, had in the past, related to their patients as friends, the boundaries of which might presently be questioned. Other narratives regarding hospital treatment created ethical dilemmas requiring my seeking supervision and legal advice within my Trust, to ensure no further action needed to be taken. Assessing ethical issues of the past from positions of present professional thinking is a difficult one to resolve in work with an older population. I found that narrative content in these interviews was less carefully edited by participants than might be the case in therapy. I understood this as product of participants being left to narrate without interruption, possibly becoming more immersed in the emotion and contexts of their telling. Although I sought necessary advice I am left with the "hauntings" of having witnessed unresolved past stories which sit uncomfortably with my preferred personal, professional, moral and ethical narratives. I recognise that one consequence of narrative research is the hearing of stories which we may have preferred never to have known but cannot undo. We are inevitably changed as a result.

Narratives of suicide felt particularly painful to witness, transcribe and analyse. The language construction, tone, repetition and performative aspects of these narratives pulled me experientially into these events. Listening repeatedly, and in detail to these

through transcription felt gruelling and resulted in need for me to pace this work in order to process content and prevent vicarious traumatisation. Harrison (2000) notes how engagement in narrative research requires awareness of narrative's potential to heal or re-traumatise narrators. I would add the potential for traumatisation is also present for immediate audience, given the amount of time spent in isolation with the narratives. Harrison (2000) notes how decisions regarding the extent to which we are able to "delve into the process" of narrative interview and analysis constitutes part of the "moral maze" of this methodology. I feel this decision should to some extent be guided by emotional intensity of content and the potential impacts these may have upon researcher. Possibility exists for difficult emotional narratives to be focused upon more or avoided by researcher. It is hoped in this study the process of reflexivity and seeking of appropriate support allowed fair focus to be given to these areas and prevented too much inclusion in write up.

Suicide narratives were difficult to listen to without interruption and I worked hard to inhibit impulses to interrupt. Reflection allowed identification of how my professional, internalised scripts of risk assessment may have contributed. Not being able to follow a rehearsed risk assessment conversation within interviews felt anxiety provoking and quite debilitating professionally. However, this experience taught me how participants were aware of and did include information which alleviated my fears, but within a contextualised and fuller suicide narrative.

Some participants narrated how spirituality had influenced decisions not to attempt or re-attempt suicide. My Christian belief and spirituality are intertwined with my own narrative constructions of resilience and survivorship through difficult life events. Perhaps not surprisingly then, participants' spiritual narratives were of interest and although not hugely narrated they were included as significant within findings and write up. In addition, given spirituality was narrated as a preventative and redemptive factor to suicide within contexts of above mentioned researcher anxiety, they offered a sense of reassurance for me.

A main motivation for participation in this research project was narrated as the redemptive aspect it would add to their illness narrative, through belief their struggles may benefit others. Similarly, one of Hýden's (2008) participants noted "if you think

someone else can be helped by what I've been through that's good" (Hydén 2008 p.53). The hope participants conveyed, having shared such difficult narratives, created a strong sense of responsibility in me to ensure wider audiences were accessed. When I have considered discontinuing this doctorate due to personal circumstances this has influenced my decision to continue. This process has highlighted how a strong past narrative from my childhood of the responsibility of keeping one's promise has been influential, not only here but throughout my life. I am aware however, that however much I try to represent the perceived narratives aims of participants, I am ultimately limited in my attempts since, "Narratives are always open to reinterpretation. By passing them on to new audiences we pave the way for possible new meanings and as they are passed on they make entrance into new power relations" (Hydén 2008 p.129).

6 FAMILY RELATIONSHIPS

6.1 INTRODUCTION TO FAMILY RELATIONSHIPS

This chapter outlines main themes identified in and across narratives relating to family relationships. Family narratives were considered in relation to relationships across the life span, changing dominant cultural ideas of children and families (Sluzki 2000; Reissman 2002) processes of narration (Bornat et al 2002) and use of audience. Narratives of family were intertwined with narratives of MH and ageing and across the life span, supporting proposals that we entwine narratives of experience with narratives of relationship (Andrews, Day Sclater, Squire, Treacher 2000). In the following section headings are divided into significant themes and the types of significant familial relationships narrated.

6.2 EARLY FAMILY RELATIONSHIPS

Some participants offered childhood narratives spontaneously, others made little or no reference to these until prompted. Participants spontaneously offering narratives of childhood often did so in relation to "grand narratives" of MH and reflected how early experiences may have disadvantaged them emotionally. For example, Participant 2 began his narrative from early childhood until onset of MH problems to explain their root. Early in his narrative he noted feeling that limited educational experiences due to socio economic factors had disadvantaged his life.

Participant 2: *"this is what money can buy what it can do for your social position you know and erm yeah that angered me greatly"*

Similarly Participant 4 also began her narrative with early childhood experiences perceiving these as related to her MH problems.

Participant 4: *"I never had family from being younger if you start from being younger…I think that's what started the mental health thing ……that always held me back"*

Insightfully, this participant noted how it is only as she has lived and became aware of potential alternative childhood experiences (i.e able to take a life span perspective) that she is able to recognise the potential these experiences may have had upon her.

"I haven't really had much life you know (pause 2 sec) not what I would have liked, now that I can see what life can be (pause 3 secs) I should have liked to have close you know family or something"

However, comparison of her childhood experience in an orphanage to present media revelations of institutional care also allowed her to feel positive about her past through comparison to what might have been.

Participant 4:*"….all we got was rapped on the knuckles you know if we misbehaved and that hurt with a ruler an all. That's all we got on the knuckles that's all we got we never got mistreated or nothing in this home"*

This narration seemed to act as a catalyst to accessing positive aspects of her childhood in relation to her resilience through life.

Interviewer*: "Well you are such a strong lady"*

"Yeah well I had the nuns used to say "You've got a strong foundation to get through" There has been a lot that they have taught me"

And later.

"I was brought up a catholic ….like I said before it has kept me out of trouble hasn't it?"

Narration of loss or separation from parents seemed a recurrent theme in this study. Participant 6 narrated having been evacuated as a child however, perhaps significantly, this sub narrative was made in relation to ageing rather than being viewed as significant to later MH difficulties.

***Interviewe**r: "If your mother died it's difficult because you have not got any close model have you?*

***Participant 6:** "Well I was evacuated during the war so I never had a close relationship with my mother…..It's difficult to relate to say what my mum did you know because for a lot of it I don't know what she did"*

However, as with participant 4 (above) the cue of past childhood memories activated reflection from a life span perspective.

***Participant 6**: "They (billeted parents) were an elderly couple I'm saying that but they can't have been an elderly couple he was a miner probably in his forties"*

Reflection then continued in relation to her experience of evacuation and different parenting, supporting Bornat's (2002) finding that participation in life span research facilitates elders' narrative co-construction through the opportunity to tell it affords.

"…. four and a half years I was with them so the influence they had over me was probably more so than my parents obviously when you think about the time from four to nine and a half"

Connections continued to be made as to how this experience may well have impacted on her relationships and life choices.

"You don't create relationships the same apparently when you have been evacuated you know but erm but I mean to have lots of friends but I don't pick out a friend"

"I am sure that it was them that gave me the opportunity to be where I am today"

Reflection also led to connections being made between this experience and the relationship to her birth father.

"*My father erm (sighs) I was frightened of him but I had reason to be frightened he was six foot two. I don't know why but I suppose it's because I didn't know him"*

This participant was the only one to narrate evacuation experience even though it was one likely to have been faced by many in this cohort. The issue of evacuation has only recently been acknowledged as potentially significant to the MH of older people. For example, Pesonen et al (2007) found children evacuated during middle childhood were much more likely to suffer depression, particularly in later life and suggest a neurological trauma from attachments created with two sets of parents as cause. The lack of cultural and professional acknowledgment of the impact of separation at this time no doubt influenced availability for narration of these experiences, integration into overall life story and understanding for elders of its significance upon their lives.

Interestingly, as this participant moved her narrative back to her father she held coherence in narrative telling by relating back to the original focus of unavailable models for her own ageing experience.

"Anyway….. and the porter said to me "Your Mr ….daughter aren't you?" and I said "Yes why?" and he said "Nice man, nice man" and I said "I think we are talking about a different person" I can't relate back to them getting …I mean my father had dementia he remarried he got erm muscular dystrophy so I can't relate to that"

Participant 1 narrated another common wartime, separation experience for this cohort; loss of a father figure to military service.

Participant 1: *"Yeah I think I missed out a terrific chunk you see my dad was in the army for six years and I can remember…he was a stranger to me you see he wasn't at home"*

Pesonen et al (2007) researching effects of wartime childhood separation from fathers found no significant connection to depression in later life, however findings were limited by low numbers of participants.

Family experiences during adolescence were also narrated as being of significance to this participant.

Participant 1: *"I was fifteen my cousin had two illegitimate babies and it was taboo then you know it was dreadful erm and I never ever I don't ever really got over that….then you know it was dreadful"*

The strength of past moral cultural narratives regarding sexuality is very much felt in this narrative construction. It is also interesting that, although the event happened to her cousin, witnessing familial reactions was sufficiently powerful in changing her feelings and choices throughout life.

"I mean like as regards you know closeness and personal things never …… never have any intimate relations with my husband with the light on ***never never*** *and that goes back right from when I was fifteen and all of this disgrace you know"*

Impact of past, strong moral narratives regarding sex and family life was also narrated by Participant 3.

Participant 3: *"I had* ***very good parents*** *(pause 2 secs) they brought me up the right road the good road to look after my family"*

This moral narrative was one she wished to pass down to her daughters and consequently affected their relationship when the values were not kept by them. Narrating her reaction to her daughter's pregnancy.

"It was either a case of my daughter doing the right thing and proving that he is the father and erm finding somewhere else to live"

Bornat et al (2002) notes how elders create private and public discourses when faced with dilemmas related to shifts in cultural, familial moral narratives and these allow them to remain supportive of offspring. This participant did not follow this finding but felt need to choose between her own strong moral narrative and her daughter's choice.

"I'm sorry she knew how to have sex (pause 4 secs)"

There seemed less worry regarding past sexual morality for male participants. None narrated past cultural expectations having restricted sexual relationships, rather they narrated taking advantage of changing cultural ideas regarding sexual freedom and ideas.

Participant 7: *"To force her dad's hand (to agree to their marriage), obviously, we had a baby she had a baby come, we did it on purpose to force their hand, it wasn't a mistake and erm he still said no her dad did (pause)"*

Although this narrative informed audience of a stance against past cultural morals, its construction included justification to avoid audience disapproval indicating awareness that disapproval may still exist of his choice.

Some childhood family narratives were only made when prompted.

Participants 9: *"…my parents used to like to drink and I can remember as a child standing outside erm pubs ….and I think that* ***put me against drinking****"*

Although a link between childhood experience and future life choices was made in this narrative construction, no recognition of potential neglect or connection to later MH difficulties was made. This exemplifies how lack of focus upon children's needs and opportunity to narrate for this cohort can result in unquestioned internalisation of childhood needs being unmet. This participant did however reference her fears of thunderstorms to being left alone as a child but again without recognition of potential neglect implicit in this story.

"I can remember my mother and father being away once when there was a bad thunderstorm …… and not daring to go and ask for help"

6.3 CONNECTIONS BETWEEN FAMILY ISSUES AND MENTAL HEALTH DIFFICULTIES

In the previous chapter note was made of pivotal events being associated with onset of MH difficulties. Most of these related to family and in particular family bereavement or transitions.

Participant 3: *"I was fine until I lost my husband…my husband was killed"*

"They (family members)) asked the doctor to give me something because if I was suicidal they couldn't cope with me"

The previous chapter noted how child rearing responsibilities had been perceived as helpful to MH symptomology. However, the familial transitions inherent in children growing up had the effect of onset of difficulties for participant 9.

Participant 9: *"Oh yes well they didn't need me and I just felt abandoned I think that's what it amounted to in the first place"*

"Perhaps being lonely (pause 2 secs) and sort of it was the empty nest syndrome"

This narrative construction employs a common developmental life narrative - the empty nest syndrome (Matthews and Sprey 1989) to provide an explanation which it is presumed is understood by audience.

Transitions to becoming carer to family members were also noted as pivotal.

Participant 5: *"Well I think my problem started when I started to care for my sister"*

As was getting married.

Participant 1: *"…after I was married it sort of kicked in"*

The reason for difficulties emerging once married by this participant seemed to include internalised, past, gendered narratives of marriage preventative of sharing difficulties.

*"He'd (her husband) not been used to a **weepy female** around the place you know his mother was a strong lady and he wouldn't want me snivelling about so you try just erm to carry on"*

The consequence of this silencing was retrospectively identified through reflection, however, despite this, self-blame for emotional difficulties remained evident in her narrative.

Participant 4 had created narrative connection between lack of family connections, leaving an orphanage and their contribution to onset of MH difficulties, but then went on to consider how creation of her own family system served as an antidote to MH problems.

***Participant 4**: "I was alright when my partner and mi husband was alive I was alright with him"*

"Then when I got married and had kids it went off"

In the face of disappointment at lack of contact with her grown up children in the present this participant narrated how she had learnt to shift her definition of "family" to the system where she had been cared for and now worked as a volunteer.

"I think the hospice is my family"

Narrative understanding of ***why*** this system was helpful in relation to past experiences is clearly made for audience, illustrating how later life narrative can be enriched in meaning through time and life experience.

"I like it there I think for me it's like I've been used to those enclosed you know like a convent with people all around all the time I think that's why I like it there such nice friendly people you know I feel quite at home there"

In my role as interviewer I cued one participant regarding connections between family and MH by asking what support he was received following his bereavement.

Interviewer: *"…will your family talk to you about your wife?"*

Participant 8*: "No because they know it upsets me"*

Interviewer: *"Would it be helpful to you if they did?"*

Participant *: "No"*

Interviewer*: "You prefer not"?*

Participant *: "It's something between me and my wife"*

Interviewer*: "So it's more private?"*

Participant*: "Yeah they have their own lives and husbands and things like that"*

Retrospectively, this narrative questioning revealed preferred professional narratives on my part of bereavement being a shared family issue. However, this is resisted by the participant through use of a current cultural narrative of offspring being too busy to be burdened by older parents.

6.4 CARING ROLES IN FAMILIES

Care for elderly relatives by participants was an identified cross narrative theme. Three participants nursed terminally ill spouses and three more narrated experience of being involved in the care of elderly parents or siblings. It was noted in the Mental Health chapter above how caring roles had acted:

As a means of coping with mental health symptoms.

Participant 5: *"I couldn't think of myself I had someone else to think about and that sort of helped me but erm (pause 2 secs)"*

A contributing factor to their exacerbation.

Participant 5: *"She would sit for hours with coins in her lap and she would say, oh hundreds of times, "What is sort of the value of that?" and "What is the value of this?" and then she would sit with the newspaper……..."*

And narrative selves which participants wished to defend in the light of these conflicting caring stories.

Participant 5: *"There was nothing outside that, but I don't regret it one bit, err if I could turn the clock back I wouldn't say "Oh I'm not going to go through that"*

The findings and reflections below clearly connect with these but were felt to better relate to this chapter. However, the interrelations between the areas of family care and MH are clearly acknowledged.

One finding of interest was the sense of responsibility noted by participants with regards caring for their own elderly parents and relatives. Participant 1 noted how parenting and caring for her own parents had coincided in her life.

Participant 1: *"…… one summer after I was married my dad was in hospital and I lost a* ***terrible six months of the summer*** *just went you know I was getting home at nine o'clock at night (5 secs) and I feel guilty about that now because it was time that I ought to have shared that with someone else, someone else ought to have shared some of it with me I realise that (2 secs)"*

This reflected upon narrative formation enabled the participant to look back and acknowledge she should have received more help. However, interestingly she appeared to blame herself for not having accessed this.

Participant 6 noted her ability in later life to resist pressure from wider family to care for a sibling with cognitive difficulties.

Participant 6:*"…she (sister) has got daughters and so, no, I have no worries there that she's not, she has got a child who is still at home and that is a worry of course but the girls will sort it out"*

This participant was able to justify being freed from caring roles because her sister has daughters, fitting with literature which suggests elders are more likely to be cared for by female offspring (Brubaker and Brubaker 1995). However, Participant 5 (quoted earlier) cared for her sibling despite the fact she also had daughters, highlighting the individual nature of familial care decisions. Interestingly, Participant 1 narrated how the decision to care for her own parents in the past was resulting in other elderly relatives casting her into this familial role.

Participant 1: *"…erm my only auntie and uncle and he's ninety seven and she's ninety four and they live in their own bungalow and we're not very close but and they've got no children so they think I should be everything that that and* ***I can't, I just can't do it*** *……..they've made me feel* ***guilty*** *you see over the years that's part of it (pause 2 secs) but I don't do things you see and I can't be to* ***them*** *what I was to my mother and dad because they're not my parents you see but they make me feel guilty"*

This participant's narrative construction included rationalisation to self and audience for exemption from the caring role; that is the relatives are not her parents. However, despite this she continues to feel guilty, highlighting how this cohort of elders still live with familial and internalised societal narrative regarding care for older family members.

It was therapeutic work which helped this participant begin the process of questioning and resisting guilt feelings resulting in greater sense of agency in later life.

Participant 1: *"but then as I say we had parents that were ill that I needed you know to help and they relied me emm…so you know I'm a lot happier* ***now*** *I suppose*

because things are more (pause 1 sec) under control I feel a little bit more ***in control*** *of myself because I haven't got quite so many people erm pulling different (pause) ways you know"*

Narratives of care offered insights into the complex familial situations this cohort of elders face in their later life. Researchers such as Horowitz 1985 suggest women generally take caring positions in the family and make more self-sacrifices than men. Both men and women narrated caring roles, however, males had cared for spouses whereas females' caring roles were multiple and extended through the lifespan.

6.5 BECOMING PARENTS AND CHILDREARING

Decisions to parent, birth experiences and early parenting were narrated by most participants as pivotal to life narrative. Decisions to have children were narrated as influenced by wider cultural and familial narratives.

Participant 2: *"…. she'd only really become pregnant because of this pressure put on me by my parents wanting you know to* ***run my life****"*

Although appearing to take a victim position in relation to his parents this narrator revealed more general, cultural narratives of the time that couples should have children and provide grandchildren. The strength of this cultural narrative is also highlighted in Participant 1's narrative of a comment made by a stranger in the street.

Participant 1: *"then about seven years into my marriage someone by chance just said "Are you going to have a family?" I said "No" you know. I didn't feel up to it the rest of it…fears. So she turned round and that changed my life and she said "Well I think you are* ***very very*** *selfish" (pause 2 secs) …it probably gave me a jolt and I said "What do you think if I start a family doctor?"*

This narrative exemplified how internalised narratives that she should not have children due to anxiety was challenged by a wider cultural narrative regarding roles of women and was affirmed by medical opinion. This highlights the multiple and contradictory narratives faced by women with MH difficulties fifty years ago.

Participant 5 narrated having experienced different social narratives when she was unable to conceive. This narrative reveals grief that her past experience is not that of women presently.

Participant 5: *"We didn't have any children which was a big disappointment to us but in my day you didn't go to the doctor and say can I have intra….err what is it? …It was accepted "well she's just barren" it was always the woman's fault so erm there was no question of going to the doctor and asking for help"*

Contrasting this pain of childlessness, participant 7 narrated past dilemmas of children being conceived where a hereditary disorder was present.

Participant 7: *"The doctor suggested we did not have any more children with genetic but this time we were pregnant with our (child's name) and he suggested taking you know like a tablet but we said "No we're having her' cos the one thing the wife and I feel when they are little kids and in there they were still loved by us and if it happened again we wouldn't get rid of it so baby came along"*

This narrative does not retrospectively criticize medical opinion but (possibly because these medical narratives remain presently) justifies to audience a decision to keep their child.

Participant 2 also narrated having a child with disabilities in the 1950/60s. His description included a choice to use language familiar to the time he narrated of but creates ability to do this to a current professional audience by illustrating awareness of the changes to acceptable terminology.

Participant 2: *"Oh by the way we eventually did have a (indiscernible) after we'd been married for about 21 months she was a mongol which today of course is Down's syndrome. You got no* ***help at all*** *in fact the way …"*

Comparison between past and present service provision and particularly support available for parents was able to be made in this narrative and served to justify the participant's reaction of grief at the birth of his daughter.

"And I thought "Good Heavens" is this what we've got is this what it's going to be like?" You know, and it would have been you know, because you got ***no help*** *and when I've seen mothers, perhaps not quite so much today as much as it used to be with all the publicity, but in* ***those days*** *women aged prematurely if they'd got one"*

Both male and female participants narrated perceiving themselves as having been good parents, however, gender differences of how this was defined existed. Male participants narrated having fairly disciplined and well educated their children, which was evidenced in their success in life. For example Participant 7 narrated having been a fair but firm father.

Participant 7: *"that was when he (his son) was leaving school it was time to leave and I said "You are not leaving school til you've got a job" So he went out and got a job"*

He later narrates of his son's career.

"I can't believe he's come out high I'm dead proud of him"

A narrative inclusion also noted in Participant 8's transcript.

Participant 8: *"…he went to a boarding school in Germany which did him the world of good …he is working down in London now…"*

Female participants defined their good parenting as successfully protecting children from perceived, potential impacts of their MH difficulties.

Participant 1: *"I've always put on the "no way would he (her son) know that I was down in the dumps or just had a couple of valium" No nothing like that* ***no****"*

"I wouldn't say much at all because I suppose it is ***protecting*** *my son"*

This participant appeared to hold internalised narratives that anxiety, use of medication and discussion of her difficulties should be concealed from her children.

Emphasis made perhaps highlights her perceived need to reassure audience of her responsible actions and acts to allow her to lay claim to being a successful mother.

"I think I was a very good mother, caring, you know, still am I think"

Participant 9 used evidence of her children being emotionally well in adulthood as proof of her success in hiding her MH difficulties from them.

Participant 9: *"…I mean the girls seem to have* ***coped with*** *it we seem not to have passed it on"*

"erm I don't think the daughters realised, we tried to keep it from them as much as we could erm"

For participant 4 the need to protect her children related to domestic abuse as well as MH problems.

Participant 4: *"I got through it (the domestic abuse) didn't I? The kids got through it (pause 2 secs) and* ***it didn't really harm them*** *with them seeing it sometimes* ***it can harm a child*** *can't….It didn't seem to harm them they made good mothers and (pause 3 secs) so I must have been doing something right didn't I? (pause 6 secs)"*

Although this participant acknowledged her own need to survive domestic abuse, more focus was given in this narrative to illustrating awareness of the potential impacts these experiences had on her children (possibly created through more recent cultural and professional narratives) and her attempts to protect them. Evidence is then offered to illustrate this success through a common cultural narrative of good mothers creating good mothers and audience invited to agree with it. These findings are reflective of some of the ideas offered by Gunnerson, Hemmingsson and Hydén (2013) following their study of narrative interviews with mothers whose children were ill. They found mothers used narratives to "present, defend and sustain their identities as "good parents" (p. 447) and felt this was considered necessary by them to claim to being a responsible parent and moral person.

6.6 LOSS OF CHILDREN

By far the most difficult to hear and analyse cross narrative theme was loss of children. Participant 7 lost two of his children and narrated initial diagnosis as a pivotal life event.

Participant 7: *"He (GP) said "I'll come down" and he came down and he looked at her and he said "Do you mind if I get the consultant in to see her?" and I said "No" never dreamt what would happen and err he said "Are you in tomorrow night?" I said "I'm at work" He said "Could you get out of work?" I said "Yes" so he said "Okay" so we'd got no phone at that time and he got the consultant to come round on Saturday morning (pauses, upset, sharp intake of breath)"*

Interviewer*: "He must have been worried"*

"….I said to him "Is she going to die?" hang on a second he said "Yeah it's the brain" he said "We don't know much about it I'm not certain about it but I'm 99% sure. I'm sorry I'd like to get a second opinion and get some tests to confirm (pause) which he did….."

As with other highly emotionally charged narratives in this study (see suicide narratives) construction takes the form of detailed reconstruction of conversation creating the effect of pulling audience into the experience. As immediate audience this created heightened emotion, perhaps explaining my interception.

"…then we had (child's name) and she died same thing happened again (cries)"

Interviewer*: "Twice? The same thing?"*

The distress of the loss of children was narrated in detail, but narrative meanings created included a redemptive narrative. A finding reflected in Reissman's (2004) research of illness.

Participant 7: " *So there's a lot happened to me in our family which I can't change but also I try to look on the bright side and say "Look its horrible if our two children*

died but at least we've got some more children and grandchildren whereas some people haven't have they?"

"He was a lovely doctor ….and I was talking to him like you, you know, and he said "How the hell do you get over (cries) losing two children I said to him "you watch over what you have got"

This participant was the only one to connect loss of children to his MH difficulties. Participant 4 narrated death of her son when asked her how many children she'd had.

Interview 4: *"I have three…I lost one at nine years old he was in a wheelchair (pause 3 secs) he couldn't talk or anything so (pause 2 secs) at the time it was very sad but sometimes when I think …if he'd have lived …the family didn't want to know it would have been hard for him wouldn't it? So maybe it was better, I don't know (pause 2 secs)"*

This loss narration seemed unrehearsed with the telling creating emotion and consideration of meanings being created. Like participant 7, this narrative recollection of her child's death led to attempts at creating positive ideas relating to the death, in particular appreciation of her other children.

Interview 4: *"I couldn't have had better children you know they have caused us some upsets of course but it's part of them growing up (laughs) I remember…."*

Some participants seemed to minimise death of children in their narratives, possibly as a result of previous cultural narratives experienced by this cohort that such grief should remain private. Having narrated the birth of his daughter with Down syndrome Participant 2 made no more narration of her until I asked at the end of the interview.

Interview 2: *"(quietly) Yes, yes that's what happened with mine. Well actually I had the carry cot over the arm of the chair and the mother in law was holding her at the time' 'cos she was making noises"*

No reflection was made of impact this loss had upon him, only on his wife and consequently their marriage.

"But of course when she died that was another big problem for the wife you know"

Again this child's death included redemptive aspects here the participant narrated how the event enabled him to act promptly, through recognition of symptoms to save the life of another baby.

Participant 2: *"What was I going to say about my baby dying? Oh yes it helped me save another life!"*

6.7 ELDERS CARING FOR GROWN UP CHILDREN

Participants narrated experience of continued parenting, changed relationship with their children and their continued involvement in the care of grown up children. These narratives were charged with past and present familial and cultural expectations. Findings around this particular family dynamic were easily related back to literature.

Sluzki (2000) notes how some elders struggle to shift narratives of being parent to their children a finding reflected in Participant 3's narrative which included evidence she still felt responsible for her daughter's behaviour.

Interview 3: *"I am a very very* ***observant*** *mother"*

"But I don't know maybe it was a mother's instinct I had a niggly feeling"

Here a cultural narrative of innate, instinctive knowledge of her children was employed to justify the position of holding rights as well as responsibilities as a mother. This narrative included assumptions that audience would be familiar with cultural narratives of what "mothering" means.

Participant 3: *"I helped her in a way that a mother* ***should*** *help her"*

"….. she lived with me (pause 2 secs) helped her out (Pouse 2 secs) still saw the boyfriend the father of my grandson (pause 2 secs)"

This narrative continued with emphasis on how she supported her daughter before introduction of how her daughter's behaviour became challenging and her consequent dilemmas. This allowed a sequenced, rational, evidenced and therefore justifiable narrative for the decision to withdraw support. An action which could potentially be viewed as "bad" mothering.

"And err I still stood by her"

"I wanted her. I didn't want her to leave but I couldn't ***cope****"*

Sluzki (2000) posits that there is a relational point where elders and/or children recognise they no longer agree with each other's outlooks. This recognition was narrated as particularly difficult for this participant. Her narrative later included her younger daughter returning to live with her and a sense of restored purpose as a mother.

"That made me feel happier and that made me like it was something I was looking forward to getting her up in a morning and that and coming home and cooking for her"

However, this participant's suicide attempt also had the result of bringing her daughter closer.

"…. we're ***closer*** *well we've always been close but it just seems like we're that little bit* ***closer*** *and erm err I mean all my medication was taken off me (daughter's name) was in charge of that and the tablets are back with me now she* ***trusts me……"***

Participant 4 differed in the relationship with her adult children, in that she felt their expectation of continued care from her were unreasonable. She justified this decision with cultural narratives of caring roles between children and parents needing to be reversed as parents age.

Participant 4: *"So It's about time (pause 2 secs) I had it my way now isn't it? I don't think It's me who should run after them do you? I think it's them who should come down to see me. It's only down the road"*

By using question form this participant assumes agreement from audience with cultural narratives that elders have right to receipt of care and should not be expected to continue to care for their adult children. The inclusion of information that her family are geographically close emphasises to audience the unacceptability of this decision by them, given there is no "culturally" acceptable excuse for it.

Both participants 3 and 4 use cultural narratives to justify their positioning in relation to their grown up children to audience and present preferred narrative selves, but highlight the conflicting cultural narratives in this respect through presentation of contrasting perspectives. Quinn (1989) notes that transitions between elders and grown up children depend upon both being willing to facilitate this process. Where there is disagreement about how roles should change (as for participant 4) transitions are difficult to achieve and where past roles are firmly held by the parent (as for participant 3) other family members may struggle to move in new directions in their lives.

Participant 1's narrative revealed insight into shifts in cultural expectations of respect between elders and adult children. Speaking of her daughter in law she notes.

Participant 1: "*She would never call me mum or anything like that, I would never expect her to, but with my husband's mother she would be mum, she wouldn't be her, name her name was (name of mother in law) but I would never dream of calling her that, erm it was different wasn't it? You know the generations, as we say everybody now seems a lot closer and younger (pause 2 secs) I have a different relationship with my* ***daughter in law*** *than I had with my* ***husband's mum*** *and I suppose that's (2sec) the generation gap really and how things work"*

Some participants narrated the unexpected return of adult children to their home for financial reasons or following relationship breakdown. Participant 9 notes.

Participant 9: *"And (pause 4 secs) I think she came for about 3 weeks continually whilst she was off work because she was so upset then ……she would come to us for the whole weekend erm (pause 2 secs)"*

The impact of the daughter's need for support upon family dynamics was noted.

"Yes I think it upset my husband more than me erm (pause) ….I suppose it's having girls in a way they tend to talk more to him than they do me …"

(Logan and Spitze 1996) were quoted in the literature review as highlighting how unexpected shifts in family dynamics, as a result of changing needs of adult children, are more significant to this relationship than the changing needs of elderly parents. Despite such findings this seems a poorly focused upon caring role of our current cohort of elders.

Participant 1 narrated a continued, close, loving and mutually supportive relationship with her son wherein she could express feelings

Participant 1: *"I'm not very err tactile you know,* ***I am with my son****, I can fling my arms around him, he's six foot you know big (2 secs) lad (laughs) well he's in his forties but I will throw my arms around him without a second thought more than I would my husband"*

Walker et al (1989) calls on researchers to consider the complex and reciprocal relationships between elders and families and Ramsay and Bleiszner (1999) note ageing well is partly dependent on elders being allowed reciprocal familial relationships. This analysis highlighted how transitions elders made in relation to their children was individual and based on family history, preferred parental and moral narratives, family scripts and the unpredictability of their grown up children's lives.

6.8 GROWN UP CHILDREN LOOKING AFTER OLDER PARENTS

In relation to the above section themes of grown up children caring for their older parents were also identified.

It should be noted that not all participants in this study had children and some had no contact with their grown up children. Brubaker (1990) notes how, contrary to common cultural ideas, childless elders do not necessarily have less social contacts, but do create different social lives. However, they found that when health declines childlessness can be perceived as detrimental by elders who often turned to nieces or nephews for help. Participant 5 was childless and noted.

Participant 5: *"Well if my health starts to break down I don't want to be a burden, I don't want to have to ring my nieces and say and say "Will you do this will you do that? And erm..."*

In this narrative seeking help from nieces was perceived as synonymous with being burdensome. Participant 7 included a very similar narrative again assuming that asking to stay with his children would be perceived as him being a burden.

Participant 7: *"I wouldn't put on my children saying "Can I come round and stay with you" like that"*

Interestingly, this participant also narrated how despite holding a narrative of not receiving care from his children he constructed his decision not to care for his own parents full time as a failure.

"I wasn't what you would call a good son to them I couldn't sit for ages with them I would take them their dinner round Sundays and things like that erm"

This contradiction the observation I have made clinically of this cohort of elders being caught between two opposing cultural narratives regarding care of elderly parents. On the one hand they were expected to care for their own elderly parents, but on the other they fear being disapproved of or being burdensome if they expect this of their own

children. This fear of being a burden upon family was narrated as related to MH as well as age for some.

Participant 1: *"Until the psychologist started coming* ***the family*** *really didn't know I had these anxiety problems. I didn't tell anybody"*

Cultural narratives of elders not being burdensome seemed internalised and unquestioned by some participants and rationalised by a societally acceptable idea that younger adults' lives are too busy to accommodate care of elders.

Participant 5 narrated these ideas as culturally common but by referring to their impact generally upon elderly people she does not own the impact of these upon herself.

Participant 5*: "Well I think in the case of a lot of elderly people they, their relatives, are working full time work and their life is full…."*

"Elderly people probably get the feeling "I'm being a nuisance" and they are apologising all the time saying "I'm sorry to have to ask you this" and they probably get "Well it's alright but I do have to do this"

Participant 6 also narrated offspring's demanding lives as reasoning for not seeking their help but noted consequences of this upon her relationship with them.

Participant 6: *"We are close to a point but they're busy. I'm busy but we see each other"*

This participant also narrated feared impacts burdening a particular daughter because of her own emotional strains, reflecting findings of Peek et al (1998 quoted in Allen, Blieszner and Roberto 2000) that elders changed expectations of care to fit what they perceived offspring would actually offer.

"*she had really enough to cope with and I'm very wary this is another reason why I turn to one rather than the other"*

Participant 1's narrative reasoning for not seeking help however was one of resignation

Participant 1: *"But now he is very supportive erm so is my daughter in law if I tell them anything but I don't say much at all (pause 4 secs) because you feel at my age you know (pause) is it worth it? (pause 3 secs) anyway (laughs)"*

In keeping with the literature (see, for example, Harwood and Lin 2000) unquestioned narratives that asking for help or care from younger family was wrong was present across narratives and differing rationales offered for this being the case. However, participants' narratives also included awareness that as they had aged their grown up children had become more concerned about their welfare

Participant 8: *"my son phones me up every night and he says…"Are you all locked up and everything?"*

Interviewer: *"So do you think your children maybe worry about you more than you worry about yourself?"*

*"**Oh yes yes yes"***

Although this participant acknowledged his son's concern he believed this to be unnecessary. Participant 6 also narrated perception of children becoming more protective but narrated feeling uncertain as to whether this occurred because of her MH or her age.

Participant 6: "…."*Can't I take you? We'll go such and such" you know. Whether that is age related or she looks at my car and knows I won't drive or whatever I don't know"*

This participant also feared her daughters experience pity toward her .

"You don't realise you know you just get on doing and do it well I just don't think about it (pause) they are probably looking at me thinking "Poor old soul" you know"

Kopito Motenko and Greenberg (1995) found poor communication regarding care between elders and offspring results in inappropriate or unnecessary help being given. No participant narrated communication with offspring regarding care giving and where care was offered it was narrated as determined by offspring. In some cases this support was accepted gratefully, although the lack of participation by the elder was noted.

Participant 9*: "The older daughter comes and she seems to sort us out by finding out if we can cope with what money we have got in fact she has just tried to organise for us to put what savings we have into a better account"*

"…..my daughter organised it (a holiday) from start to finish and she would be what? Seven or eight months pregnant?"

Other participants perceived this uninvited help as unnecessary.

Participant 7: *"He says "Dad get another car I can get you a car cheap" I say "No" he can get them really cheap"*

"And they say "Well how are you with the car are you still paying the house?"

For some participants practical care was provided by daughters, fitting with Merrill's (1997) finding that females family members are more likely to care for elderly relatives.

Participant 3: *"…..my daughter and err my other daughter does a tremendous amount of* ***heavy things*** *erm cleaning windows, hoovering"*

"She comes back from work she makes sure I've got a meal that I'm having a meal that I'm warm"

Earlier this participant had narrated how she enjoyed caring for her daughter in the past and present, illustrating reciprocity of care between them, across time and in changing needs (Fingerman 2001).

Participant 8 narrated not needing care from his son. However, later in his narrative and almost as an aside he narrated his daughter in law taking on some active care roles.

***Participant* 8:** *"I do the shopping she will pick me up from here…and my daughter comes once a month, in a fortnight's time, and she always brings something to eat"*

Globerman (1996) and Peters-Davis, Moss and Pruchno (1999) note daughter in laws often have the equivalent caring roles as daughters without the same acknowledgement, possibly a reflection of lack of research focus on wider family systems and care.

Participant 4 narrated perceiving her grown up children as neglectful in their duty to care for her in later life, contrasting their actions with internalised narratives of other family systems. She makes a direct connection between this sense of disappointment and her MH difficulties.

Participant 4*:"…I get stressed half the time especially on a Sunday when I'm in the kitchen and I see (pause) the daughters and the sons coming to see the neighbours you know they come every Sunday to see their mums or their dads but nobody comes like that cos that's caused stress really that can stress you it upsets you but that's the same as stress isn't it? "*

This participant had been brought up in care and a recurrent theme in her whole narrative had been loneliness and disconnection from family units. Her hope for care in later life may be a reflection of hoped for difference in late life.

6.9 GRANDPARENTING

Several participants narrated grandparenting relationships. Research has highlighted ambiguity associated with grandparenting roles in Western culture (Sprey and Matthews 1982 quoted in Brubaker 1990) which lead to the necessity of creating individual grandparenting roles within particular families. (Shanas 1980 quoted in Brubaker 1990). Females in this study narrated relationships with grandchildren more

than men, reflecting Harwood and Lin's (2000) finding that women talk more of grandchildren and family history. A recurrent theme emerged of emotional relief, either through older grandchildren being confidantes in a way grown up children were not, or joyful distraction created by younger ones. Participant 4 introduced her grandson into her narrative as a positive comparison to her children who were failing to visit her.

Participant 4: "*….my grandson comes he's not too bad the 23 year old he comes"*

Similarly participant 3 perceived her grown up grandson as supportive.

Participant 3: *"My oldest grandson in his twenties, if he were here you'd be looking up at him like* ***this.*** *He'd say Gran don't get upset over it"*

In a particular moving excerpt this participant narrated her grandson's compassion and persuasion to disclose what medication she had taken in her suicide attempt.

Participant 3: *"….Heard this voice again.* ***No****."Gran" "(Grandson's name)" "Gran tell me what you've taken. Tell (grandson's name) what you've done" (pause 3 secs). He asked me again (pause 4 secs). I knew it was my grandson I knew who it was (pause 2 secs). Then he got his hand and he got my face my face rested on his chest (hits chest several times) there I told him what I could remember of what I had taken"*

Hodgson (1998) and Uhlberg and Kirby (1998, quoted in Harwood and Lin 2000) note longer life spans and resulting relationships with grandchildren which extend into the grandchildren's young adulthood allows mutually affectionate, satisfying long term relationships (Williams and Giles 1996). Dellmann-Jenkins, Papalia and Lopez (1987 quoted in Brubaker 1990) also found adolescence resulted in positive changes in relationships with grandparents. In this study participants narrated the importance of physical affection from grandchildren.

Participant 6: *"……. he's fifteen and we've got this whereby "Don't give me hug" but he cuddles up to you, you know "Are you alright grandma?" I've never been a huggy person anyway he will come and give me a hug"*

***Participant 9**: "Yes the grand daughters are very touchy feely which I appreciate"*

Participant 1's grandchildren were small and involvement with them narrated as positive, distinct from other family relationships, and influential in ameliorating anxiety.

***Participant 1:** "Mmm and different with my grandson he gives me a lift"*

"…..that's nice (that he calls grandma a special name) it makes me feel happy (laughs) nice to feel happy (4 secs pause) and I really don't feel that very often (pause reflectively 3 secs)."

Similarly participant 9 narrated how the distraction of care of grandchildren helped with MH symptoms

***Participant 9:** "**Oh yes it takes my mind off it completely** I'm sure that's part of the trouble is I've got too much time on my hands"*

Harwood and Lin (2000) suggest grandparents do not feel they can expect particular relationships with grandchildren and so better appreciate interactions experienced. A hypothesis emerged from analysis here that, given the previously noted fear female participants had experienced of their MH symptoms negatively affecting their children, the freedom to enjoy grandchildren (given reduced responsibility) was particularly meaningful and releasing.

Brubaker (1990) notes grandparents play varied supportive roles in grandchildren's upbringing including financial and practical and this increases for single parents. Some participants narrated being recruited by offspring into helping practically with grandchildren.

***Participant 6:** "I was key keeper you know to check he was alright so I kept getting "Yes of course I'm alright grandma"…so it's that kind of thing you know and "Can you fetch the other one, can you fetch her from school and take her to school"*

Participant 9 narrated being happy to be given greater responsibility but also included note in her narrative of the physical demand this created.

Participant 9: *"and then she asked them if they wanted to stay and they were jumping up and down you know which made us feel a lot better and they really enjoyed it and we enjoyed it ….but (laughs) it's a lot of work you don't realise that you have to give them attention all the time …"*

In both these narratives participants appear to have been asked or expected to care for grandchildren rather than being collaborative planners in this process.

One participant noted how one consequence of grandchild care had been recognition of change between past and present parenting practices and cultural expectations.

Participant 9: *"Oh yes just now (my daughter) says she treats her child)* ***completely different*** *if she says something like that and she is expecting someone to tell her off she just puts her arms around her and hugs and she says that does the trick"*

Participant 9: *"To what we had to* ***our children yeah*** *oh yes, yes they wouldn't have said "Boo" back to you and they (grandchildren) get so much attention and* ***the school is completely*** *different"*

Palmore (1990) and Wheaton (1992) suggest that in contexts of ageism and multiple losses elders covet relationships with grandchildren, which may result in them being much more accommodating to adopting different child rearing approaches. I would add that present child rearing practices are often at odds with their own past experience as parents and require narrative skill in accommodating. For example, in this study participants used their narrative to make clear to audience their awareness of differences in child care practices and to justify their previous parenting strategies.

Participant 4*: "I mean I was a lot stricter in them days we'd slap them on their backside or on the legs.* ***Now you'd be in court if you did it now wouldn't you?)*** *but I don't think it did em any harm I just did it on the back of their legs nowhere else"*

This excerpt exemplifies dilemmas faced by and skill of elders narrating to younger and in this case professional audiences in the face of changed cultural expectations.

6.10 PRESENT SPOUSAL RELATIONSHIPS

Despite lack of research focus on development of spousal relationships post retirement some researchers have identified elders' perceptions of this time in their marriage as one of relationship growth (Ryff 1989) and increased intimacy. A result of years of relational investment (Sluzki 2000). These findings were reflected in narratives regarding marriage offered here and may have specific relevance to elders' relationship and their MH.

Participant 6 for example began her narrative interview with reference to her marital relationship.

Participant 6: *"Well there's my husband and I have to say this without him I wouldn't be here today because I would not have coped"*

"He's a wall to me"

"I don't want him putting an arm around me or something and I don't want, I just want to tell somebody"

Participant 9 also perceived her husband as central to helping her deal with MH problems .

Participant 9: *"He's been so good so patient"*

"and I know how difficult it must have been for my husband he's always been (pause) always behind me all the time sort of helping he used to when I went to the hospital"

The position taken by both participants was one of passive, grateful acceptance which connected to fears of having been troublesome.

For participant 8 continued intimacies with his wife despite her death were narrated as facilitative to coping, fitting with Berman's findings (1987 quoted in Fingerman 2000) that positive memories of past close family relationships help elders survive difficult life situations.

Participant 8: *"I get depressed (pause 5 secs) like I say my prayers every night and there is always a* ***tear*** *because I speak with my wife"*

"Well I have a little card you know a bereavement card its special the verse on the back if it …tells you that the departed have not really gone they are in the next room and that's how I feel I talk to her all the time stuff like that (blows nose upset)"

However, Bourque et al (2005) found marriage could also have negative impacts on functional well-being of older women. Participant 9 narrated how some of her husband's actions may have been contributory as well as helpful to her MH difficulties.

Participant 9: *"…..but he never pushed for* ***me to drive,*** *sometimes I take that as a sign that he did not want me to get independent which might be part of the (pause) sort of what is happening what did happen to me err (pause 2 secs)"*

Brubaker (1985, 1990) points out lack of research around negative aspects of marital relationships in later life and Allen, Blieszner and Roberto (2000) suggest this has led to oversimplification of factors affecting older couples. Brubaker (1985, 1990) identifies timing of retirement between spouses as a contributory factor and one also narrated by participant 9.

"He didn't want to retire he didn't retire at the normal time …I wanted him to come and be ***with me,*** *well to sort of do a different kind of life I suppose, and I felt it was rejecting me, I think because he wouldn't retire (pause) and he'd never had a hobby so I think the job was a hobby yeah erm (pause 5 secs) Oh I don't know"*

Interestingly, she noted how post retirement the role of helping with feelings of stress changed in her marital relationship.

"My husband is he was getting cross with himself because he couldn't use the (indiscernible) properly because of his arthritis and (pause) I find I am calming him down instead of him having to do it for me erm"

The ability to think about relational issues in this narrative were perceived as resulting in part from opportunity to think systemically about her problems in therapy.

"…she (therapist) is finding out things out about (Husband)..] that he didn't know, he tends not to put himself first all the time, and I think that is part of his trouble if he put himself first"

Sluzki (2000) notes women in long term marital relationships can experience a sense of their husbands encroaching on their roles post retirement. An experience narrated by participant 6 but perhaps difficult to challenge given her husband's past support.

Participant 6*: "Whereas I was doing everything, well not everything, but the majority of things, erm my husband took over some of it, and then after this he took over, I mean he helps me with the cleaning and whatever you know it…it changed (pause) I mean he was carer if you like when I first had it (MH problem), and gradually he now automatically does things I mean he just gets on with it"*

This participant, like participant 9, narrated her husband as having lost motivation post retirement, creating need for her to be emotionally supportive. Interestingly however she blamed herself for his change.

"…. he's (pause) needs a push sometimes now, I mean he never did before…he seems to have lost all incentive since he has retired, ***that*** *is worrying* ***in itself*** *because whether I pushed him to retire you know, I sometimes wonder if it's a bit of erm my fault he is feeling this way"*

6.11 WIDOWHOOD AND DIVORCE

Less than half the participant's spouses were still alive. Those bereaved narrated positive aspects of their past spousal relationships without prompting. Those

narrating past divorce or separation focused on reasons for relationship breakdown. Participant 4 who had experienced both divorce and bereavement was able to narrate comparatively on the loss of relationships.

Participant 4: *"I had two good men and a not very good one…I used to get belted and everything"*

One narrative theme offered across interviews where spouse had died was inclusion of pivotal relational events. Participant 4 gave the most detailed attention in her narrative to her last and most positive relationship.

"we met at a railway station (Pause 9 secs) I don't know what I was doing there I don't know what I was on the railway station for (pause 2 secs)"

The long pause in this narrative seemed indicative of how beginning to narrate this event created reflection and then difficulty recalling detail, perhaps indicative of limited narration of this event previously. Moss and Moss (1996) note how marriages and relationships in later life are often viewed through the lens of previous marriages, facilitating adaptation to new long term relationship. This participant's adaptation seemed to have been facilitated by comparison of this partner to her more general view of men.

Participant 4*: "He was friends with everybody and that suited me because I liked that and* ***he stuck with me*** *he sat in hospital day and night ….. you don't get many like that, as I say he was marvellous, and he was ill himself with heart trouble"*

Allen, Blieszner and Roberto (2000) note later life marriages as rich resources of companionship and support. Participant 5 narrated the relationship with her late husband in idealised terms to illustrate significance of the long term companionship between them.

Participant 5: *"No we had a good marriage it wasn't an exciting marriage but liked the same things and erm (pause) it was good it was very (pause) calm, calm good marriage"*

"We would sit for hours and probably never exchange a word but because the other person's there and when you get to this age "

It is interesting that this participant utilises cultural narratives of long term relationships to justify to audience the fact she and her husband did not communicate very much.

Participant 8's interview was dominated by experience of spousal grief for his wife who died eight years previously, an event pivotal to his emotional health. He described how longer term relationships alter the impact of loss.

Interviewer: *"Do you think it's harder when you are older to lose someone or do you think it's the same"*

Participant 8: *" Well it's knowing someone for such a long time, you know married and I think it does get harder the older you get (pause 2 secs) ….."*

Brubaker (1990) notes both physical and emotional health of elders as affected by spousal bereavement. However for this participant loss of his wife had become so pivotal that his narrative of time itself was measured against it.

"Count the days since my wife died"

Interestingly however although much narration was given in relation to his own grief only after prompting did he narrate events of this past relationship

Interviewer: *"I don't know if you want to tell me more about your wife, what would you like to tell me about her?"*

Participant 8*: "Well I was in the air force when I met her….."*
"…she was a divorcee with one son ….she was the daughter of a fisherman her brother was a skipper a fisherman erm I got on well with the in laws ..."

Once cued this participant offered a long narrative of pivotal times in his marriage including, separation due to work, adoption of child, birth of children and house moves.

"…(pause) never had any problems with our marriage at all you know (speaks softly) Nothing, we had our arguments of course but I ***did spend*** *a lot of time overseas on detachments but….."*

Like others in this study this participant began narration of his marriage by recalling it as problem free with identification of problems and pressures they faced as a result of narrative reflection.

Participant 3 identified the traumatic death of her husband as pivotal to her MH problems and this event used as commencement of a narrative of resilience and survival.

Participant 3: *….. "and erm he worked on the railway and he was knocked down by a train …knocked him, killed him, left arm off, left leg off , side of his face, spinal cord broken and erm having two children and two daughters I erm grieved but I was trying to be strong (pause 3 secs) "*

This participant narrated how when she was younger she feared future narratives of widowhood.

"…I had a premonition for quite a number of years; I never had my husband from my ***old age"***

Given women expect to live longer it may be that their future narratives do encompass possibilities of bereavement but also allow for planning possibilities for reconnection with other family members.

Divorce in mid or later years is not unusual for our current cohort of elders, yet the impact on quality of later life post divorce appears little researched. (Brubaker 1990). Participant 2 was the only participant to narrate divorce earlier in life and the discovery of his wife's infidelity was a pivotal section of this story.

Participant 2: *"I just went into the bedroom to get a handkerchief and blow me nose, there was this folded letter in there and I thought "what's this?" He (his wife's lover) was there he'd just come …you know it was a knife in the guts you know erm"*

A position of victim was taken in this narrative despite his having previously narrated his own unfaithfulness. As this divorce narrative continued this position changed to one of resilience and recovery as he evidenced to audience his closure.

"I think I've seen her once more but I wouldn't speak to her or have anything to do with either of them and if I heard if someone said "Oh the woman's just died" I wouldn't be ***bothered one way or the*** *other and yet we had thirteen I think good years out of the sixteen we were together"*

However, this particular narration seemed to lead to some recognition of the incongruity between the length of his relationship and his current feelings.

Brubaker (1990) highlighted financial and social impacts divorce can have particularly upon older men. This participant chose to include issues of financial loss in his divorce narrative.

"I was ***footing the bill*** *for this like and* ***keeping the kids*** *she got the allowance for them but other than that she'd got a* ***good number****"*

6.12 SIBLING RELATIONSHIPS

As elder's close family systems reduce through loss of spouse or unavailability of offspring, sibling relationships can become more valued (Cicirelli 1985) resulting in reconnection. Sibling narratives were included by participants particularly in relation to later life.

Participant 1 *"… I've got one sister …we didn't use to get on at home we used to fight like sisters, like some sisters do, but we get on alright now"*

Participant 1 used a common familial narrative to normalise poorer relationship with her sister earlier in life. Initiation of reconnection between siblings seemed partly dependent upon past familial roles, expectations and siblings' needs. Participant 5 narrated her sibling relationships helping her survive spousal bereavement and how loss of this support left her struggling to cope emotionally.

Participant 5: *"when he'd (husband) had gone it was so empty ……but I'd got my two sisters who were both perfectly healthy and we all three used to go around together so they, well being (eerm) I think that was how I got through it the family connections as when my sister died last year (pause) they're both gone"*

Evidence suggests sibling relationships become more compatible in later life Cicirelli (1985) and siblings become confidantes (Ross and Migram 1982, quoted in Brubaker 1990). However, Cicirelli (1985) also identified gender differences with sisters tending to be closer and women more effective in creating and maintaining sibling relationships than men (McGee 1985; O'Bryant 1988 quoted in Brubaker 1990). Findings reflected in participant 5's narrative.

" and as I say I've got my brother err I mean it's an affectionate connection but err he won't come to me …"

Participant 8's siblings were still actively in contact and regularly visiting him, but his narrated passive role in these relationships was apparent.

Participant 8: *"Oh yes my sister I still see them every eight weeks and I speak to them every Sunday on the telephone and my brother in America I speak with him as well all my family keep in touch yeah (pause)"*

"*I don't go (to visit his siblings). I'm quite happy just on my own in the house you know (coughs 10 sec pause)"*

Anderson (1984 quoted in Brubaker 1990) noted widowed elders often seek more contact with siblings (especially sisters) and that this is helpful in adjustment to grief.

Participant 5's narrative illustrated understanding of the impact the loss of her sibling relationships had upon her MH.

"…I think "Oh if only I could talk to the girls (her sisters) (laughs) but I can't so I just have to I wake in the mornings and I'm a bit depressed …"

Although perhaps not as proactive in their maintenance, male participants also narrated loss of sibling relationships of particular significance given their unique nature.

Participant 7: *"I've got no brothers and sisters I'm alone now"*

"I'm the only one …she (his wife) says "Well you have your kids" but it's not the same thing…because there is a different love between a father and his children and brothers and sisters"

Issues of sibling relationship in later life for participant 4, who was raised in an orphanage, were different.

Participant 4: *"I've probably got brothers or sisters or step sisters somewhere haven't I? (pause 1 sec) It's a bit too late to find them now isn't it? I am nearly 70."*

Here, later life indicated lack of opportunity to find lost siblings. Questioning of audience perhaps suggested a wish to pursue alternative options.

Participant 9 was an only child. She did not narrate impact of having no siblings upon later life but did feel that lack of siblings had affected her ability to create relationships and her preferences for her own children.

Participant 9: *"you tend to I don't think you* ***trust people*** *as much I suppose that was my case because you get used to being on your own, parents are doing different things"*

*"I'm an **only one** and my husband an **only one** so we did not want our own child to be an only one…."*

Sibling relationships then were perceived as significant as support in later life, as an emotional impact when lost and for some having organised decision making through their lives.

6.13 SUMMARY

For participants in this study familial relationships seemed central to overall narrative regardless of whether they currently viewed themselves as part of or isolated from close family systems. Familial narratives were most often intertwined with central MH narrative but perceived as pivotal particularly in relation to onset of MH difficulties and to some extent its course. Narratives of family relationships were past, present and future and related to the ageing experience.

Analysis highlighted a tendency for participants to lack connection between early childhood experiences and their later MH difficulties, which it was felt may illustrate the impact of silencing of children's voices in the past.

Childrearing was an important life narrative. Narratives of cultural and familial expectations influencing decisions to have children were given and the impact on those who did not fit cultural norms through being unable to have healthy children, were reflected upon as significant. Consideration was given to the narrative constructions included which strove to present self as parent as "good".

Loss of children earlier in life was a significant narrative theme for several participants and analysed as significant in relation to MH narratives. Narratives reflected the lack of care given to bereaved parents in the past and for some appeared to have resulted in very difficult loss narratives having been subsumed.

Grandparenting was narrated by women as a positive influence particularly in relation to MH difficulties and emotional support. Grandparenting was felt to highlight differences between past and present child care practice and narrative skill needed to maintain consistent self narrative.

Loss of spouse through death or divorce was narrated as pivotal to MH difficulties. Impact of this loss was negatively perceived, except where relationships were understood as abusive. The transitions faced in later life relationships e.g. retirement, loss of roles and confidence, were perceived as more complex given history of illness and creating constructions of meaning around difficulties.

Themes identified between grown up children and their parents highlighted internalised unquestioned stereotypes that asking for support would create a burden on younger family. Narratives illustrated awareness of change in wider familial narratives with respect to care of elders and personal narratives adapted to accommodate these. The need for grown up children as well as their parents to reflect on and change family narratives and roles for individuals to age well was noted. Participants noted continuing to care for their grown up children in various ways and children expecting this.

Recent studies have identified the significance of sibling relationships in later life. Narratives offered in this study highlighted how these relationships were perceived as unique and that their loss or absence lowered opportunities for support later in life. Thought will now be given to how the findings relating to family relationships impacted upon me personally and my reflexive thinking in their regard.

6.14 FAMILY NARRATIVES AND REFLEXIVITY

I found narratives relating to disrupted or difficult childhood experiences particularly poignant. Upon reflection I feel this was partly due to lack of emotion in most and awareness this was in part due to silencing of children's voices in the past. This inevitably clashed with present cultural and my preferred narrative of children's right to a voice and expression of emotion. My unquestioned assumption of this latter stance was challenged through witnessing participants' narratives of resilience, emotional survival and forgiveness despite this neglect. Andrews (2008) notes from her research with elders how,

> "What I saw and wanted to see in the four cases I presented in my paper gives me personally, as a mother, hope for my children. Despite how imperfectly we may parent they and we as adult children still have within them the ability to overcome whatever blows we may deal them however inadvertently. The accounts of the narrators serve as an antidote to the stories of those adults who continue to see their parents as the ultimate arbitrators of the individuals they have become. We can shape our lives but not in circumstances of our own choosing" (Andrews 2008).

Like Molly Andrews, my doctoral research was interconnected to pregnancies and early motherhood. Interviews were conducted whilst pregnant, transcription and analysis on maternity leave and write up an on-going juggle with work, active toddler and another pregnancy. Inevitably this influenced how I was perceived as audience, interpretations of narratives transcribed and led to change in my own personal narratives in a continual hermeneutic process. For Example, when heavily pregnant I had a sense that female participants included narratives of mothering and grand parenting more frequently and included advice to me as a first time mother as well as interviewer. As I have parented I gained reassurance from the confidences these women offered me, and use of some of their advice in my own parenting has resulted in creation of on-going collective narratives of mothering of which I have become a part.

I also felt moved by narratives regarding impacts of strong moral narratives upon clients' lives particularly with regard sexuality, marriage and parenting. I listened to these stories as a woman given permission by my present culture to divorce and became pregnant before remarriage with little fear (perhaps with the exception of my church) of disapproval and continue with opportunities of education and employment. The choices I have been free to make have in turn given me a sense of agency, financial resources and ability create preferred personal narratives. Contrast between my own and narratives witnessed created feelings of, anger, sadness and privilege. Additionally, I became aware of the sensitivity shown, and possible shifts in preferred narratives of my own ageing parents during my life changes through their continued support.

The strongly internalised cultural narrative (past and present) of women (particularly with MH problems) potentially having negative impacts upon their children created

sadness and possibly fear in me. My experience of early motherhood had resulted in shock regarding unquestioned assumptions of my responsibility and potential blame as mother (in comparison to the father) for the wellbeing and behaviour of our child. This awareness pulled me to both resist these narratives (feeling upset at their internalisation) whilst also becoming curious as to how female participants had previously survived them. I also became more aware of professional prejudices in my work regarding MH problems potentially restricting parenting ability, resulting in a questioning of how these may be influencing my work.

Another distressing narrative theme was loss of children. Upon reflection I recognised these were more frightening to hear and analyse, given my relatively new experience of parenting, since they inevitably made real the possibility of losing my own child. The frequency of these narratives within such a small sample felt shocking, despite awareness from my clinical work that this is not an unusual grief for this generation. I wondered if immersion in these narratives, through different stages of analysis, as with suicide narratives had created deeper emotional involvement than would be the case in therapeutic work. One phrase made by a participant (narrating loss of two children) has remained almost as a mantra for me since. Noting how he had survived this grief he recalled how he had learnt to "watch over what you have got". I feel this narrative connected to and thickened my own preferred narrative of living in the present and undoubtedly influenced me to appreciate family time more.

I also found myself interested in participants' narratives of grown up children, particularly boys. I think this was because these narrations opened windows into my own potential future as a mother. During interview, transcription and analysis I experienced unexpected hope and happiness through witnessing narratives women gave of positive and loving relationships with grown up sons. These offered alternatives to my feared, cultural narrative that mothers lose intimacy with their sons following their marriage. I was surprised how easily I had internalised such narratives without question, despite being surrounded by evidence to the contrary. It was only when positioned as immediate audience to these alternative narratives that this recognition was possible.

Loss of family members and its relation to MH problems was identified as an across narrative theme here. Early in this research my father died suddenly, leading to questioning whether I should have focused more on our relationship and his narratives than my research project. Narrating and creating a relationship with him in his absence has painfully accompanied this research. I wrote this on the anniversary of his death and recognise both a sense of loss for his presence and awareness of the influence of his pride in me to completing this work.

The narrated tendency by elders in this and other studies, of not seeking medical or professional help through resignation of symptoms and/or fear of disapproval was particularly difficult to connect into without anger. My father refused to share symptoms he was experiencing for fear of "bothering" his daughters or medics unnecessarily. Probable fatal consequences of his not accessing necessary and timely treatment led to strong feelings regarding the influence of negative and erroneous narratives many elders hold of not being a burden and the inevitability of their experiencing physical difficulties. This has led to a very real recognition of the potential influence such ageist narratives have not only for elders but also their families.

Sibling relationship narratives also opened up new thoughts for me through reflexivity. Those without siblings constructed this experience as a loss and one which had influenced choices regarding the number of children they chose to have. I have a sister, with whom I have never felt exceptionally close. My husband however, was an only child, and we are both older parents. The wish for our son to have a sibling, particularly when he is an adult, has felt important to my husband. Witnessing these narratives allowed greater understanding of why this might be the case. Hearing narratives of how relationships with siblings changed in later life, particularly following death of spouse and peers, also allowed reconsideration. My sister's husband is now in his seventies and I recognised that she may want greater sibling closeness in the not too distant future. Furthermore, narratives of the particular grief of losing siblings allowed recognition that, although I may not consider myself emotionally close to my sister, we have shared and created joint childhood narratives which are precious to me. The cued consideration of what I might experience were I to lose her brought fears of future pain and familial isolation.

Freeman (2004 in Daiute and Lightfoot 2004) write that in addition to increasing knowledge and insights NA "can support aims of increasing compassion, sympathy and a sense of connection to others" (p.79). Reflective journeying of my own family relationships through this study increased insight into the generosity afforded to me by my own parents, the potential future joys and pains I may experience as a parent and widened appreciation of my family members.

7 AGEING

7.1 INTRODUCTION TO AGEING

This chapter focuses on narratives offered in relation to later life. Specific narratives regarding being older needed to be cued for all participants. However, as noted in previous chapters ageing issues were embedded in narratives of MH and (particularly) family life. Growing older appeared to be the least rehearsed narrative and often resulted in reflection. Sections here cover main narrative themes around the concepts and experience of being older and its relation to MH and family relationships. Issues of changing familial roles as participants aged has been covered in the previous chapter but could have been included here. The narratives were analysed in relation to cultural narratives past and present of age and ageing, audience and participants preferred personal narrative selves. The themes which emerged are considered in relation to previous literature.

7.2 NOT BEING OLD

The overall emergent theme across narratives was "not feeling old" and most participants narrated not *feeling* old as reason for not constructing self as old.

Participant 7: *"I don't feel old 'erm in fact it sound silly but you don't"*

Participant 8: *"Oh no I don't think age has affected me at all you know I will be 80 in March but err I've been the same since 70"*

Not *feeling* old was a rationale for avoiding reflection and narration of ageing.

Participant 1: *"I don't want to be reminded of it because most of the time I don't feel anything like my age"*

Bluck and Li (2001) studying younger adults' and elders' recollections of emotional issues found elders often positioned themselves as observers of others' ageing experience, making this an objective rather than a personal experience. Participant 9 noted how she watched her friends age but did not subjectively experience this for herself.

Participant 9: *"we've been friends now since I was four years ……and I can see her getting old but I don't feel as though it is* ***related to me****"*

Being asked to narrate on this issue led some participants to reflect on the lack of acknowledgment of their ageing experience.

Participant 6: *"We were only talking the other day, we don't appreciate that we are getting older but I mean it's there and you don't appreciate it"*

Reflection led to differing ideas as to why they did not perceive self as old.

Participant 4: *"When I was younger ladies used to sit on the front (at the seaside) and they used to say to me "Don't get old love don't get old" and I used to think "Oh what are they talking about" you never think (pause 2 secs)"*

Bluck and Li (2001) note narrating past stories can create a "phenomenological spark which allows us to recognise and potentially re-experience the remembered life" (p85). This process seemed to occur for participant 6, who identified how believing she would not get old when younger led to avoidance of the subject throughout life. Other participants noted lack of available models of ageing as significant in this respect.

Participant 6: *"We don't appreciate that we are getting older and we are getting slower because we relate back to our parents, you know and my mother died when she was sixty one erm of dementia"*

Paulson and Wilig (2008) note lack of personal ageing narratives can result in feeling shocked when one is confronted with outward signs of being older. An idea narrated in this study.

Participant 1: *"I see myself with all the lines on my face like the craters of the moon and I think "God!" and I step back a bit from them you know"*

Participant 9: *"I said something about wrinkles and she said "And what do you put the rest of the wrinkles down to?" (laughs) you know 'erm you stop looking in the mirror I think"*

These narratives fit with Conway and Peydell Pearce's (2000) theory that maintenance of stable self-narratives sometimes necessitates distortion or dismissal of contrary information and Hurd's (1999) finding that elders use denial as a "powerful means of resisting stereotypical views of old age" (Hurd 1999 p.421).

7.3 DISTANCING FROM BEING "OLD"

Distancing is an active narrative construction which allows separation of self from wider cultural narratives not fitting with personally preferred ones and was a technique noted previously in relation to MH but also identified here. Marshall and McPherson (in Hurd 1999) write "Most older people exempt themselves from stereotypes…..and strive to distance themselves from those they deem old" (p.12). They feel elders achieve distancing through "paradox of substance" in narrative tellings, whereby they reference and define self to others by what they are not. Examples of this type of narrative construction were found here in relation to ageing. Describing how she was ageing differently to her parents participant 6 noted.

Participant 6: *"but they were you know people were old when they were in their fifties you know erm (sighs)….."*

Then comparing herself to a stereotype of an older lady she narrates

"….. I try not to dress like granny buggins I don't like granny buggins clothes …"

Paulson and Wilig (2008) note older women make comparison to their mothers to illustrate their different ageing self and are more constrained than men by culturally defined physical expectations resulting in less narrative choices for self-representation. Jacobs (1990) also suggests women face particularly negative stereotypes of ageing once unable to meet cultural images of beauty and youth,

resulting in shame and dislike of their own and other women's ageing bodies. Exemplified here.

Participant 1: *"I mean what I do if I'm going into town I choose the time I am going to go…I might not see anyone I know then and they can't think "Gosh she's old, she's got fat, she looks like an old battle axe"*

Wearing (1995) suggests elders' "activity provided a powerful means of resisting stereotypical views of old age" (p 421). By emphasising capabilities contrast is created between self and cultural narratives of decline and decay in later life. This comparison was particularly evident.

Participant 8: *"I don't feel like I'm getting older (pause 2 secs) I do things methodically like make myself breakfast……I make a cup of tea do this, make my evening meal, do this, put stuff away"*

Participant 6: *"what they do (this generation of elders) they go out because they are not prepared to just sit at home but they (previous generation) had to…… they had to stay at home you know …"*

Narratives used to illustrate distancing from being old often related to domestic and physical independence. Paulson and Wilig (2008) view these constructions as evidence of participation in "third age culture" of fitness and activity which serve to keep effects of ageing at bay and create social acceptability.

Participant 9: *"we still do all the gardening ourselves we've never had a gardener or a cleaner I'd be cleaning before the cleaner came*"

Participant 1: *"…that's it we do things. Go out for lunch. Go for walks. Go on holidays…."*

Radley and Biling (1996 quoted in Jolanki 2004) feel use of constructions which present self as socially worthy make assumption that immediate and wider audiences

also hold these dominant cultural stereotypes of age. Such assumptions were identified here through inclusion of "you know" to immediate audience.

Participant 6: *"I go swimming, I do aqua aerobics and I don't get the aches and pains that I might because, you know, I am doing something"*

7.4 PHYSICAL DECLINE AS EVIDENCE OF AGEING SELF

Although participants appeared to resist ideas of being "old" ageing processes were acknowledged and possibly defined through reference to failing health and physical strength. Hurd (1999) notes health and body image tend to undermine a sense of not being old and Kunzman et al (2000) report how in later life functional health is more of a predictor of wellbeing than chronological age. These findings have led to ideas of "dualist construction" (Paulson and Wilig 2008) in elders' narratives, whereby they perceive and present themselves as young in mind yet with "ageing body out of control" (p.110). This theme was identified across narratives. In the excerpt below the participant narrated not "feeling" old but recognised he would be defined as "old" if physical decline was considered a social construction of ageing by others.

Interviewer*: "And do you feel older?"*

Participant 7*: "No but ask another question* ***how does an older person feel?*** *Yeah my legs don't work very well"*

For some participants recognition of physical decline was described as frustrating particularly where comparison was made to previous physical selves.

Participant 9: *"….but really it is really a frustration to find you could dig off one side or half the garden in one day and no I have to do about* ***twenty feet*** *at a time now"*

Comparison of past and present physical selves and others' observation of their physical change and decline was used to evidence difference resulting from age.

Participant 6: *"there is four of us and we'll say "Well last year we could do… couldn't we? (laughs) we're not doing it this year " Like this year I didn't swim as much, they observed that I wasn't swimming as much as I did do I did more walking than swimming"*

Participant 3: *" I love walking now that's something I'm not good at doing now but before I used to be up my garden I used to be up* ***my garden*** *climb over the fence and I used to wander all the way down onto the villages"*

Both these participants qualified their confession of physical decline; one through noting that one activity has been replaced by another, and the other through highlighting to audience that past physical self was much more active.

Some participant's narratives suggested their frustration of physical decline lowering ability to distance themselves from the identity of "being old".

Participant 5: *"…and I think I get this erm (pause) spasmodic drops in blood pressure and that bothers me a little bit because I don't want to go out and splurge all over the pavement"*

Participant 2: *"I don't feel seventy I know you* ***should feel*** *by rights but you know it's a bloody struggle really, you know not being able to do the things I want to"*

Paulson and Wilig (2008) also note from their narrative study how concepts of ageing which were on the one hand perceived as threats were simultaneously used by elders to rationalise physical restrictions and illness. Similarly, Jolanki (2004) found "being old" was used as a self-evident narrative reasoning for physical restrictions, another narrative construction identified here.

Participant 2: *"my legs are* ***terrible terrible*** *but there again your body ages doesn't it? Nothing is as good as it was*"

Participant 1 *(narrating a fall) "Well I suppose it's just part of this getting older thing"*

Participants narrated pivotal events regarding physical changes which had led to narrative reflection.

Participant 1: *"I fell over outside Boots, flat out I was, the first aiders came and put me on the chair and that shook me up a bit that's made me think a bit now about going to places like that …but you do tend to think "*

Participant 3: *"….. then my problems started, aches and pains one thing and another. I have tinnitus very very bad (more quietly) very bad it takes me over sometimes (pause 2 secs) that was gradually getting worse, arthritis and one thing and another …And I thought "You've got to do something about this. Your problems are setting in, your house is getting neglected. So I spoke (pause 2 secs) to both of my daughters"*

Recognition of possible need for support or medical intervention highlighted internalised cultural/professional narratives of the futility of seeking help due to negative stereotypes.

Participant 1: *"I'm really scared to go and see my GP. I feel a total waste of time, a nuisance (2 secs pause) you know, all that (2 sec pause)"*

One participant noted how her medical career allowed her to feel more confident in asking for help from her GP.

Participant 6: *"…I think I've got an advantage over a lot of elderly people in that because I've done that I'm not afraid to speak, I'm not afraid of the doctors, I'm not afraid of them, I know I can speak to them whereas a lot of people go in and think they are gods and will put up with it"*

Sanders, Donovan and Dieppe (2002) studying elders' narratives of chronic arthritis found, where physical ailments were seen as an inevitable outcome of ageing, help was not sought, thus making issues invisible to professionals. They posit awareness of limited health resources and cultural narratives of lowered legitimacy in elders accessing these, as having influenced decisions. Ignoring physical needs in later life may result from choices to deny, or minimise their relevance from fear of judgment or

a belief there would be no point. The result Sanders, Donovan and Dieppe (2002) found was elders resorting to stoicism. An approach witnessed in this study, for example narrating extreme stress of caring.

Participant 5: *"….and then I would say "Yes you can (laughs) mind over matter" as father used to say "You press on! Go and make a cup of tea….." I would do that……..but there we are. I've come this far. I'm sure (laughs) I can go another mile and so get on with trying to (pause) get over it all (sighs)"*

Jolanki (2004) found elders form defences to physical decline and failure by immediate qualification and reassurance to audience of capabilities to cope. Talking of her eczema …

Participant 5: *"……it really is terrible…….I have a good wash in cold water (laughs) slap on my aquaeous cream and get going, I can get through the day but erm how a lot of these elderly people get on I don't know"*

Interestingly at the end of this description of coping she felt able to create distinction between herself and "these elderly people".

7.5 COGNITIVE DECLINE AND AGEING

Participants then were able with needful narrative defence to "confess" physical decline associated with age however, this was not so with cognitive decline. Indeed evidence of the absence of cognitive decline was given to qualify admissions of physical decline and to evidence "ageing well" to audience. Participant 5 noted.

Participant 5*: "****I mean I'm not going senile****, far from it. It's just that there are certain things sometimes that I want to do (physically) and I can't do it"*

And participant 2 noting the new limits on his active lifestyle noted.

Participant 2*: "oh yes…it's not* ***mental at all. Oh good heavens no****. No I mean no no no that doesn't put me off…"*

Paulson and Wilig (2008) use "gerotranscendence" to term the narrative method of quoting active mindedness to rise above physical ageing. However, the narrative defences created in relation to cognitive decline appeared here to be evidence of a greater threat to participants' narrative selves. It is hypothesised this is due to the social stigma associated with dementias and erroneous wider cultural narrative that ageing is synonymous with cognitive decline. Conway, Peydell Pearce (2000) note failure to maintain preferred self-narratives in the light of negative stereotypes has "far reaching implications for mental health" (p 266). Given participants in this study had lived with impacts of MH on their lives, they may have felt even more keenly the need to hold preferred self-narratives in this regard. Reflecting internalised cultural narratives of approval of cognitive abilities in relation to chronological age one participant narrated.

Participant 6: *"I meet with my ex colleagues one of them is 83. Wow, she has bits and bobs wrong with her ….but she has a marvellous brain"*

Given cognitive ability in later life was viewed as praiseworthy by participants it should perhaps not have been surprising that cognitive failure was met with disdain. Cognitive mistakes made during interviews resulted in self-mocking or criticism.

Participant 3: *"…and then sometimes I erm get a little bit confused and this starts up here where I want to say something but it's not coming out quick enough I can't open my gob quick enough"*

And descriptions of what cognitive decline entailed seemed exaggerated.

Participant 4:*"…I've not started talking to myself yet. That's to come yet isn't it? (pause 1 sec) and I know it's when I talk back and I start answering myself that's the time to start worrying"*

Participant 4 revealed internalised cultural narratives of cognitive decline being synonymous with age. Contradictions in participants' narratives between need to distance from cognitive decline and use of the assumption their cognitive mistakes are due to age was noted through the study.

Participant 4: *"…(pause 3 secs) I've lost track a bit now.* ***Its old age*** *you know your mind doesn't quite latch on"*

Interviewer *And has that (cognitive abilities)* changed.

*"****Yeah ….****(pause 1 sec) oh before I'd sit for ages watching a film and I'd sit watching a film throughout, no I pick up a book the same time the film is on, I pick a book up at least I am occupying myself aren't I? "*

This participant utilised the loss of train of thought as a cue to confession of cognitive deterioration, but quickly qualified this by reassuring audience and self that she keeps her mind active. Similarly, participant 8 noted occasionally forgetting then immediately qualified this information with evidence of memory aid use.

Participant 8: *"….but if there is something* ***I definitely want to remember*** *I have a folder and I* ***write in it and go back to it*** *so I will remember it something to jog your memory you know…."*

Jolanki (2004) notes how such qualification is necessary given admittance of memory mistakes can "easily cast doubts of the cognitive capacities of old people since the suspicion of dementia is always there looming in the background" (p. 496). Featherstone and Hepworth (1991) also suggest that to lose cognitive skills risks loss status of a capable adult and can result in a huge "danger of social unacceptability" (p 497).

It was striking and upsetting that participants in this study seemed unaware of the contradictions they made regarding their cognitive abilities, their internalisation of unquestioned ideas of cognitive decline with age and the prejudice they were showing toward elders for whom this was a problem. It seemed that the aim of protecting preferred self-narratives on this issue overrode other considerations, limiting reflection and alternative stories. Only one participant identified an alternative narrative to explain cognitive mistakes.

Participant 4: *"I can generally go from the living room to the kitchen and I think "now what have I come in here for?" Now plenty of young people have said they do it so I can't …that's made me feel better that they…because…"*

Questioning and creating alternative narratives to cognitive mistakes was felt to be reassuring for this participant. Clearly these findings hold relevance for work with elders with functional MH problems and will be discussed further in the Clinical Implications chapter.

7.6 DRIVING AND AGEING

Smith, Braunack-Mayer, Wittert, and Warin (2007) found the potential of losing rights to drive a threat to the independence of older men, a finding reflected in my clinical experience with both genders. Much research exists on cognitive decline and driving ability but little on experience of elders with MH problems. In this study driving was spontaneously narrated by several participants. For example when asked his age participant 7 used driving assessments to contextualise his answer.

Participant 7: *"Seventy two now because when you are seventy you have to renew your driving licence every year.* ***I don't like being old****"*

The main theme across narratives of driving was its anxiety provoking potential.

Participant 5: *"I've got my little car but I think now "I'm not going down that main road…I'm not that sort of driver and err oh I would get very worked up if I had to go down there and do all that lane swapping"*

Participant 7: *"I was so pleased when you said you could get me a taxi because it absolves me having to get in the car and come here (pause*)"

Participant 6: *"I won't drive very far now whether it's age related or anxiety I don't know"*

Participant 8 externalised his unwillingness to drive and suggested in his narrative construction that I (a younger person) would act in the same way therefore normalising his decision and ruling out an age related explanation.

Participant 8: *"I have a car that I use from time to time but I use public transport most of the time because it's a waste of time going to town in a car, you probably know yourself, its far better going on the bus to travel anyway"*

Participant 7 and Participant 5 although openly admitting their concerns also noted dilemmas faced as a result of lowered confidence.

Participant 7: *"….but you see without my car I would be lost you know every time I go to the car I'm stressed out "Will my car break down? Will I crash? But like we get there and get back, it has broken down once"*

Participant 5 *"We are all giving up our cars we're not going to drive anymore. I'm going to give up my car and err cars are so useful"*

By creating a collective peer narrative construction participant 5 utilised cultural narratives of elders needing to stop driving, thus creating normality and credibility in her decision making.

Driving was referenced in narratives even by those who did not drive themselves. For example Participant 1 narrated being a passenger as becoming more anxiety provoking with age.

Participant 1**:** "*We used to go to Scotland three times a year and we don't do that now because of me. I felt the motorway was like a white knuckle ride and I was literally* ***terrified*** *…so we don't do that so we go off into small more local towns in the country. "*

Driving is clearly an area of concern and dilemma for elders with MH problems and should be given consideration in research and clinical services if we are to gain clear understanding of the issue and clients' needs.

7.7 TIME AND AGEING

A theme emergent from this analysis previously identified in research in palliative care is that of time. Indeed one participant narrated how growing older changed her view of time itself.

Participant 1: *"Well years ago you don't think numbers and time. I don't think numbers and time now I think well there's just no time to worry about jumpers and shopping as long as I feel okay and don't have the valium…."*

This participant noted moving her terms of reference to not having time to worry rather than the details of chronological time and described this awareness of decreased availability of time as providing a helpful rationale against anxiety. Similarly, Participant 7 noted how time "running out" lessened anxiety regarding finances.

Participant 7: *"I said (in relation to money) "It doesn't matter its going down" …" It sounded horrible but if you knew how long you had got and how much you had to spend and how long you had to spend it wouldn't be…if you knew (clicks fingers) but that's what's in my mind now we've got this money and we can enjoy it and it's not going* ***to last forever"***

However, the idea of time running out also created grief and loss for this and other participants.

Participant 9: *"…but knowing there are things out there that I haven't done I've never been abroad (pause)…"*

Participant 5: *"I think to myself "I've seen the sea for the last time I shall never see the sea again" now I am thinking to myself "I shall never go to the country anymore and walk" err it's all gone and all that's really left for me now is books and err the wireless"*

In this last excerpt use of repetition and superlatives e.g. "I shall never….it's all gone….I shall never…it's all gone" created a dramatic and poignant feel around life experiences generally considered life affirming. Lindqvist, Rasmussen, Widmark and

Hydén (2008) similarly note in a case study of men dying of cancer the narration of lost future opportunities. They suggest the lowered likelihood of experiences has effect of "shrinking" future time.

Adame and Hornstein (2006) propose narratives elders received from past MH systems conveyed possibility of recovery over time. One participant gave an interesting narrative of how this previous narrative hope was being transformed into threat of failure as he aged.

Participant 7: *"..as you grow older you haven't got much time and that's the problem I've got now, as I've got older people will say, like psychiatrists, people say "It will take time to get better" things like that I say "When I was young I had all this time to do it now I'm older how long is it going to take to get better "*

Unlike physical illness MH problems are not made more probable by age, therefore ruling this argument out as rationale for the presence of MH difficulties or resignation of them. Furthermore, considered alongside influential later life span theories (e.g. Erikson), those with MH problems which remain unresolved in later life are to be presumed at higher risk of being "off time" with regards life tasks such as "integration". A failure which it is presumed will lead to the alternative of despair. Hydén (1997) notes how the lack of ending in illness narratives creates a problem since they are always "reliant upon possibilities of a new or different ending" (p.61). This theory would add to understanding of the existential crises faced by elders with MH problems as time runs out and alternative endings become progressively lower.

Participant 7: *"When you are younger you think you have got time to get through these things but as you get older you think "Oh God I don't want to be like this the day I die"*

Conway and Pleydell-Pearce (2000) studying autobiographical memory construction propose time takes three forms; chronological, thematic and thematic knowledge and those meanings associated with certain time periods often become more high order constructions than chronological time. For this participant adulthood was narrated as a

period when recovery was most possible whereas later life was associated with lowered possibility.

Participant 4 conveyed how her previous sense of time extending before her allowed hopefulness regarding possible life changes but, as she ages opportunities for change diminish.

Participant 4: *"Well I've got nothing to look forward to. When you are younger you think "Oh my life will change I won't bother" and as you get older and older you think "Oh there's nothing to look forward to now". Can you see what I mean?"*

Levine, Stein and Liwag (1999) note how in recalling autobiographical memory "experience of an emotion is always signalling change in working self-goals that have (or have not) been attained" Ideas of time being limited when older generated emotion and reflection, possibly indicating participants witnessing personal unrehearsed stories of time in relation to preferred future selves. Brown and Schopflocher (1998 quoted in Conway and Peydell-Pearce 2000) suggest that as autobiographical memory clusters event knowledge recalled memories relating to personal success or failure will in turn cue threatened future goals. In this study narratives of time running out, specifically in relation to achieving specific long term goals seemed to cue feelings of resignation and decision not set any further goals for some.

Participant 4: *"So now I'm not looking for anything else"*

For others it lowered expectations.

Participant 1*: "**As long as I'm okay** you know peace of mind really is all I want 'erm I don't crave for anything **special** just peace of mind and to be left alone really (pause 7 secs*)

Sanders et al (2002) interpreted comments such as "I'm 83 I don't expect much" as partly a reflection of elders' attempts to hold with cultural expectations of not being burdensome. However, here such comments seemed connected more to resignation

and helplessness in relation to lack of time and opportunity to achieve goals. For example, participant 7 narrated having been thwarted in attempts to secure his financial matters because of his MH problems and now age.

Interviewer: *"Are there things you would like for your future?"*

Participant 7: *"Well they are gone now it was only having the house paid for and having a decent pension".*

Smith et al (2007) noted the most important aspect of successful ageing for men was maintenance of culturally expected identities. For another male participant, who had a successful and long career prior to his MH difficulties, retirement led to a sense of increased time and opportunity.

Participant 8: *"Oh yes yes yes plenty of time because sometimes I would work a twelve hour day you know."*

Supporting the idea that achievement of cultural and personal expectations may be essential to ageing well.

7.8 FUTURE NARRATIVES, DECLINE, DEATH AND FUNERALS

Lindqvist, Ramussen, Widmark and Hydén(2008) note how as time shrinks for those approaching death the lack of future narratives grows. Where future narratives were narrated these were often related to potential decline and wish to avoid being a burden as noted in the previous chapter of Family Relationships.

Participant 5: *"Well if my health starts to break down I don't want to be a burden I don't want to have to ring my family and say "Will you do this? Will you do that?"*

A couple of participants narrated specific future fears of residential care. Participant 7 shared past narratives of working in nursing homes to give credence to his fears.

Participant 7*: "…. 'cos all those elderly people, well I still see them some of them just sitting there, all those elderly people drugged up they are well down. I don't want that."*

Participant 4 also narrated wanting to avoid formal care but also highlighted the dilemma elders often face in thinking about this issue.

Particpant 4: *"There again I don't want to be in a home and I don't like it on my own. Oh I am awkward aren't I?"*

Additional to the dilemma of care and lack of care choice available for elders this excerpt highlights internalised self-criticism for not accepting options available One perceived potential solution to such dilemmas was offered in Participant 5's narrative.

Participant 5: *"Now my father went to bed one Saturday night and he didn't wake up now that's what I want. Wonderful"*

Negative cultural narratives of elders being burdensome and needing care can result in the idea of death prior to needing care being seen as a solution. Participant 5 went on to suggest that elders should have the right to choose euthanasia a finding also in Smith et al's study (2007). They conclude that loss of independence and quality of life is feared more than death itself. In this study narratives of death were often narrated as logical but fears around it present.

Participant 7: *"I can be logical about growing older (pause 2 secs) I don't know when my time comes, you know but there again there's no point getting worried about it because it is going to happen sometime its bound to do. Do you see my point? It's the one thing that's certain in this life isn't it? Dying and it frightens me …yeah"*

Participant 4: *"I think I was born* ***alone*** *and I am going out* ***alone*** *(pause 3 secs) I think that's what started the mental health thing…."*

Some fears of death were related to funerals, either their practicalities or whether the participant's wishes and preferences would be respected at this ritual. Lindqvist et al

(2008) suggest that as future narratives for self diminish future narratives about others are constructed, one of these is being the putting into place one's wishes post death.

Participant 3: *"I hate the awful sight of them (particular relatives) and my daughter she will tell you even when my time comes I told them I don't want "Oh she was such a nice lady…"*

Uncertainty regarding practicalities of funerals also caused emotional distress.

Participant 4: *"I don't know what I'll do about my funeral when I'm buried what happens when you die on your own like that? This is what sends me sometimes when I'm at home"*

Other future narratives around death of others were also perceived as the cause of emotional distress.

Participant 9: *"…my husband started talking about things like erm…Oh.."When I'm not here" only in passing but he didn't realise the effect he was having on me and erm (pause 5 secs) sorry (wipes tears away and pauses 2 secs) he didn't realise the effect"*

Participant 6 noted how thoughts of her future death resulted from low mood rather than caused it.

Participant 6: *"…… and on occasions when I'm run down and I think "You are going to die" I went through a period a little while ago and I was frightened I was going to die …"*

One coping strategy for such feelings was avoidance.

Participant 6*: "I don't look ahead to think what it is going to be like or what's ahead of me because that wouldn't help my anxiety if I did….it's just better to carry on you know, sort of carry on"*

It was clear that future narratives were lacking for participants and where they did exist were focused upon fears of future decline, death of self and others and funerals. These narratives affected and were affected by feelings of anxiety and lack of agency.

7.9 LONELINESS AND VULNERABILITY IN LATER LIFE

One cultural narrative of ageing often portrayed in media is of elders being lonely and/or socially vulnerable. Throughout analysis narratives revealed participants' awareness of shifts in their social positioning. Participant 7 for example reflected how lowered social contacts impacted on present loneliness.

Participant 7: *"…and err all these people younger than me* ***die*** *friends of mine. Now I think I am lonely but when I was at work I was not lonely"*

Comparison to idealised narratives of past culture and their attitudes to ageing seemed to heighten feelings of isolation for one participant.

Participant 5*: "Oh from years ago?* ***Ohh certainly Oh yes*** *when I was a child I remember* ***all my school friends*** *almost without exception there was a grandmother, grandfather , aunt or some family relative who lived…had a room upstairs or maybe downstairs even and erm my friend would be told "there's a tray waiting in the kitchen you take it through to grandpa" and they did it* ***willingly****…."*

This narrative construction of comparison allowed a meaningful and non personal rationale for lack of family support by relating it to cultural changes. Other participants offered presently accepted cultural narratives for lowered family care of younger family being too busy.

Participant 6: *"…erm two daughters both married one has two erm sons the other one has a daughter erm one a mile away from me the other one's about two miles away from me and erm yes I see them but I mean they are busy. When I was at work I was busy I see them but I mean I only have to ring and say"*

This participant noted lack of contact with her grown up children then qualified why they did not see her very often. It was hypothesised that this allowed witness to audience that she did not expect care, thus ensuring her daughters were not perceived as uncaring. She illustrated how she, like many elders, was "keen to ensure that they were not viewed as a burden either on society as a whole or in a more personal way to their families" (Sanders et al 2002 p.248)

Participant 4 narrated her perception that ageing made her more vulnerable in society and highlighted this through the narrative construction of comparison between past and present narratives of young adults. Possibly illustrating her own internalised, negative cultural narratives of this age group.

Particpant 4: *"Mind you we didn't have all these gangs on the corners causing trouble then did we? If you look at it we didn't have all those gangs "*

"I go to my midnight mass. I go to ……. Well there's my flat and there's the church well I can't get punched like because there are so many people and they have floodlights on church…"

For other participants perceived increased vulnerability as a result of age was experienced as advantageous.

Participant 9: *"…you sort of go to a doorway and if there's a younger person they open it for you erm and sometimes it's the person you don't think would even…"*

Participant 9 like participant 4 narrated ageing with leaving the house less but associated this with becoming inward looking rather than as a response to fear of young people. In doing so she expressed another unquestioned assumption regarding ageing.

Participant 9*: "I think as you get older you gradually go I suppose inwards"*

Interviewer: *"Has that been your experience?"*

*"Well that's been **my experience** yes because well you don't feel sometimes you don't feel like going out I suppose that's an age process. I don't feel my age"*

The theme of becoming more disadvantaged as a result of age is present in this study. Narrative constructions were offered by participants linking ageing with lowered confidence and increased sense of loneliness. However, given the presence of MH, and physical difficulties some participants struggled to identify the cause for these changes.

Participant 4: *"I was more confident (when younger) or maybe it's this (points to disability) maybe it's not maybe it's all the mental health that's left me less confident it could be couldn't it"*

Experience of stigmatisation due to MH difficulties was noted in the Mental Health chapter to have affected social confidence of some participants. Themes highlighted here indicate confidence may be further lowered by factors associated with ageing; clearly an issue to be considered with this client group.

7.10 LEARNING TO BE OLD: NEGOTIATION OF AGEING CONSTRUCTIONS

The overriding theme from narratives of ageing was that of participants "not feeling old". Analysis revealed elders used narrative constructions to defend preferred narrative selves from negative cultural narratives of ageing but at the same time internalised cultural and political stereotypes with little or no questioning. The consequent lack of alternative narratives of ageing clearly impacted upon these participants' ability to reflect upon, make sense of and construct personal narratives of their ageing experience. Difficulties knowing how to define "ageing" appear to have contributed to denial of ageing self. More recent, politically motivated cultural narratives around "ageing well" have offered opportunity for distancing from negative cultural narratives but are fragile to signs of ill health or physical decline and seemed to restrict creation of individual meanings of what being old meant for participants in this study.

Participant 6: *"I mean as I say (sighs) because you never experience it (being old) you don't know what it's like to feel…I mean does anybody feel old except because you can't relate it to anything can you? I mean you are pregnant aren't you? If it's your first you've nothing to compare it to?"*

Peolson, Hydén and Larsson (2000) note patients living with chronic pain described the experience as a process of learning as they relate to pain experiences and themselves. Ageing was narrated in a similar way by participants here and might also be described as "a phenomenon that the individual not only suffers from but must also learn something about" (Peolson et al et al p.114) It is noteworthy that for these participants illness (MH) was a defining and known narrative self and it was the experience of ageing which was needing to be learnt.

Interviewer*: "Can I ask how old you are?"*

Participant 9*: "Coming up to 78"*

Interviewer*:" Gosh"*

Participant*: "So it's been a learning process I think….."*

It is argued here that ageing cannot be understood through experience alone but necessitates opportunities for narration and reflection of these. Harrison (2000) writes how unless opportunities to narrate experiences exist narrative formation and understanding cannot take place with the result of personal chaos. This need to explore meanings of being old is heightened for this cohort as social constructions of ageing change and they struggle with past and present issues of MH.

When asked at the end of the interview to comment a little more on growing older participant 7 narrated.

Participant 7: *"It depends it's a thing like the* ***dying*** *I might be a hundred and five. Nowadays they talk about sixty being young old people but some people are old at fifty, which isn't me. "*

Hurd (1999) notes how there has been a lack of focus on understanding how older people negotiate conflicting cultural narratives of age and how contradictions in personal narratives are inevitable when protecting preferred narrative selves. It is posited here that the lack of available alternative narratives of ageing in our society and opportunities for elders, particularly with MH problems to narrate and reflect on the experience of growing older will hinder the process of adaptation and this time.

One participant whilst sharing that she had enjoyed offering her narratives for this study reflected how more applicable and specific contexts for elders with MH problems to narrate might be.

Participant 4: *"I don't know if you had a few it would only take one to start and the others would say "Oh that's what I had"……I think it would, I think it would help a lot of people….Yeah I think that would help 'cos especially the older ones, the younger ones no because they'll say it straight to anyone won't they?"*

Burt, Kemp, Grady and Conway (2000) note how unless experiences are narratively rehearsed they are lost from autobiographical memory but if autobiographical memories are cued through mutual sharing of narratives co-construction of self occurs. The clinical implications of these ideas will be considered later.

7.11 SUMMARY

It was noted as significant that narratives of ageing needed to be prompted for the majority of participants in this study. Reluctance to include ageing in narrative content seemed related to preferred self narratives of not being old and desire to avoid being socially constructed as such. Narratives reflected internalised, negative cultural stereotypes of ageing and wish to separate (distance) from these. Personal narratives of being active and independent seemed to serve as evidence for participants and their audience that they fitted with cultural narratives of "ageing well".

Difficulties in how to define "old" were identified and connected to generational and cultural changes in relation to social constructions of the ageing self. However, participants noted physical illness and decline acting to "betray" their preferred self-

narratives through evidencing their bodies becoming older. Ambiguities were noted between denial of being old (as noted above) and use of cultural narratives of age to excuse behaviour and cognitive mistakes. The significance of these conflicting ageing narratives will be discussed in the following chapter.

A surprisingly strong distancing from cognitive decline was noted and appeared associated with internalised negative cultural narratives of dementia type illnesses in later life.

A distinct narrative theme emerging from the ageing section was of time and time running out, particularly in relation to MH problems and increased awareness of mortality. In this respect future narratives focused on decline and death, with lack of positive self narratives. Participants narrated dilemmas of future care needs and faced with choice between being alone, being perceived as a burden on family or going into residential care, timely death was seen as a solution by some.

Participants in this study identified ageing as a learning process which it was difficult to narrate through lack of experience of ageing and opportunity to narrate. It has been identified here how this may pose particular threat of emotional difficulties in later life for those with MH difficulties. As with other findings sections further consideration will be given to clinical implications in the future chapter however now thought will now be given to how the findings within this section influenced me as researcher and my reflexive thinking in this regard.

7.12 AGEING NARRATIVES AND REFLEXIVITY

Analysing ageing narratives highlighted how, despite professional training I have remained blind to contradictory cultural narratives. In particular, those of elders being burdensome, but at the same time responsible for keeping themselves well and contributing to society. I have since witnessed that such narratives are left unchallenged and often found amusing throughout our society and even within elderly services. I have experienced shame at my own collusion through previous lack of challenge in the face of prejudice and surprise at how difficult this is to do.

Further questioning of my own future narratives of ageing occurred from the early stages of the literature review and interview process. I have previously reflected on issues of physical and cognitive decline in relation to my own future ageing, but not of how cultural narratives such as "ageing well" might influence my thinking and behaviour. This perhaps highlights how I have been "prepared to know certain things and not others…" (Rosaldo 1998 in Andrews 2008). Attempts to keep myself physically fit, intellectually challenged and looking young "not dressing like Granny Buggins" in my mid-forties could all be understood as attempts to avoid evidencing any culturally unacceptable aspects of ageing self. Questioning the extent to which I am prepared to reject such cultural influences and how they interrelate with preferred personal narratives is necessary to remain curious and facilitative in my therapeutic work with elders.

Being part of participant's co-constructions also led to direct challenge of my preferred narrative of not being old. This occurred through some narrative co-constructions confronting me with how I might be viewed as "old" in the eyes of younger adults.

***Participant**: "Just an instance, a funny instance, say you are in town and they are handing out leaflets it's so obvious when they don't hand you a leaflet because you are too old (laughs) you…. they don't need to say it"*

***Interviewer**: "(laughs) Yes that happens to me! You know when there are… I don't know… raves or something they just look away as you walk past"*

***Particpant**: "Yes things like that (laughs) they don't acknowledge you it's an age related thing I feel like saying to them "Why are you not giving me one" just out of sheer devilment you know erm (pause and sighs)"*

Interestingly both the participant and I chose to find this shared experience humorous. I later questioned whether, if a racist or religious exclusion experience had been discussed, we might have felt more justified in questioning the attitudes of others.

In another exchange, previous advice given by an elder to the participant is passed on to me

***Participant**: "Stay the age you are, don't get any older."*

In this instance rather than join with the negative cultural narrative I attempt to resist it by reminding the participant of positive aspects of ageing she had outlined earlier.

***Interviewer**: "But I will get more patient"*

This prompts a response outlining another negative narrative that she must be boring to listen to.

***Participant**: "Well you've sat there listening to me for an hour so you must have a lot of patience"*

This exchange illustrates the continual, fluid influence negative stereotypes have in the conversations we (as younger adults) have with elders and the distinct co constructions we create through these negotiations. As Kohler Reissman (2008) notes "storytelling happens relationally and collaboratively between speaker and listener in a cultural context where, at least some meanings and conventions are shared." (p.81).

In conversations with elders I have taken more care not to collude with negative stereotypes even if invited into this through humour.

Close exploration of data allowed me to better appreciate the intricate, co construction of narratives elders make and how these have previously been invisible contributors to my own professional and personal narratives. Andrews (2008) notes how "revisiting one's data is not so much a journey back into that time, as much as an exploration of that moment from the perspective of the present with all the knowledge and experience one has accumulated in the intervening time" (p.89). The knowledge I have gained here of the influence cultural and social stereotypes have on conversations with elders will create new perspectives and positions in my future ones.

8 CLINICAL AND SERVICE IMPLICATIONS

8.1 NARRATIVE THEORY, RESEARCH AND THERAPY

Phoenix, Smith and Sparkes (2010) suggest later life involves engagement in dynamic inter-relational processes with others and that by taking narrative approaches when considering ageing new perspectives emerge, which can displace dominant negative views.

Taking a narrative approach to research and analysis in this study allowed findings to emerge which highlighted importance of narrative approaches in understanding "how" elders construct meaning in relation to their lives. Analysis gave insight into constructions of impacts of MH, family relationships and ageing in relation to narratives selves. The influence of past and present cultural and familial narratives upon these constructions was also identified. The potential harm caused through scarcity of available positive narratives, particularly in relation to ageing self, and lack of opportunities to narrate was identified. Throughout this study the influence of audience (clinical and professional) and past contexts to narratives offered was noted. The availability of trusting, genuine therapy was narrated as helpful as was the opportunity to narrate in this study.

Participant 7: *"Well if you want any more cos okay I've helped you, you've helped me really ……if you want me to come and talk all day I will be happy because it helps me to be with somebody talking rather than just sitting at home you know"*

All the above mentioned findings offer argument for use of narrative thinking in clinical work generally with elders and the potential value of Systemic and Narrative Therapy specifically. Narrative theory can "provide a common and comparatively non-technical vocabulary with which to forge connections, theoretical and practical, between the various fields that address themselves to ageing" (Kenyon and Randall (2001 p.5) and facilitate professionals' practice through offering new alternatives to medical constructions, causation and variables related to MH (Adame and Hornstein 2006). In this chapter findings outlined previously will be utilised to make theory-practice links for both clinical work with elders and the wider services clinicians work within. To make more explicit links between findings and their potential connection to clinical and service issues, ideas offered here are firstly organised into sections

corresponding to the findings sections (MH, Family Relationships and Ageing) followed by other themes/issues felt to be significant to the therapeutic context.

This study's genesis is grounded in my experience clinically and recognition of the potential usefulness of Narrative Therapy with elders. A narrative approach to the research and NA were used specifically to enable connections back to the therapeutic context. Given their particular foci, differences exist, to some extent, between Narrative Therapy and Narrative Analysis. Extensive consideration has been made of Narrative Theory and Analysis in previous chapters. To facilitate ease of connection between findings and Narrative Therapy a brief overview of my understanding of Narrative Therapy is made below.

8.2 BRIEF OVERVIEW OF NARRATIVE THERAPY

Narrative Therapy differs from narrative theory in its move from focus on significance of construction to that of working with individuals' narratives to create "re-authored stories" which in turn lead to changed lives. Narrative Therapy, like theory, perceives narratives of ourselves, others and the world as meaning making stories of experience created, witnessed and constantly changing. Narrative Therapy proposes that we live by the stories held of ourselves and that these result partly from dictation of wider narratives about how we should live.

Dominant cultural narratives are perceived as holding the greatest possibility of being internalised as "truths" or "thin descriptions" due to lack of possibilities to question them. This can result in silencing voices of those whose narratives do not fit these "normalised" ideas and their marginalisation in society. Dominant narratives exist in many systems; family, education, medical, local and wider society and limit possibilities for exploration of multiple, alternative and evolving selves. One purpose of Narrative Therapy is identification and "externalisation" of thin descriptions, perceived to have led those experiencing difficulties into "problem saturated" narratives and their source. The identification of "unique outcomes" in life stories, i.e. narrated experiences and selves which break from unquestioned narratives, also offer possibility of alternative, less problem focused ideas being considered. Methods such as "outsider witnessing", where narratives offered by clients are witnessed and

reflected upon by others in addition to therapist, can be used to introduce new perspectives and ideas. Once alternative stories or narrative selves have been identified gathering evidence to support new or preferred descriptions can occur, creating a "thickening" of "alternative plots", the possibility of re-emergence of previously subsumed experiences and narrative selves. Techniques such as "mapping" can be used to identify how, where and to what extent problems affect a person's life and enable consideration of impacts previously unhelpful narratives may have had. This then allows consideration of ways in which control of one's life might be taken back, increasing sense of agency and a "re-authoring" of the problem situation.

At its core Narrative Therapy aims to facilitate rethinking and renegotiation between dominant, internalised and alternative stories of self or problems so as to allow greater self-validation and new ways forward (White and Morgan 2006).

8.3 MENTAL HEALTH

8.3.1 Illness Narratives

The importance of creation of illness narratives has been well documented through narrative research. Hydén and Bulow (2003) note how narratives of illness include selection of events, organisation of descriptions between them and, in turn, questions or reflections of one's responsibility for being ill. Through analysis it was possible to identify how narratives offered in this study appeared to focus around a core genre of mental illness. However, these narratives were not coherent in telling and initially it was difficult to follow whole narratives offered given their complex life span content. Pivotal life and familial events were helpful in orientating my focus as researcher on what might be the main purpose of the for participants, particularly through its twisting and turnings of sub narratives prior to its completion. Likewise it has been my experience that working with life span narratives in therapy can feel initially confusing and clients do not tend to orient their tellings when narrating emotionally difficult and fragmented life stories. It may be that the identification of pivotal events and understanding of their significance may serve as a referencing strategy to staying with life span narratives in therapy. Application of narrative analysis ideas to

consideration of therapeutic sessions retrospectively and in supervision would undoubtedly also be helpful in this regard, and be used in my future clinical work.

In this study metaphors were often used to describe experience of MH symptoms in participants' lives. Metaphors identified in this study conveyed lack of agency and helplessness in relation to illness. Metaphor use in Narrative Therapy can be facilitative to externalisation of problems enabling moves toward non blaming positioning between sufferers and their problems. Listening for metaphor use, particularly in relation to experience of MH difficulties could provide helpful therapeutic connections to clients' experience and be used to facilitate alternative relationships to MH.

8.3.2 Influence of Medical Systems

It was noted that some narratives of MH e.g. suicide seemed influenced by past tellings to other professionals. Gunnarrson and Hydén (2009) noted that those suffering with illness "represent themselves ……in relation to interviewer and perhaps even more importantly in relation to medical professionals (who are often imaginary listeners to their stories)" (p.171). Elders are more likely to offer rehearsed narratives which include influence of past and present medical systems given the extended length of their illness. I have learnt from experience the importance of ensuring that when working with elders we hold awareness of and respect life long illness narratives and their contexts and do not rush to offer contrasting alternatives (see Smith 2007). I believe curiosity, genuineness and alternative language on the part of therapist are key to creating a therapeutic atmosphere of trust and safety, which in turn may allow clients to explore new ways of narrating in therapeutic contexts. Indeed, in this study participants narrated the importance of genuineness in their therapist and how such therapeutic encounters had allowed exploration of their preferred treatment choices in the present.

These views are ones shared by Stott and Martin (2010) who write how previous modernist medical systems affect elders' abilities to talk openly and trust therapeutically. They suggest that understanding contexts for such fears and considering how elders can make themselves safe in collaborative therapy are necessary. Further, they note the position of the therapist as non-expert to be essential

in this process, “When we approach or work from the perspective that our clients know their lives better than we do we become curious and ask questions to facilitate our understanding” (p. 110).

It was significant that all the elders in this study had been prescribed medication as a first treatment option and many were still in receipt of medication despite their reservations as to its usefulness. Being prescribed medication for MH problems was perceived as pivotal to constructions of their illness by medical professionals at point of onset and was related to feelings of agency and control. Confusion regarding responsibility and choice in medication use may well be a particular concern which relates back to previous medical interactions for this client group, Further it is one which may be facilitated when receiving therapeutic work which would inherently offer a comparable alternative. Again however, sensitivity and respect on therapists’ part of remaining influences of modernist medical systems and preferences regarding present medication use will be necessary.

8.3.3 Suicide

Participants narrating suicide attempts in this study perceived this event as pivotal to their MH narrative. All who attempted suicide narrated this event as influencing their decision to never attempt again. These findings seem to contradict professional narratives that one suicide attempt increases risk. Future narrative studies offer potential for revealing insight into how subjective meanings around suicide attempts in the elderly influence future risk. Narratives of suicide in this study were connected to relationship loss and change and particularly feeling abandoned, betrayed or bereaved. Participants also narrated how feared future narratives of care and/or being perceived as a burden led to ideas of death being preferable and euthanasia. Insights such as these may allow more meaningful risk management planning within our services for elders with MH.

8.3.4 Interrelations between Physical and Mental Health

Narratives in this study allowed insight into the interrelation between physical and mental health problems for elders. It is my clinical experience that there is often little connection between these two service provisions and consequently partial

understanding for both in the treatment of the patient. Unattended physical needs will inevitably impact upon emotional wellbeing and vice versa. The need for greater integration between physical and MH services for elders and better understanding by professionals of interrelations between the two therefore seem essential if we are to move toward the individually focused and inclusive care packages necessary to ageing well.

8.3.5 Family Relationships and Mental Health

The areas of MH, family life and ageing were clearly integrated within the narratives offered in this study and need to consider these in therapeutic work with elders diagnosed with particular MH problems essential. Given this chapter is particularly focused upon systemic work with elders, consideration of particular therapeutic foci and service implications will be included in the discussions below relating to Family Relationships, Ageing and identified additional areas of significance.

8.4 FAMILY RELATIONSHIPS

8.4.1 Relevance of Systemic and Narrative Therapy to findings on Family Relationships

Familial narratives were mostly intertwined with core MH narratives in this study. Pivotal familial events were very often connected to onset of difficulties in a meaning making process. However, other familial narratives which, as therapist I would perceive as significant to MH, appeared minimised. For example, early childhood events, and these will be considered in more detail below. Thin descriptions of family care in later life seemed preventative of narrative exploration by elders of present familial relationships, role changes and care concerns.

Systemic approaches offer particular relevance to facilitation of narration, consideration and sharing of family members' narratives of the influence MH difficulties upon their family lives. For elders past familial narratives could have potential influence upon their future narrative selves in the face of changing needs and roles.

8.4.2 Caring roles in family relationships

Elders caring for a relative in adulthood and later life was identified as a focused role but, draining of resources and with consequent impact on MH of some participants. Cultural expectations of care roles have dramatically shifted in one generational cohort and although participants still felt pulled by expectations to care for elderly relatives they internalised current cultural narratives that they should not expect care themselves from younger family members, leaving them in a particularly vulnerable position. The caring roles elders narrated having assumed in this study were perceived as helpful and/or unhelpful at different life stages and influenced by past and present wider cultural and familial expectations. Careful attention to these issues in relation to elders' own changing physical and emotional needs would need to be considered in therapeutic work.

A sense of fear and confusion regarding the considered acceptability of receiving care and support for themselves seemed evident for elders in this study. Care given by grown up children was determined by offspring and even when accepted, perceived as not necessary by participants. Furthermore, although concerns regarding possible need for future care were narrated, no participant narrated having discussed this issue with younger family members.

The potential for systemic approaches to facilitate consideration of the reciprocal and life long care giving trajectories in families and address future care concerns in the light of current cultural stereotypes is clear. Ribeiro et al (2007) however, notes importance for those working with elders of attending to changing cohort expectations and cultural stories when considering evolving self-narratives in later life. The identified internalised, cultural narratives of care being synonymous with burden for participants in this study would need to be gently explored both in the light of preferred personal narratives related to ageing well and past familial care-giving roles.

8.4.3 Past moral narratives

Societal narratives of familial morality in the west have changed significantly in the last sixty years. Impacts of past cultural values around sexuality were narrated by some participants as having had profound impacts upon their relationship and sexual

choices throughout life. Faced with current moral attitudes and afforded sexual and relational freedoms, elders may legitimately experience feelings of anger and grief through awareness of the possibility of difference and consequent awareness of the impact of past cultural narratives. As inevitably younger therapists we represent a cohort (particularly as women) who had different choices. Exploration of the impact of past cultural narratives upon the lives of elders will therefore necessitate particular need for sensitivity and reflexivity on the part of the therapist.

8.4.4 Early childhood experience

Some narrated early childhood experiences, although clearly emotionally distressing to audience did not seem as such by participants and/or were often not acknowledged for their potential contribution to MH difficulties later in life. Examples included childhood separation from fathers, evacuation and being left outside pubs. It has been hypothesised here that this may result from lack of focus in past western culture upon the emotional needs of children and consequent silencing of their difficult experiences. Narrative therapy may be an approach which can sensitively encourage exploration of these stories as they are included in life span narratives to facilitate greater understanding, integration and recognition of their effect.

8.4.5 Parenting and Grandparenting

Parenting was identified in this study as a positive past narrative. It is therefore one which could be utilised in Narrative Therapy to access positive narrative selves. The need to narrate self as a good parent (particularly for women) was one identified in this study as having been threatened by past by MH difficulties, medical and cultural stereotypes. Impacts of these and alternative descriptions of good parenting may be usefully explored in therapy. Identification of resilience through parenting in the face of, not only MH but the consequences of family issues which had contributed to them (loss of spouse, domestic abuse, caring for elderly parents), seems vital to facilitating recognition of personal strength. It can however be easily missed by therapists if focus is only on current difficulties and elders feel need to minimise past traumas.

8.4.6 Loss of children

Narratives of loss of children were noted as minimised and subsumed by some participants and felt (as noted above) to be connected to previous silencing and wider cultural narratives. Therapists could witness to the importance of such experiences by proactive curiosity around this issue. For example, when asking about past parenting, introduction of questions which include the possibility of children having been miscarried, stillborn or dying would be a proactive indication to clients of willingness to witness such narratives. The difficulty in listening and analysing these for the purpose of this study has been noted and will be explored further in the Reflexivity chapter. However, this has taught me the need for supervision and debriefing, when listening to such stories embedded within medical practices and attitudes, if I am to remain open and curious for clients during these tellings.

8.4.7 Parenting Grown up Children

Parenting grown up offspring was perceived as important to elders' present lives and MH. Clinical experience and analysis here informs me of the extent elders care for grown up children in various ways and the stress this can cause. Despite this a common assumption endures in our society that elders are the main recipients of care in families. Work with later life families may allowing these subsumed familial narratives to be explored further and facilitate younger family members recognising the impact their choices may have upon their elderly relatives. However, this is an area which elders are reluctant to explore in the presence of other family members given changed power dynamics for them. Barusch (1987) notes how in family therapy work with elders powerful positions can easily be covered up by younger family members as being in the interest of their elderly relative. Consideration by therapist and elderly clients of which family members are invited to sessions and when would be essential.

8.4.8 Other significant familial relationships

Relationship with grandchildren was narrated in this study as a valued familial relationship and an emotional support in relation to MH symptoms. To date I have not specifically invited grandchildren to family therapy sessions. However, grandchildren

may be an extremely rich source of positive alternative narratives and trusted allies of the elder. I will therefore be considering this as an option in the future.

Similarly, sibling relationships were narrated as significant in later life in that they were perceived as providing enduring and unique bonds. Loss of a sibling was a significant and specific grief and one which should be considered both therapeutically and through research for its potential detrimental effects upon the wellbeing of elders. Furthermore, proactive accessing of past and present sibling narratives or invitation of siblings to therapy may prove more valuable than I have previously thought.

8.4.9 Spousal Relationships

Therapeutic work with clients and their spouse or partner could allow access to many rich past narratives given the long term nature of these relationships. This would provide opportunity for more systemic, co-constructed and longitudinal narratives to emerge regarding MH difficulties and the resilience of the relationship. However, common assumptions that long term relationships are healthy and helpful to clients would be erroneous. Past and present spousal relationships were narrated here as having had some negative impacts upon MH and, even where spouses were perceived as supportive, consequent feelings of guilt at being burdensome were expressed. Facilitated conversations regarding reciprocity of these relationships, role change and the emotional and practical support the partner with MH difficulties gives to their partner may go someway to allowing movement from positions of being burdensome.

8.5 AGEING

8.5.1 Difficulties in creation of ageing narrative selves

Participants described difficulty creating narratives of their individual ageing experiences due to lack of personal ageing experience, role models and appropriate narrative templates. Consideration in Narrative Therapy of the meaning of growing older and how to construct a personal understanding of this time is essential. Lack of opportunities to narrate one's ageing experience and the potential negative impact this may have upon elders is reason to argue for this being a specific focus in Narrative Therapy with elders. In this study evidence of a physically ageing self was an

identified trigger for most participants to acknowledge aspects of ageing self and might be used to introduce this issue into the therapeutic context.

Lack of templates for narratives formation at a time when there is need to hold a coherent sense of narrative self may explain why some participants referred to former selves when narrating later life. For those participants whose preferred self-narrative or coping strategies focused on physical competencies when these were compromised integration of narrative self became problematic. Freeman (2004) notes how "premature foreclosure" of narrative self results from elders feeling unable to meet culturally acceptable norms and leads to feelings of desperation. Grieving for inability to perform preferred selves, anger at culture which restricts this, and celebration of past preferred selves may become part of therapeutic processes focused on adaptation in later life. Stott and Martin (2010) suggest working narratively with elders involves making visible their competent selves to allow creation of stories which offer alternatives to those focused upon as problematic. They feel this can be achieved through "ability stories" which reconnect elders with past selves to help identify "resources and reignite hope" (p.168).

8.5.2 Driving

Another specific issue related to ageing raised in this research was that of driving. This was narrated as becoming more anxiety provoking with age and decisions whether and where to drive were being made on this basis. This is indication of the need to explore factors such as anxiety as well as cognition in relation to elders' driving ability and the possibility of creating collaborative decisions in his regard. This is particularly the case given the independence driving affords this age group.

8.5.3 Future Narratives and Funerals

Narratives of death and funerals were offered by participants in this study. This was interpreted as possibly connected to past cultural narratives of social stigma and the lack of future narratives. Consideration of the practicalities of one's funeral, how elders would like their narrative selves and their life to be represented by others and how to ensure this will happen was of concern. Funerals are not always an issue

therapists proactively introduce into therapeutic work for fear of offence however, this may be important to clients.

8.5.4 Social Withdrawal and Loneliness

Findings here suggested that entering later life having struggled with past MH difficulties created greater risks of lowered self-confidence and social withdrawal. Elders narrated social withdrawal as a secondary factor to their MH problems and ageing as a source of social anxiety. Loneliness and vulnerability were also a narrated issue associated with ageing. Potential exists in therapeutic work for identifying connections and disconnections in familial and social networks of elders and how these may be affected by narrative constructions of feared stigmatisation or vulnerability. Furthermore, several participants narrated feeling uncomfortable attending communal older adult, MH provisions as they found them inappropriate to their needs. We may therefore do elders with MH problems a disservice if we encourage or refer them to communal facilities without considering how comfortable they are attending these and whether they fit individual needs.

8.5.5 Negative cultural narratives of ageing

Insights gained in this study regarding impacts of past and present dominant narratives upon elders with MH and elders' attempts to hold narrative integration in their wake were significant. Pheonix et al (2010) note how Narrative Therapy offers "alternative maps regarding ageing in ways which can displace the dominant story" (p.3) and Katz (2000) suggests by finding and offering alternative narratives for themselves elders might provide new political forces for change. Reflection in therapeutic work of how individually changed narrative selves could influence wider service and social (Pheonix et al 2010) attitudes could offer an important redemptive angle to the lives of elders with MH problems. Reflection with clients of how we have learnt from them and how we will use and share insights gained will be important in this respect.

A potential therapeutic dilemma however has been raised for me in relation to the issue of distancing particularly from negatively perceived aspects of ageing. Wearing (1995) suggests distancing can be a useful, powerful protection from effects of

negative stereotypes of ageing. This being the case the question should be raised as to whether it is helpful or ethical to challenge such coping mechanisms. Distancing on the other hand colludes with negative stereotypes and allows them to remain unquestioned. Furthermore, it is becomes more probable (but not certain) with age, that attempts to distance will be challenged by poorer health (physical and/or cognitive) as witnessed in the narratives of these participants. Working to help clients recognise their narrative distancing could be viewed as protective if as professionals we anticipate this future narrative dissonance. Use of outsider witness technique may be one way of introducing alternative stories without directly challenging client's defences or risking clinician's ideas decentring the voice of the client on this issue.

Although participants were reluctant both to narrate and relate to some issues of ageing they did include concerns attributed to age. These included physical decline, being more vulnerable socially, being alone and at risk of needing care in the future. I felt these findings fitted with Hydén's theory that where there is "an overpowering sense of one's future as being totally bereft of opportunities and choices" and that where there are lack of opportunities for narrative expression the narrative itself becomes the problem. As a clinician I can see how such narrative formation leads to "problem saturated" stories. Clinicians working in this specialism need to not only hear feared future narratives elders bring, but be educated in awareness of the wider systems and contexts within which they are formed and elders currently live. Failure to do so may result in moving elders away from problem saturated stories too quickly and being unrealistic regarding availability of practical and social alternatives. (Stott and Martin (2010) write of their difficulty when these conversations "tend to draw our clients and us (as therapists) back into problem talk …and stop us noticing possibilities" (p.161). Clearly a balance is needed between the two extremes and this is not a comfortable place to be as therapist. I feel it is one of the more difficult and skilled aspects of Narrative Therapy with elders.

8.5.6 Wider Service Implications from Ageing findings

It was noted above how therapeutic work might help address influences of unquestioned, cultural narratives of ageing on elders lives. However, these efforts would be diluted if vigilance was not also given to their presence within elderly services. Katz (2000) for example, notes that assessment of daily living checklists

shows bias toward unquestioned narratives of healthy, middle class activities and exclude questions of relevance such as sex or social drinking, suggesting this highlights implicit ageist assumptions in services of elders not engaging in such activities. It is argued here that raising awareness of unquestioned, unhelpful and ageist narratives within our services needs to occur at individual, local and strategic levels.

The impact of internalisation of present cultural narratives of "ageing well" was identified in this study as creating fear of future decline and distancing from some aspects of ageing. Adams and Blieszner (1995) note ensuring individuals age well needs carefully monitoring and planning on a policy and clinical level if services offered to elders are to be appropriately altered as needs change. They write that "…such well informed efforts might then be able to help older adults make effective relationship choices in their pursuit of ageing well" (p.220).

Johnson (2002) writes how, "The professional and the older adult are both intimately involved in the process of ageing well and in the outcome. As a sign of this intimacy they suffer together and celebrate together" (p.127). As a result of this research I have greater appreciation of the responsibilities we have on personal, therapeutic and strategic levels to stand alongside and in defence of elders (particularly those with MH problems) whose needs are easily marginalised through current ageist ideas, and to facilitate their ageing well and meaningfully through finding voice for their experience.

8.6 ADDITIONAL THERAPEUTIC AND SERVICE ISSUES

8.6.1 Positioning of narrative selves

One issue of narrative interest in this study was positioning of self within narrative constructions to illness, others and events as well, as to audience. This aspect of analysis highlighted the potential usefulness of considering how clients position themselves in their narrative tellings. In particular, positions of self or other blame in relation to MH difficulties and family relationships. Identification and consideration

of these may be significant to creation of new narrative meaning, client choice and agency.

8.6.2 Reflexive Ability of Elders

It was noted in the narrative theory section how, given the time difference between experience and its narration, evaluation of self and life become possible (Linde 1993). Reflexivity is therefore needed if meta positions are to be taken of our experiences (Holstein and Gubrium 2000). Listening to narratives of elders in this study led to appreciation of how reflectively skilled elders are in narrative telling. I was able to recognise how having lived longer created more reflective space and potentially comparative experiences. Use or encouragement of comparison in therapy through accessing previous selves could clearly be an advantageous therapeutic technique in Narrative Therapy with elders.

8.6.3 Outsider Witnessing

Outsider witnessing is a method advocated in Narrative Therapy to generate alternative ideas and unique outcomes through inclusion of others in the therapeutic context who can witness and reflect upon narratives offered. The identification in this study of lack of opportunity for elders to narrate experiences and the potential consequences of this suggest this maybe a particularly useful technique with elders. It was also noted above it maybe helpfully utilised where sensitive but potentially restricting self narratives are being explored (e.g. distancing from narrative self) as a protective factor to the therapeutic relationship. Where outsider witnessing is used attention to differing ways elders may in the past, have needed to adapt narrative telling should be given consideration and adaption made of accordingly. Use of diaries, art, music, the importance of “performative” aspects of narrative telling (Hydén 2013) and connection to elders' language use are all examples.

8.6.4 Adaptation to changing cultural narratives and stigmatisation

One criticism of Narrative Therapy has been its potential naivety in identifying influence of negative cultural narratives without recognising and helping clients to find ways to negotiate the continued vulnerability of living in their presence. This analysis illustrated how, although elders may acknowledge and disagree with some

negative cultural stereotypes, they recognise the need to protect preferred core narrative selves particular contexts. This narrative skill is complex and illustrates insight on the part of elders of the usefulness of differing narrative selves. I believe this is also realistic and helpful for elders given their need to negotiate changing and conflicting wider narratives across decades, particularly so where stigmatisation has also been faced through MH difficulties. Therapeutic skills necessary to support and further facilitate elders' negotiation of negative cultural narratives include willingness to understand benefits of offering different narrative selves in different contexts, awareness of the impact of past and present cultural narratives and reflexivity regarding risks of being personally and professionally biased.

8.6.5 Time and Narrative

The reality of limited available time for elders, their narrated sense of time "running out" and future narratives of ending prompted revisiting my past opinion of the unhelpfulness of Erikson's developmental theory (1950). In particular I have reconsidered the idea of elders needing to achieve the task of "integration" to avoid feelings of despair. I had previously felt this idea potentially labelling of elders struggling to achieve coherent narrative selves. However, since my ideas of narrative coherence and integration have changed, focusing more on individual and personal meaning making, I would advocate "integration" as a narrative achievement and argue for elders to be given opportunity to achieve it.

One internalised narrative identified as anxiety provoking for some participants related to past medical narratives of recovery from MH being a matter of time. This idea coupled with narratives of time running out, appeared to lead to feelings of despair rather than integrity. The impact of past professional narratives upon formation of later life integration should be considered by practitioners since our involvement will influence clients' futures as well as their present. Identifying, externalising and deconstructing past medical narratives and how they are currently influencing recovery may be important in relation to feelings of failure, and self-blame.

8.6.6 Coherence in Narratives

Mishler (1999) suggested that narrative coherence should be viewed as a method of managing conflicting ideas about ourselves, past, present and cultural changes rather than neat temporal or cohesive story constructions. Meaning making, rather than temporal coherence was reflected in the format of narratives in this study. Narratives tended to be organised in relation to pivotal events related to the life span (mostly illness) narratives. Narrative telling and retelling as a form of meaning making would therefore seem a more appropriate focus of Narrative Therapy for elders than working to create temporally coherent life span narratives. Becker (2001) researching narratives of elders experiencing chronic pain and illness found some participants created narratives seemingly "circular and repetitive" (p.106) they perceived these as particular to old age and pain and reflective of the repetitive pain faced in their lives. Given findings in this study supported this, it is argued that necessity exists for therapists to be skilled in recognising significance of different narrative forms elders may use and appreciative of how these may be reflective of life experience and difficulties.

This study revealed how personal narrative formation had been prevented, interrupted and influenced by circumstance, MH and dominant narratives. Consideration of the impact of these factors will also be necessary in work toward integrated meaning making.

In this study elders chose to offer particular narrative content from decades of experience. It is important for us to recognise that narratives elders choose to offer in therapeutic work will (even if not dramatic) be of significance to their dilemmas and overall narrative self. Where narrative content is not expanded upon therapists should make note and return to them with an attitude of curiosity. I have learnt from this study to more closely consider the relevance of narratives not included in telling by clients as well as those that are.

Narration in this study led to reflection, alteration and creation of more personally meaningful stories, and in this sense more coherent narratives. This occurred in absence of any therapeutic intervention, perhaps highlighting the power of witnessed narrating in creation of different and more integrated storied selves. For example,

participants narrated not being old and distanced themselves from negative ideas of ageing, however when encouraged to narrate on this subject reflection occurred. Narrative work specifically in relation to ageing experiences has already been noted. One participant suggested specific group work for elders with MH problems may be facilitative to this process. Creation of narrative therapy groups may provide helpful and safe environments for such exploration and one I would like to facilitate and evaluate in my clinical setting.

8.6.7 Whole and Lifespan narratives

Stott and Martin (2010 p. 172) note how genuine curiosity and openness to hearing elders' allows therapists access to "unique knowledge, understanding and experience of their problem" (p.172). The process of narrative interviewing highlighted to me how listening with no or minimal interruption was facilitative to understanding life span narratives, being able to connect issues with contexts over time and appreciating relevance to present narrative selves. Further, I recognised this facilitated participants' ability to identify and/or solve dilemmas. As a result I appreciate staying with clients' narratives in early stages of therapeutic work to allow witnessing of "whole" stories, resilience and ability to solve difficult life dilemmas.

Listening to whole life span narratives also allowed recognition of elders' differing narrative selves (past, present and future). Such richness of knowledge could be used by therapists to highlight presence of "unique outcomes" when listening to present problem saturated stories. It maybe that given elders rich narrative content, patience maybe more facilitative in eliciting potential alternative and more hopeful narratives than specific questioning methods proposed in Narrative Therapy. Similarly, questioning and structured mapping may also be unnecessary given that life span narratives work allows problems to be intricately understood and detailed mapping to take place (Stott and Martin 2010). Indeed, I would venture to suggest that Narrative Therapy with elders may be more about mapping how different life experiences and multiple wider narratives have influenced to create a problem than mapping how a single problem has affected their lives.

Findings highlighted how elders living with MH problems intertwine lifelong MH narratives to those of family, past life events, physical illness, cultural stereotypes and

ageing and how past, present and future narratives are all influenced by changing wider narratives. This highlights the unique therapeutic skills (not to mention time) needed to understand and map the interrelations of elders' lives, to allow their difficulties to be meaningfully addressed. Psychotherapeutic services therefore need, not only to be available, but offered by those specifically trained to work therapeutically with this client group.

8.6.8 Additional wider service issues

Participants who were or had been in therapy narrated this input (apart from short term counselling) as helpful and therapists as genuinely interested in them. For some this created contrast to more medicalised relationships with professionals in the past. This research has further convinced me of need for elders to receive psychotherapeutic input. The highlighted awareness of limited time and opportunities to narrate and integrate life experiences for elders generally and elders with MH difficulties specifically increases the necessity for this provision. Understandably however, access to therapeutic work may trigger grief regarding denial of such treatment options previously and itself require therapeutic consideration.

In addition, findings reflected my clinical experience that elders struggle to justify receipt of such input and are often apologetic for their need of input. This was understood as an internalisation of current ageist narratives which may necessitate psychotherapeutic services taking more of an outreach approach to legitimise elders' right to them.

Presently, many functional MH services for elders are being amalgamated within adult services with rationale (apart from financial savings) that equality for elders is synonymous with therapeutic needs being the same as younger adults. It is difficult to be optimistic that proactive approaches and necessary specifically planned therapeutic services will be a near future option and I fear such developments will result in elders' voices being silenced further.

8.7 PERSONAL REFLECTION OF CLINICAL IMPLICATIONS

All of the above noted connections between findings in this study and their clinical implications have been written with awareness of professional and personal responsibility they afford me in relation to my own practice. I feel these understandings are now integral to my therapeutic thinking and practice. Given my experience of using NA my Narrative therapeutic work will now include more analytic attention particularly in supervision. I am also aware of the potential I have in forwarding ideas advocated by participants within my therapeutic and on a local and wider professional level.. Further detailed consideration will be made in the following Reflexivity chapter of how this research project and its findings have resulted in my own changed professional and personal narratives.

9 REFLEXIVITY

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9.1 INTRODUCTION

In Narrative Analysis it is accepted that subjectivity of researcher is "integral to all stages of the research process as "researchers' lives become the basis for how others' lives are viewed" (Harrison 2000 p.43). The process of NA creates second order, co-constructed narratives (Bury 2001) with transparency of researcher's influence (as opposed objective validity) being sought. Achieving this requires reflexivity and reflection from the researcher in all stages of the study (Harrison 2000). Plans for reflexivity in this study were outlined in the Methodology chapter and, although transparency was sought, the second order narratives created were accepted as "tenuous" (Daiute and Lightfoot 2004) and remaining open to change throughout the study and new interpretation upon reading by others.

My reflexive stance has aimed to show responsibility for use of self as researcher (Hardham 1996). Speed (1999) writes how the revelation of aspects of self through reflexivity also allows us to see more of our clients and Gergen (2004) describes the need to "distinguish" self "from the narratives collected in order to claim authority to conduct narrative analysis" (Gergen 2004). Those writing of reflexivity in clinical practice suggest "decentring" of therapist as one method facilitative of self-observation by therapist and a way of ensuring clients are kept central in therapy (Tamboukou 2008).

Results of my reflexive, deconstructing and decentring process as researcher are summarised further in this section. Consideration has been given within findings sections to how narratives from three areas of analysis (Mental Health, Family Life and Ageing) connected and disconnected with my own preferred personal and professional narratives. It is hoped this has served to illustrate how the pull to focus on some aspects of narrative and not others was dealt with and how my personal narratives connected to these have changed as a result.

I now wish to extend this reflexive thinking to consider aspects such as my relationship with interviewees as researcher, trained therapist, immediate audience and conveyor of participant's narratives to wider audience. With final, consideration of my relationship to this project over time, its relation to my changing life circumstances and my understanding of NA.

9.2 REFLEXIVITY IN RELATION TO INTERVIEWS AND AUDIENCE DYNAMICS

As noted in the Narrative Theory chapter, NA acknowledges the interactive importance of narrative formations and accepts "events are perceived as selected, organized, connected and evaluated as meaningful for a particular audience (Reissman 2008 p.81). The narrative content and constructions offered here were, at least in part, constructed to engage audiences and therefore changed in relation to them (Andrews 2005). In recognition of the mutual need of audience and teller and impact my presence, profession, reaction and own preferred narratives had upon the narratives offered consideration of audience issues are presented below.

9.3 PERSONAL REFLECTIONS ON EXPERIENCE OF BEING RESEARCHER RATHER THAN CLINICIAN

The position of qualitative researcher was a new one for me, necessitating shifts both in my relationship with participants and in professional self narratives. I found listening without interruption and relinquishing roles of "managing" therapeutic conversations difficult. This effect has been exemplified in detail in previous reflection of the impact of narrative findings e.g. suicide. In another example, I found the language and attitude of one participant sexist despite being aware that his narrative was embedded in past culture. I was disappointed at his seemingly limited awareness of the impact this may have had upon me as a woman. Being unable to explore or question these ideas felt disempowering resulting in my personal offence and distancing from these particular narratives.

I reflected upon possibilities that "one off" narrative interviews might have allowed participants to be less concerned or fearful of possible impacts their narrative construction had upon me, given our time limited relationship. Transcribing and closely re-evaluating these narrative interactions was difficult as it forced a revisiting of these personal offences. It also led to questioning whether my uninterrupted listening might have led to collusion with language and narratives I did not personally or professionally agree with. Furthermore, these exchanges influenced my emotional reaction to the participant and needed to be carefully considered in supervision to prevent bias in analysis and write up.

Listening without interruption however, did allow narratives to be heard in forms which surprised me and taught me how whole narratives allowed emergence of solutions of dilemmas in ways I might not have predicted. Had I steered narratives by questioning they would have been differently constructed and less reflective of the participants' own construction of events.

Being aware I was in receipt of participants' goodwill created a significant shift in relational dynamics within the interview context and I wondered if the gratitude I felt left me feeling I had less right to interrupt or challenge narratives. In therapeutic work, where this relationship dynamic is reversed, I experience much more expectation from clients of my opinions and contributions.

9.4 REFLECTIONS ON USE OF SELF

Hardham (1996 in Flaskas 2002) notes a therapist "both positions and is positioned by her or his felt reality and the broader context shapes both the embodied and embedded aspects of the therapist's position" (p.86). The particular context of this study and my experience as therapist in elderly services, inevitably led to professional narratives influencing my position. An example can be seen in the excerpt below.

Interviewer: *"Do you think there is a difference between the sadness and the depression?"*

Participant*: "Yes I think I suffer from sadness which is a kind of depression I know but a* ***deep sadness*** *yeah"*

Interviewer: *"Yeah so do you think the staying in bed and things like that?"*

Participant: *"That is* ***a result*** *of the sadness"*

Interviewer: *"So it's nearly like the sadness is so bad that …".*

Participant: *"I get depressed yes (pause 5 secs) Like I say my prayers every night and there is always a tear because I speak with [wife's name.] I always cry …yeah …"*

Here I begin to interact in a curious fashion more fitting to the therapeutic context and introduce professional ideas regarding his symptomology. This preference biases the narrative and may have the influenced participant's ability to present their preferred construction of their MH difficulties. In retrospect I felt that I had become concerned through interview that this participant may not be appreciating the severity of his symptoms and as a result I had taken the role of responsible therapist. This reflection left me feeling uneasy regarding my loss of neutrality when I could have better connected with the participant's narratives (Becker 2001).

9.5 BEING POSITIONED BY PARTICIPANTS AS AUDIENCE

Narrative interviews raise sensitive issues for interviewers as the immediate audience and this inevitably changes interview processes (Hydén 2008). A sensitivity I experienced which in turn may have impacted on interviews was the way I was positioned as immediate audience. Reflexive consideration through contrasting examples is made below. The first example highlights a positioning which felt discarding of my opinions.

Participant: *"….But anyway that doesn't come into it. Are you alright time wise?"*

Interviewer: *"Yes but you have been talking for about an hour now so I don't know how you are feeling?"*

Participant: "Yeah well I'm a good storyteller. Anyway what **happened eventually** I went down there and……."

And used me as a prompting their narrative.

Participant: *"Then they had these, what do they call them? They wear maroon …"*

Interviewer: *"Auxiliaries"*

Participant: *"Yeah yeah and this one walked by and ……"*

These exchanges left me feeling I was being asked to act more as a mirror to narrative telling rather than co-constructor of them and that my ideas were of little significance to what seemed rehearsed or set narratives. Hydén (2008) notes a similar experience in his research interviews with a participant writing; "No way do I remember her showing any signs of understanding or sensitivity toward my embarrassment. She simply continued. I tried to introduce some more neutral topics into our conversation …..I had no success in my efforts…" (p121). Despite noting in the Narrative Theory section how narrators do not merely tell stories for but also use audience (Reissman 2002) my personal reaction to being "used" as audience in this way was not positive. Upon reflection I perceived this was due to my feeling deskilled clinically and excluded narratively, which in turn resulted in my difficulty remaining focused and emotionally connected to the conversation. Interestingly, when I presented this reflection to peers, feedback highlighted this narrator's skill in offering a pure narrative interview (as had been requested) and how difficulty lay not in his narrative telling, but how this differed from how I would preferred to have been positioned. I can now perceive how, if narrators wish to present a preferred and/or rehearsed narratives of self, attempts by audience to reinterpret these will not be welcomed. Further the narrative construction in relation to audience will reflect the need for a stable narrative. This participant's narrative then probably reflected his understanding that, given the research context, I was interested in his views and this was not an opportunity for therapeutic/narrative change. This insight has afforded greater understanding of the shifts in thinking required to conduct narrative research interviews as opposed to therapy sessions.

In the second example the narrator seemed to position me as therapist, rather than passive listener. I wondered, considering the whole narrative context, if this may be related to the participant's previous experience of therapeutic work and/or role as volunteer in helping others. Ann Phoenix (2008) writes how in narrative interviews "Research participants bring their histories of previous positioning and their expectations of the interviewer and the interview to the research context" (p.71). This participant invited me into co-constructive conversations throughout the interview and seemed to view me as someone who could "help narrators interpret and make sense of their narratives through reflection and judgement" (Linde 1993). The example below highlights this.

Participant: "*…..and as you get older you think "Oh there's nothing to look forward to now". Can you see what I mean?"*

Interviewer: "*Yes"*

Participant: "*I was sixty, now I'm seventy and I think "God next thing I'll be in a home" mind I might do well in a home. Do you think? I think I'd keep 'em all going in there!"*

This narrative was incomplete and light hearted in its tone, despite its difficult subject matter. The participant checked I understood what she was communicating, reflected on herself and checked my opinion of how this might influence future selves. These narrative constructions, her previous of co-constructive positioning and the presentation of self as giving and humble, all served to connect with my own personal and professional preferred narratives. Given how difficult it had been to witness some of the content in this lady's and other narratives, I also experienced relief through this participant's use of humour. For example, talking of a previous depression group not being very helpful she noted.

Participant: "*Do you think I should go back again? Because maybe I didn't give them chance what do you think?"*

Interviewer: "*You think maybe that you could say to the people leading the group…"*

Participant: "*They were all there for depression weren't they?"*

Interviewer: "*Wasn't someone leading it?"*

Participant: "*They said she was depressed …." (laughs)"*

Interviewer*: "(Laughs)"*

When I was invited by participants to co-create narratives I felt trusted. This confidence given me, use of humour and willingness to self reflect by this participant

put me at ease. In turn, I felt warm and attentive and engaged in these narrative tellings. This created risk of preferencing these narratives and the need for reflective space to recognise my prejudice and potential risk of bias my analysis.

9.6 REACTION TO PRESENTED NARRATIVE SELVES

Positions taken by narrators occur within as well as without narratives. Within narrative positioning relates to characters narrators include, positions taken in relation to these and events in their lives. It is described by narrative analysts as revealing of the selves they wish to present to audience (Reissman 2002). For example, the positioning of self in relation to events as agent or victim (Sclater 2004). Narrators inevitably recruit audience into their creation and/or support of preferred narrative positioning to create affirmation of these. In some narratives in this study my relationship with tellers was influenced by my reactions and feelings toward presented, preferred selves as these connected with my own preferred narratives regarding responsibility, morals and personal agency. Reflections upon these differences are illustrated with examples here. In the first example the participant positioned themselves as either victim or victor. Speaking of past work situations he narrated:

Participant: *"….. By the way what they got out of this everybody did very well the bloke who dropped* ***me in it*** *instead of him* ***facing the questions*** *he got made up …"*

Then later in relation to his marriage breakdown.

Participant: *"…..Anyway I told my solicitor and she said "Right we'll have em watched"……so we did and got em red handed like you know."*

These positions in relation to life circumstances and relationships did not fit with my preferred moral narratives of not acting from spite, nor taking pleasure in others' downfall. Further, my therapeutic work often involves helping people move toward positions of reconciliation or release from past restricting hurts. The positions taken here contrasted these, leading to me reacting with sadness regarding the defensive position he had chosen to take. Upon further reflection I perceived my reaction as also

connected to my personal history of feeling scapegoated by others, with the effect of pulling me further from feeling sympathetic toward these particular positions.

In contrast, another participant positioned themselves as equal to others and having taken a role of helper despite facing her own hardships in life. Talking of their experience of a life threatening illness and their support of others with the same condition she noted.

Participant: *"I go to the hospital bed (pause 3 sec) ….and they say to me before they have the operation "Will I be able to talk like you?" and I say "Yes" (pause 1 sec) you see that does help."*

Me: "*Helping other people helps you?"*

Participant: "*Yeah and (pause 1 sec) it could help them other people to help those that have been there."*

This narrative clearly fitted with my preferred personal and professional narratives of using our skills (and inevitably life experiences) to help others. This participant had previously narrated having been in past abusive relationships and chose to deal with this by removing herself from the situation rather than revenge. I view these positions as courageous and redemptive, probably because they fitted my own past choices, spiritual and moral narratives. I hold a personal narrative of having worked in life to move from positions of potential victim to more resilient narratives of a survival through and learning from difficult life events. Clearly there was risk, particularly when I faced difficult personal issues through this study, that I would become more curious and potentially preferencing of narratives witnessing achievement in this regard.

Hardham (1996) notes how in therapy "We need to engage curiously and respectfully with people and their meanings and to recognize ourselves…… and felt realities as visible and influential within the therapeutic relationship" (p.86). Processes of involvement in NA highlighted the importance of this process in relation to listening to, analysing and interpreting narratives. A need for curiosity to my own narrative

positions was recognised as essential, as was the need to challenge preferred narratives in attempt to remain respectful, connected to and a fair representative of the differing forms of narratives I analysed.

9.7 PERSONAL CHANGE RESULTING FROM THE PROCESS OF RESEARCH

I aim to enter therapeutic work with understanding I will be changed through listening to clients' stories and my interactions with them. Shotter and Gergen (1994) note how experiences most formative of ourselves as therapists result from "interactive moments" (p.129) with clients and that from "this interplay of voices new meanings that profoundly influence our sense of ourselves emerge" (p.1291). I began this research believing myself to be aware of "dangers of narrative itself" (Freeman in Andrews et al 2004 p.83) expecting to be changed by this research through a process which would not be comfortable. Bornat (2002) notes, changes in researcher result from a willingness to position ourselves within research processes so as to enter into real experiences of narrators' lives. I have noted here how experience of this research study, the analysis and its write up have resulted in my personal narratives being challenged and enriched. Similarly, the Clinical Implications chapter above highlighted how my professional narratives have also changed and the hopes I have for this to influence my future therapeutic work. Narratives I witnessed and worked with will remain with me. They have become part of my own ongoing narrative constructions of my professional, familial and gradually ageing narrative selves.

9.8 SIGNIFICANCE OF TIME

Time was noted as a significant factor in creation of narratives in this study and was reflected in my own narrative change. Andrews (2008) notes how,

> "We researchers ourselves change over time…..Meaning is variable not only because it is always in the eyes of the beholder but equally the beholder never occupies a static position. Moreover, if views of "time" and of "temporal change" are themselves subject of change all of this feeds back into the dynamics of the interpretation and re interpretation" (p. 94).

Through the duration of this study I have aged, chronologically, physically, intellectually and professionally. I occupy a different time space and different familial, personal and professional roles.

Andrews (2008) also describes how life events change our view of NA transcripts. She describes this being particularly striking for her when she revisited previous analysis. She notes how clearly the narrative transcripts had remained the same however, she had not, with result of new interpretations. Personal reflection of my changing relationship to the doctorate will be made in this respect below.

At the start of the research I felt enthusiastic, energised being given study time from work affirmed its importance and lessened its impact on my personal life. The project represented a future narrative personally (through academic achievement) and professionally. The opportunity it also offered for exploration of my narrative understanding was energising. At the end of the doctorate I feel tired. It has taken far more time than anticipated, I am not allowed study leave and now face demands of young children, a consultant role and increased work load. My future narrative in its regard are of its end and beyond as I plan for more time with my family and friends upon its completion.

In the eight years since I began this study I have remarried and had two children. This new aspect of my identity has brought with it new perspectives. I undoubtedly focused on narratives of childcare and parenting and possibly better understood why participants felt need to take particular positions in these narrative tellings. My perspective on narratives also changed when a chronic illness created frustrations in my life. At this time narratives of physical illness and its overcoming became a source of hope and the new insights gained from rewriting this aspect of my literature review a helpful, personal resource. My autobiographical recollections of life events during the last 8 years are clustered around different phases of this research and vice versa as the relationship I had with this doctorate has become part of my understanding of this period of life. Daiute and Lightfoot (2004) note how negotiating "the methodological path between subject and researcher" can be difficult in NA (p. 17). Making distinctions of how the research has become part of me and how I have

become part of the research feels less important than embracing how this the project and these narratives are now inextricably part of my identity.

This research project is conceptualised by me as a narrative "being" in my past, present and future life and understanding. Initially it was a new, exciting friend who offered positive and prospects of challenge to my intellectual and intelligent self. A relationship I was open to at a time my personal and professional narratives were threatened by an on-going divorce and difficult work situation. When my father died my relationship with it moved from this "honeymoon phase" becoming more complex. It offered distraction and grounding in my grief, but also led to feelings of loss at no longer being able to gain a sense of pride from him for this endeavour. My first pregnancy became a motivation to push on with completion of interviews and necessitated negotiating some clear boundaries in my relationship with the doctorate. However, it determined my first child starting nursery, to allow completion of analysis and change in my working hours, since as well as being with my son I needed time to attend to "my other baby" the doctorate (as aptly named by my therapist at the time). My relationship with the doctorate has become one of required responsibility toward completion, negotiating this alongside other commitments and life aims. Through this latter process I have perceived our relationship as becoming strained as resentment has gradually crept in and I have become less tolerant of its demands. As I near completion, I wonder whether to complete the doctorate and allow an ending, it has been necessary to perceive its negative effects upon my life. So, although I anticipate the end of our relationship as a freedom I will use to re-engage with other aspects of my life, I also fear life will without its presence and the affirmation it has afforded me. I hope that letting go of this doctoral thesis is not an ending but another phase of our relationship as I will no doubt rewrite and present for different audiences in the future.

9.9 DOING NARRATIVE ANALYSIS

Consideration will now be given to my reflections of the process of this research endeavour through its various stages and how this has changed and/or enriched my understanding of NA. Gergen (2004) suggests as researchers we need to ask ourselves the following questions; Firstly "What do I discover with my narrative of

my narrative research? and then “What are the implications of these explorations for the field of narrative analysis?” (p.280). Lieblich et al (1998) extend this idea to suggest that the uncertainty which is “the very nature of such research work” (p.170) necessitates researchers' engagement in ongoing debates regarding analysing from different viewpoints. This in turn allows a continually evolving understanding of the approach. Hopefully my experience of this methodology will add to the understanding and decision making regarding its use for others.

This results from the “very nature of such research work” (Lieblich et al 1998 p.170) being multidimensional (Fiese and Sameroff 1999) and therefore requiring engagement in on-going debates regarding the pros and cons of analysing from differing viewpoints. Since this approach is analytical and inductive, questions will emerge and change the nature of analysis (Reissman 1993).

9.9.1 Early Stages

As this research progressed my view of NA as a methodology changed also. Initially I was afraid of uncertainties it presented. I have a lasting memory of waiting to sit before my local ethics committee and being asked by another applicant what approach I was using. When I told them I was using NA they informed me they had wanted to use this approach but had decided it was too risky. Ordinarily, I am not a risk taker; a fact reflected in my past research endeavours. However, insights gained from the critical review of my past research thesis, and experiences such as those noted above created a resolve to be courageous in my aim of contributing to the wider research and clinical field. NA, I felt would allow connections to be made between my preferred personal and professional stances, my work and the research endeavour and therefore felt responsibility to use it.

9.9.2 Analysis

I found the uncertainty of analysing findings in NA less daunting than I had imaged. This allowed me to change my personal narrative regarding inability to cope with research uncertainty. My experience was that the inductive nature of NA allowed me to enter fully into participant’s narratives. This felt a fascinating and privileged

immersion into the lives, experiences and emotions of participants and distracted from the uncertainty of the process.

9.9.3 Interviewing and Transcription

Reflexive issues of interviewing have been discussed above in relation to audience and the experience of being immersed in narratives through transcription. It is hoped these and the ideas I proposed through reflection of them will aid other researchers at this stage of the methodological process. I would add, in relation to transcription, how, although this process was extremely consuming of time, energy and emotion I feel it is an essential and integral part of NA and that my analysis would have been less insightful and ongoing emotionally engaged had I not personally completed this phase.

In relation to initial organisation of data I have wondered since whether having opportunity to stay with data for a consistent period of weeks might have enabled me to find more creative ways of understanding and organising data and reflections around it. Argument might then be made for using NA when studying full time and with minimal distraction in order to be fully immersed in data. However, given reflections made above of the outcomes of NA executive to the main aim of the research question (for example, integration of stories into my own life narrative) had I not carried out this research in a way which allowed its integration with other aspects of my life, there would have been much less ongoing co-construction of meanings.

My experience of analysis of data was that there reached a point where I was generating so many ideas that the mass of information, its multiple interrelations, its connections back to theory and my own reflexive thinking began to be too difficult to hold together. This was reflective of the recognition in systemic work of a point where generation of multiple hypotheses potentially becomes confusing rather than facilitative to clients. In both cases I have learnt that this is a critical point of indication that information needs to be used/interpreted/written/organised and the temptation to continue with interesting new alternatives resisted.

9.9.4 Write up for Audiences

An understanding of NA deepened for me through this research is its suitability as a methodology for those wishing to genuinely represent the voices of more marginalised groups. Freeman (2004) notes how in his research "…my aim was to be faithful to the human experience. And so, if science is about faithfulness to reality then surely I was doing it" (p.71). It has been true that my previously held "thin descriptions" around areas of MH, family life and Ageing have been challenged and changed, and my hope, that I can now extend my new insights to wider audiences.

This particular write up is, obviously, made for my doctoral thesis and as such has, to some extent been influenced by expectations of the immediate audience it will be presented to for examination. Nevertheless, I have felt strongly that, in order to present this narrative data faithfully and respectfully I have needed to move from some traditional write up formats. For example, findings and the discussion of them are intertwined in this study. I have experienced my relationship with the write up of findings and analysis an evolving and co-constructive process, which has resulted from dialogue with supervisors around areas of multiple possibilities and consideration of how these will influence reading of findings. This has involved uncertainty as to what formats will be most honouring to participants' voices (Lieblich et al 1998) and whether they will be considered acceptable by audience. When I revisit and attempt to retell this research, I will undoubtedly face new dilemmas in relation to changing audiences.

9.10 SUMMARY OF REFLEXIVITY

Although I began this research process being very much aware as clinician of the need to take reflexive and reflective stances in my work, the more detailed attention in this respect to NA has only been more recent. The time span of this research and the consequent revisiting of narrative research ideas has allowed me to witness researchers such as Reissman (1993) revisiting studies with the aim of redressing previous lack of reflexivity in their findings. NA has been noted a methodology unlikely to suit those seeking "an easy and unobstructed view of subjective lives" (Reissman 1993). Without doubt the continual reflection and reflexivity this work has

required has been one of its more demanding aspects. It has required at times my visiting difficult self issues and memories and retreating into emotionally profound places those close to me have sometimes found difficult to follow. I do feel that the implications of this aspect of NA should be considered by researchers as a factor in decision making regarding the use of the methodology.

Andrews (2008) revisiting her narrative research, reflects how "no interpretation is ever final our current framework (*of this approach)* is itself one which will change over time" (p. 90). It is reassuring that this reflexive consideration of my analysis is itself an initial interpretation and one which will be no doubt be revisited and re thought in the future not from a position of "critical analysis" but rather as another integral processes inherent to NA.

9.11 CONCLUDING THOUGHT

Cecchin (1987) wrote that "Therapeutic responsibility begins with seeing your own position in the system". As I end this chapter, the thesis and my research endeavour, I can see that my therapeutic and research responsibility began, ended and will undoubtedly begin again, by first considering my own personal and professional narratives and how they motivated and influenced this project. As changes in the systems within which I live, and this research field, have occurred, so have my own positioning, offering me new insights and perspectives. The reflexivity necessary to this process has not been easy. However, I feel privileged to have been invited into this process by participants' generosity, enriched by the changes to my own narrative selves and more determined to remain open to living narratively in the future.

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APPENDIX 1: DETAILS OF INTERVIEW PROCESS CONDUCTED WITH PARTICIPANTS RECRUITED

At the start of the interview process an attempt was made to reassure participants by introducing myself and explaining my role. I referred to written information participants had previously received regarding the study's aims and format and asked if they required expansion of these details. I explained the data would take text form and the write up include quotes from individual narratives. I explained I was a clinician but that my role was one of a researcher in this context. I asked permission to begin recording prior to the narrative question.

I asked each participant how they termed the difficulties they had experienced and used this particular language in each interview question. The narrative interview question was as follows "I am interested in three areas: your experience of Mental health (using the term they had used to describe their difficulties), your family and your ageing experience" This question was used in all the interviews. Some participants asked for a little more clarification and most seemed keen to begin narrating. I explained I would leave them to narrate as long as they wished. In later interviews I noted after an hour how long the participant had narrated and asked if they were feeling tired or wished to continue.

When participants indicated that they felt they were coming to the end of their narrative telling I asked permission to question any narratives I felt had not been included or needed further clarification. In most narratives the area of ageing had been little narrated. I made comment of this and asked if they might tell me a little about growing older. This area was therefore cued for the majority of participants.

Participants were asked at the end of the interview how they were feeling and if they wished to share anything regarding the interview process. Most noted that they had enjoyed the experience and they hoped their participation would be of use to others. Although supervision and advice was sought regarding the content of some narratives no participants required any follow up with regards psychological/emotional support following interview.

APPENDIX 2: INFORMATION SHEETS GIVEN TO POTENTIAL PARTICIPANTS

Information Sheet

Version 5 (January 2006)

Study Title: An Exploration of the way older people share their experiences about their mental health, ageing and family relationships

This information sheet explains a research study you are invited to take part in. Before you make a decision as to whether you would like to be involved it is important that you understand why it is being done and what it will involve, so, please take your time reading this information and discuss it with anyone you wish. If you need further explanation please tell the Community Psychiatric Team Worker who gave you this sheet or contact me directly. Please take time before deciding whether you would like to be included. The following questions are some that you might wish to ask: -

What is the purpose of this study?

Recently, it has been suggested that there have not been enough studies about older adults and their mental health difficulties, which have included the experience and ideas of those people themselves. In my work as a clinical psychologist one of the things I have learnt is that I am most helpful when I listen to the particular needs and experiences of clients and their families.

This study aims to contribute to understanding professionals have of people like yourself and their families through their sharing of experience. Specific issues focused on are; mental health, aging and their impact upon relationships with one's family.

Who is the researcher?

My name is Joanne Smith. I am a Clinical Psychologist and a Family Therapist. I have worked as a qualified clinician with older adults in Derbyshire for nearly ten years. I previously carried out research in order to qualify professionally and as part of my job. When interviewing as researcher I will not be acting as a therapist but do hope my skills will allow for sensitivity to those sharing their experiences and responsibility in handling such personal information.

Why have I been chosen?

You have been asked to consider if you want to take part in this study because you have experience of coping with mental health difficulties and aging and may want to share these in order to potentially help me and other professionals to understand types of issues you and your families face. If you are already taking part in another research project it is best if you do not take part in this study at the same time.

Do I have to take part?

It is entirely your choice as to whether you wish to take part. If you say yes you will keep this information sheet and be asked to sign a form confirming you wish to take part. However, even after signing the form you can change your mind at any point before the research is written up. Your choice as to whether you do or do not take part

has absolutely no effect upon the help you receive from the community team or anyone else now or in the future.

What happens if I agree to take part?

If you take part you will come and meet me (transport will be provided or reimbursed) and be asked to talk about your experiences of mental health, getting older and how such matters affect relationships with your family. The time this takes depends on you but it will probably be no longer than an hour or so. Your ideas will be audio taped and the recording written down. I will then study what you and six to eight others who have agreed to take part in the study recount using a particular method called Narrative Analysis.

What are possible disadvantages or benefits of taking part?

It is not expected that you will feel any worse or better for having taken part in this study. However, it is possible that talking about these issues may result in you feeling sad or maybe confused; alternatively you may find that after talking you feel good or gain better understanding through the sharing of your experiences. At the end of the session you will have time to think about how it has felt to take part. If you wanted more time to explore your feelings this would be arranged with another professional or Clinical Psychologist.

What if ideas or plans for this study change once I have agreed to take part?

If, through the course of the study the plans outlined need to be changed I would let you know and check whether you still agreed to be involved.

Will my taking part in this study be kept confidential?

Yes. No names will be included when the taped conversation is typed up. When the study is written up excerpts from what you have said will be used to illustrate ideas, but no names will be used so as to protect your confidentiality. Some details given e.g. ages, places may also be changed for the same purpose. Written accounts and tapes will be kept in locked drawers to keep them safe. In the interests of your welfare I will however inform those who are directly involved with your health care at present of your choice to participate. This will include your Community Psychiatric Team worker, Psychiatrist and your GP.

The only time I would need to communicate information to others involved in your care or outside agencies is if you gave information which created concern about the safety of yourself or someone else in the past, present or future. In the unlikely event of this being the case I would discuss with you and those involved in your care how to make sure such concerns were dealt with.

What will the results of the study be used for?

The results will be written up as a large piece of work for my doctorate qualification from the Tavistock Centre in London (An NHS mental health clinic and research centre). A copy of this will be stored in their library. Since a main aim of this study is to help other professionals gain understanding of issues affecting people like yourself

it is also hoped that the results will be published in journals and used in presentations to professionals and students.

Whilst I am in the process of looking at and writing up the study I will need to take excerpts with names removed to discuss the research with my fellow students and tutors. I may also consult on information with academics based at the Centre for Narrative Studies at the University of East London who specialise in the methods I have chosen to use. This sharing of information will be done to allow others to check that I am carrying out research correctly, to comment on my ideas, help me with dilemmas and to illustrate where I am in the research process. Before I write up my research I will send you a copy of any of excerpts from your transcript that I intend to include to make sure you do not feel they compromise you or any one else. Changes would be made or excerpts not included in the write up if you requested this.

Who is funding this research?

Derbyshire Mental Health Services NHS Trust are funding this research

Who has reviewed this study?

The plans for this study have been reviewed and approved independently from Derbyshire Mental Health Services NHS Trust by internal and external examiners at the Tavistock Centre in London. This means they are satisfied that I am competent enough to carry out such research, that others are supervising what I am doing and that I have thought carefully about how to protect those who choose to take part.

This study has also been reviewed by Derbyshire Research Ethics committee and gained approval from the Trust.

If you have any concerns about this study you can contact the local research ethics committee at the following: Jenny Hancock on 01332 868765. Alternatively should you wish to speak to me personally regarding this study you can contact me through the Clinical Psychology Department on 01332 292740

Thank you for taking the time to read this information sheet. Please allow yourself at least 24 hours to think through the possibility of taking part. If you feel you would like to be considered please sign the consent form attached and give it to your Community Psychiatric Team Worker when he or she next visits you.

Joanne Smith

(Highly Specialised Clinical Psychologist, Derbyshire Mental Health Services NHS Trust).

APPENDIX 3: DEMOGRAPHICS OF PARTICIPANTS

Demographic Information of Participants

Participant 1 Was white, British, married and living with their long term spouse at the time of interview.
Participant 2 Was white, British, divorced and lived alone at time of interview.
Participant 3 Was white, British and widowed. They were living with a grown up child at time of interview
Participant 4 Was white, British, divorced and widowed from a subsequent partner. They lived alone at time of interview.
Participant 5 Was white, British and widowed. They lived alone at time of interview.
Participant 6 Was white, British, married and living with their long term spouse at time of interview.
Participant 7 Was white, British and married to their long term spouse. It was unclear at time of interview whether they were separated from their spouse.
Participant 8 Was white, British and widowed. They were living alone at time of interview.
Participant 9 Was white, British and married and living with their long term spouse..

All participants were receiving input from mental health services at the time of interview

N.B. As recruitment was dependent on other professionals I was not aware until interviewing began that 3 participants did not meet inclusion requirements. Two participants' onset of diagnosed MH problems had occurred post retirement and one was over 75 years old. Given that these details were not exclusion criteria but rather preferred characteristics for the purpose of the study it was not felt appropriate to exclude at that point. Rather, these particular details were considered within the findings and integrated within the study.

APPENDIX 4: RECRUITMENT PROCESS

The ethical committee stipulated that for reasons of confidentiality, participants needed to be recruited through professionals from whom they were receiving a service and give consent prior to being contacted by myself. This was because participants were being recruited from our Trust and were currently service users. They were therefore only allowed to be identified to me after having consented to taking part in the study. At this point their details could be given to me by their named professional. To facilitate recruitment I gave presentations outlining the aims and process of my research to community teams (comprising CPNs and OTs) and Clinical Psychologists within my Trust and handed over information and consent forms to these professionals. Recruitment was slow resulting in ongoing request to teams for a year. Once details of participants consent were received I informed their GP to ensure if a participant was discharged from our services during the research another professional could be contacted if necessary.

Participants recruited were restricted by choice of their professional. This may have led to some skewing of the sample and restricted what might have been my choice of sample mix. For example there were no participants from different ethnic groups. As a result of interviews taking place whilst participants were being recruited and recruitment taking longer than expected, overall participant characteristics were not known until the final interview had taken place. There was therefore not time to revisit participant characteristics or try to recruit more participants. However, this method of recruiting did assure confidentiality was maintained. Approximately half of the participants were approached and recruited by clinical psychologists and the other through other professionals. Some were or had therefore been in psychological therapy and this was considered within the findings.

Given demographics of the geographical area from which participants were recruited I had hoped for a more diverse ethnic mix of participants and in particular, those of Eastern European origin. This may well have added different findings given the differing historical, cultural and life narratives such participants would clearly have experienced (e.g. displacement during or after WWII). Findings in this study were specific to white British elders and may have led to a greater number of cross narratives themes being identified.

APPENDIX 5: EXCERPTS FROM REFLEXIVE JOURNAL

Extracts from Reflexive Journal

The extracts included here are chosen as representative of the stages of the research project. More reflexive thought was recorded at the beginning perhaps reflecting the difficulty experienced at the end to create time and space for this process and its recording.

Initial Thoughts Regarding Methods for Reflexivity

Perhaps I could do narrative analysis from a personal perspective. Interview my parents and analyse this in relation to growing older and family relationships

I think I should write about how the narratives affected my own narratives and how these affected my writing up of ideas

Perhaps I should consider a critical incident approach of how my own life events might have influenced me

I would like to write a section about how this study influenced my experience of research and methodologies

Methodology Decisions

"Struggling with ideas regarding what to use for methodology. I have a sense of being pulled toward the idea of narrative methodologies because it connects with my work …….it would be good to work with the idea that my clinical experience has affected my research and the research can then affect my clinical work…..But it requires risks not used to doing research without being told "how" to do it"
"Restorying (Kenyon and Randall 1997) involves more than just new ideas. I would not only to "have" a new story but to "be" a new story. My actions feelings and ideas are all part of this "restorying process". Perhaps this is a restorying for me. Uncertain but may well be useful for my work. "

" I need to believe in the purpose of this research. I need to feel it is valuable and therefore ethical."

Reflective Peer Seminar regarding process of research planning and reflexivity (Two days before my father's sudden death)

"I chose to be interviewed by the other students today because I wanted to think about my relationship with my *(elderly)* parents"

"This research has made me rethink my relationship with my parents. I have begun to recognise how life is complicated and difficult and we all make mistakes, choices that seem wrong to others but we do the best we can. I think with the divorce and everything I have been faced with my own mistakes and can recognise my parents have made mistakes but have done their best. I think I need to forgive more because I can see how forgiving they have been of me. I think this shift is the filial maturity I have been reading about. Recognising that my parents are just human like everyone else. I feel much closer to my dad now. Our relationship has evolved. I am aware that they are growing older and how precious time is. I am really glad I made the effort to spend time with them at Christmas now. I am going to write a letter to my dad now to tell him how much I love and respect him."

(the letter never got to him in time!)

First revisiting of Reflexive Journal after Death of my Dad

"Wondered how I could listen to older adults' narratives having lost dad. Feel that I spent less time with dad because busy with the research"

"Feel there is a physical connection between me, Tavistock and dad as I wrote the letter to him when I was there. Part of my motivation for this research was that it would make him proud"

"Since he died I have had so much feedback of how I am like my dad. How my intelligence comes from him, my interest in listening to others. I am his legacy. I want to continue because he would be proud. Part of what makes me what I am is my motivation to please him"

"I wish I had listened more to his stories. Perhaps truth is it was easier for me to listen to others and for others to listen to my dad. Did he feel listened to though? Did he feel I'd listened?"

Reflections of work to get through Ethics Committees

"Feel like I have had much less time to reflect on the study and been focused on practicalities of getting the research through ethics committees. I feel that the research has given me a sense of achievement and pride when thing really bad personally"

"I think previously reflections focused around me and how I felt about the research and my own family. Now I feel I am mopre focused upon me and the research. I feel that I have had to defend the research for ethics and now protective of it."

"Realised not even thought about my relationship with participants. Where do they come into this? Amelia thought this was the next stage of my reflexive thinking"

Reflections as begin Recruiting and Interviews

"It's interesting reading back. Considering how difficult it was for me to think about uncertainty now I am able to move into it and embrace it in my life. It feels natural. How quickly we forget the things difficult for us previously once healing begins to take place and we move into new stories of our own lives"

"I am sure that uncertainty was a reflection to my becoming more able personally to listen to my own inclinations and judgments"

"I think Dad's death, the divorce, has thrown me more onto God and onto myself and I have realised that these two stories are integrated and one"

"The uncertainty of the research methodology was a right one and |I am glad I took it….this whole approach has made me more aware of my changing skills and my relationship to my research and the participants"

Transcription and Analysis

"I think becoming emersed in narrative theory and narrative analysis has allowed me comfort"

"Once the interviews began I knew I would feel a high ethical and moral pull to complete this research ……I think this scared me as it committed me to them. Once this hurdle was jumped I experienced many different emotions…"

"I've found some interviews difficult ……they had me as an audience….I was used for different purposes…..I gained new insights I had not been aware of previously….I struggled with ethical and legal issues embedded in past culture and the responsibility that has given me"

Reflection of Interview and Initial Transcription (written following presentation to peers)

"How this participant used me as audience was of interest. The participants who used me in a way which was more therapeutic, inviting me to deconstruct, asking me to comment made me feel comfortable as a therapist……the person I related least to was responding in a more narrative interview fashion, I was just a mirror and a cue for their story"

"The feedback helped me realise that it was difficult for me to remain neutral in relation to the narratives I hear, transcribe and analyse and the importance of me reflecting and analysing my own personal narratives"

Transcription and Final Interviewing

"There have been periods now where this research has been put onto the back burner partly through demands of work and my personal life"

"There have not been forthcoming responses for my need of more participants……given I will be on maternity leave soon the need to re plan the research timetable has spurred me on to try and recruit again……this takes energy and I have influenced recruitment through lacking this"

"As I now face the life change of having a baby the research still feels something which is a companion. I am pleased I will still have the possibility of continuing the research whilst on maternity leave …it will allow me to maintain connection with my intellectual self ….I feel confident I will complete the research in the next couple of years"

Analysis and Write up

"Sometimes relationships and commitments are burdensome and resented…..I feel I am tied to this research in a way which feels controlling……I am angry at its wilfulness not to be helpful…...I feel my relationship with it has moved …it is grinding me down rather than helping me keep stable"

"Oh my …..I am tired, tired from work, tired of the research, tired of waiting for this thesis to grow up and leave home. But I am getting a bit frightened. It has been such a constant in my life for so long. Even if its presence has felt like an ominous cloud it has at least been reliably there. I am getting tired and anxious and worried of my own ability to sabotage all this work. I will not and cannot. I must keep going"

The ending of write up

"It is time…it is like giving birth…like parenting ….the feeling you cannot go on, that you have nothing left to give…that you are beyond exhausted ….and yet knowing you will carry on and it will be completed its like a meta cognition. I think I have learnt the value of focus and discipline of work in my life. I do need it. Like my participants I think my emotional wellbeing would struggle if I did not have a responsibility. It's just that right now I have a few too many. I keep going at work, with the children, with the doctorate. In some ways it becomes harder and harder to be reflective and reflexive because I live telling myself that I must do things for others. I can recognise that this can be dangerous, it can be avoidant. I must create enough space in my own life again to be a reflective practitioner, mother and wife. I must live and "be" narrative not just research or practice it otherwise it will mean nothing."

APPENDIX 6: CONSENT FORM

Version 6: January 2006

CONSENT FORM

Title of Project: An exploration of the way older people construct stories about their mental health, ageing and family relationships

Name of Researcher: Joanne Smith

		Please initial box
1	I confirm that I have read and understand the information sheet dated January 2006 (version 5) for the above study and have had the opportunity to ask questions.	☐
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.	☐
3	I understand that sections of any of my medical notes may be looked at by responsible individuals from the Mental Health Research Unit *or* from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my research records.	☐
4	I understand that a tape recorder will be used during the interview to record data.	☐
5	I agree to take part in the above study	☐

Name of patient	Date	Signature
Researcher	Date	Signature

APPENDIX 7: LETTER SENT TO PARTICIPANTS' GP

Dear Dr ---------

I am writing to inform you that ---------- (NHS No.--------) who I believe is your patient, has agreed to take part in a qualitative study I am undertaking as part of a Professional Doctorate in Systemic Psychotherapy at the Tavistock Centre (London) and which is being funded by Derbyshire Mental Health Services NHS Trust.

Their participation will involve --------- attending one interview session where they will be asked to tell me about their experiences of mental health aging and their family relationships.

I have enclosed a copy of the information sheet, which ---------- read and considered before consenting to take part in this study. This explains in detail the purpose of the study, the ways in which the information will be used and what precautions have been taken to protect confidentiality and the well being of your patient.

Both ---------- (---------‘s Community Psychiatric Nurse) and Dr ---------- (--------‘s Consultant Psycho geriatrician) are also aware of ----------‘s choice to take part in this study.

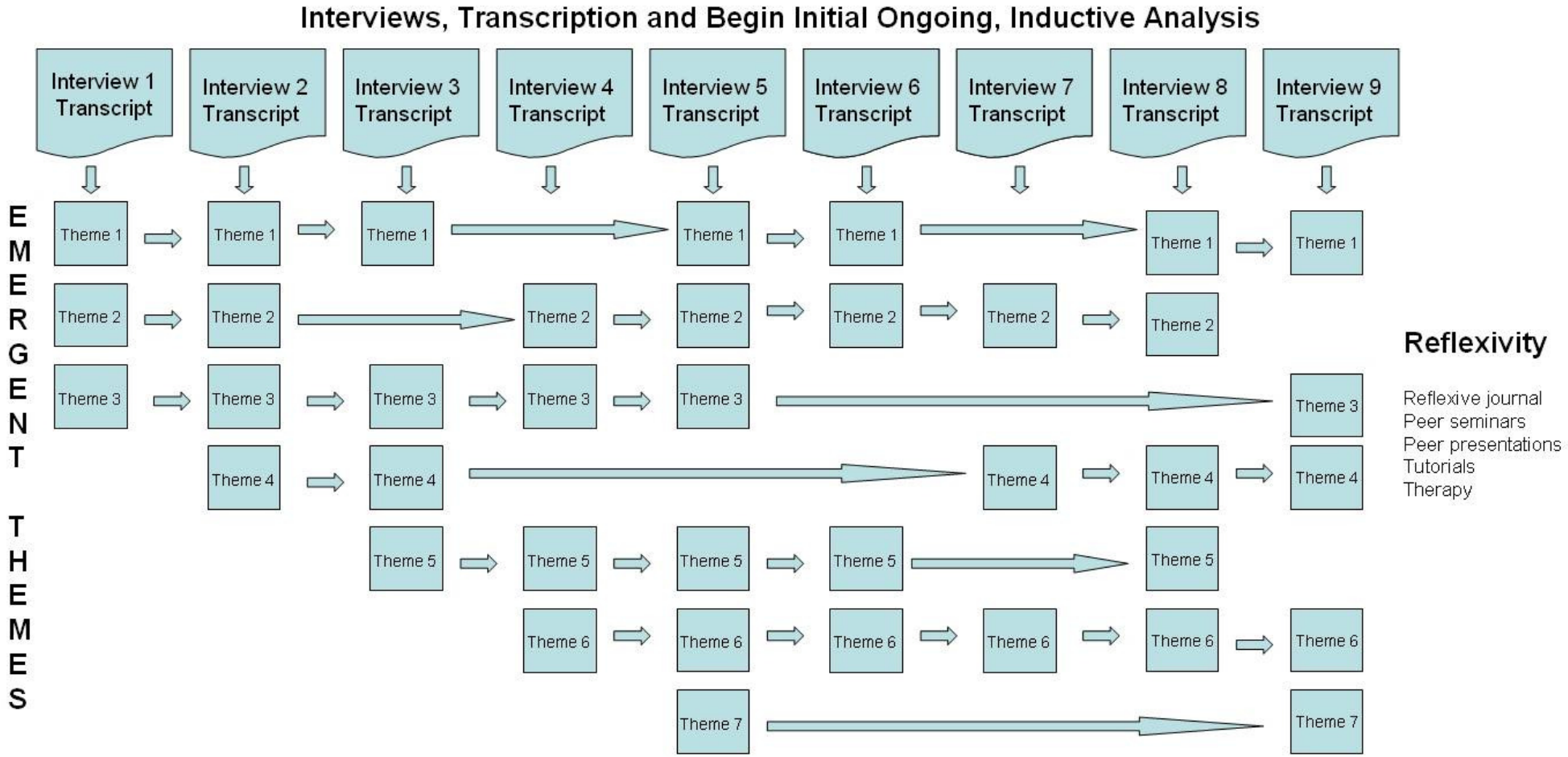
Please do not hesitate to contact me should you wish to discuss any aspect of the information I have provided about my study or --------‘s inclusion with me further.

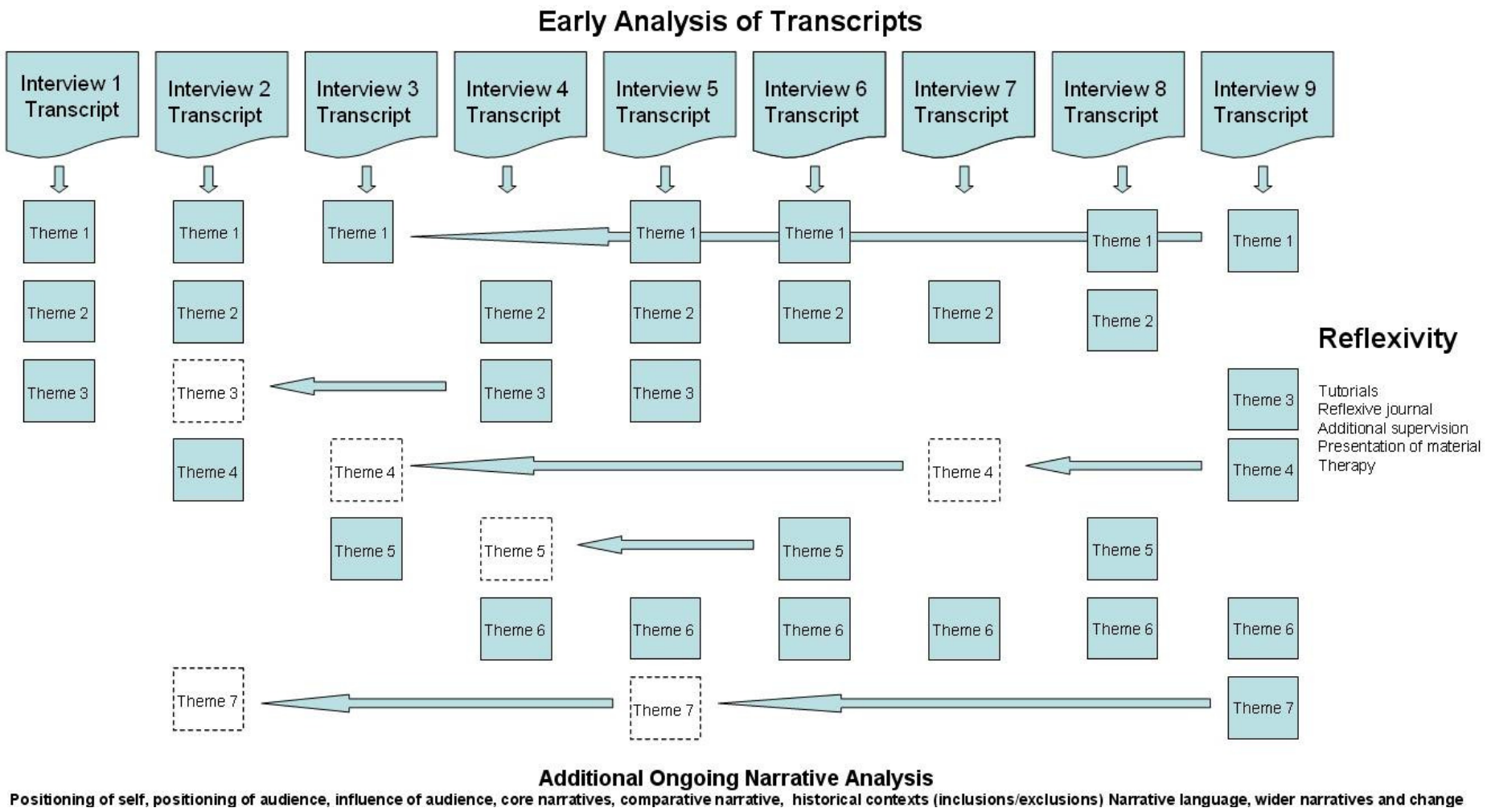
Yours sincerely

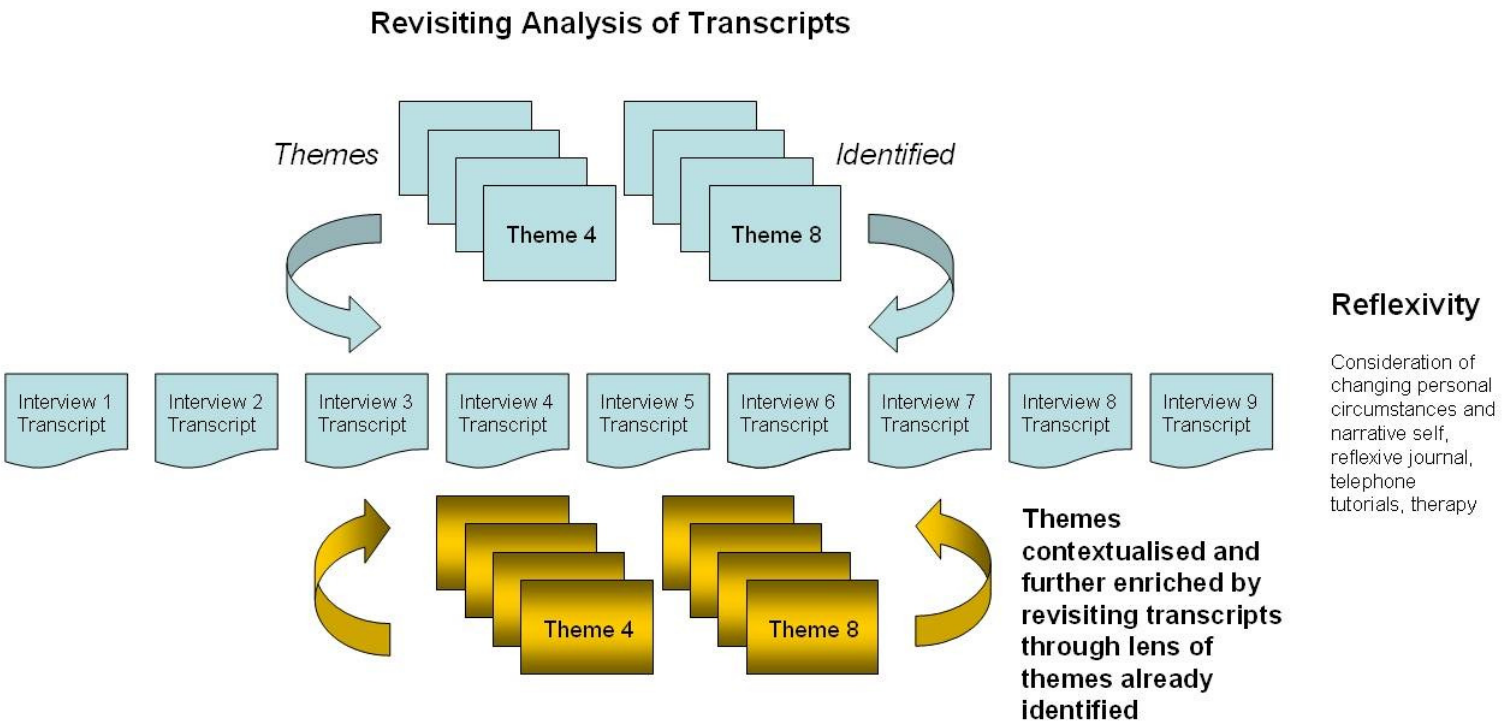
Joanne Smith

(Principle Clinical Psychologist, Derbyshire Mental Health Services NHS Trust)

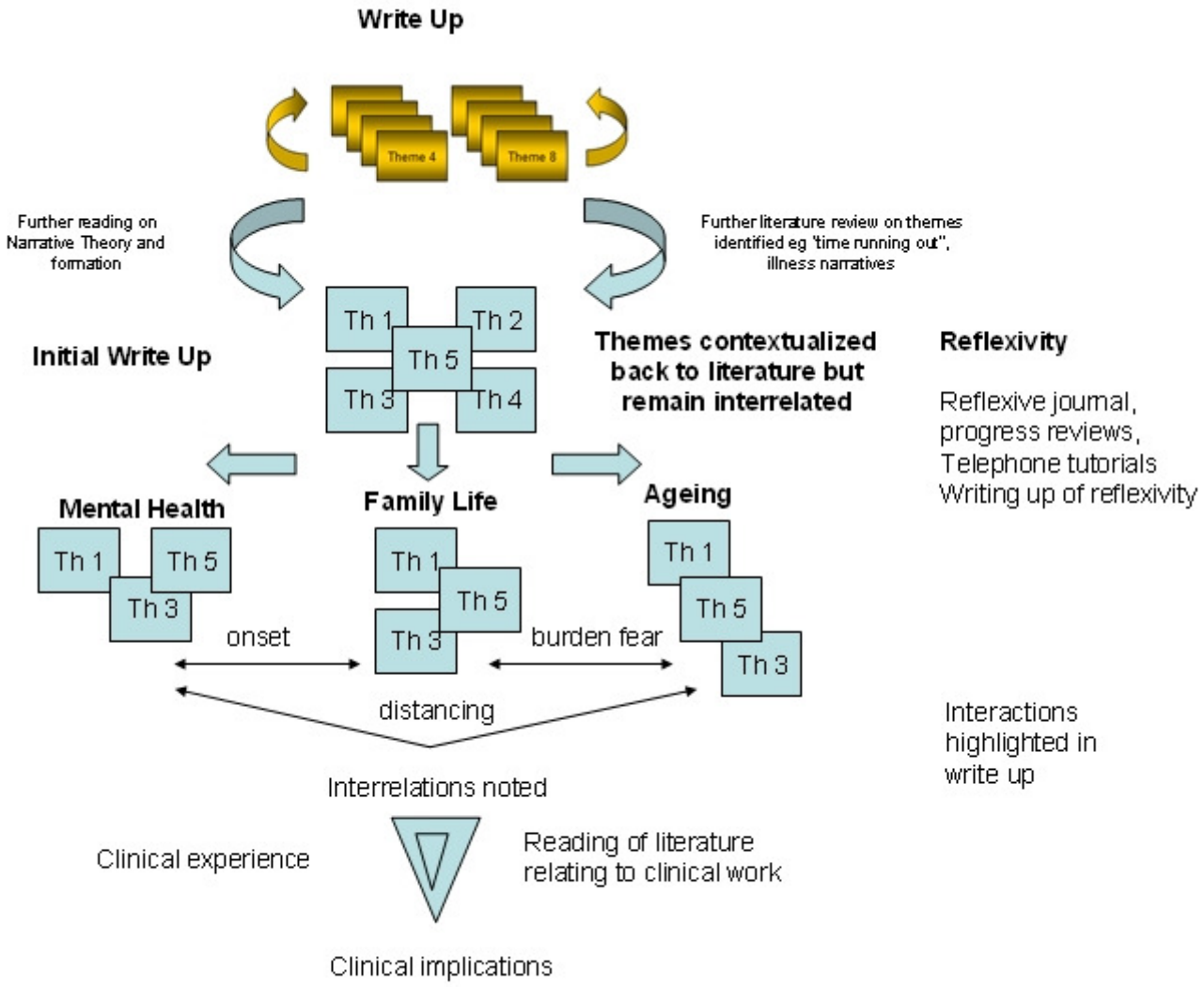
APPENDIX 8: FLOW CHART ILLUSTRATING ANALYTICAL PROCESS


Interviews, Transcription and Begin Initial Ongoing, Inductive Analysis
Interview 1 Transcript
Interview 2 Transcript
Interview 3 Transcript
Interview 4 Transcript
Interview 5 Transcript
Interview 6 Transcript
Interview 7 Transcript
Interview 8 Transcript
Interview 9 Transcript
EMERGENT THEMES
Theme 1
Theme 2
Theme 3
Theme 4
Theme 5
Theme 6
Theme 7
Reflexivity
Reflexive journal
Peer seminars
Peer presentations
Tutorials
Therapy
Analysis takes place in interview and transcription and initial analysis as ideas and themes noted after each


Early Analysis of Transcripts
Interview 1 Transcript
Interview 2 Transcript
Interview 3 Transcript
Interview 4 Transcript
Interview 5 Transcript
Interview 6 Transcript
Interview 7 Transcript
Interview 8 Transcript
Interview 9 Transcript
Theme 1
Theme 2
Theme 3
Theme 4
Theme 5
Theme 6
Theme 7
Reflexivity
Tutorials
Reflexive journal
Additional supervision
Presentation of material
Therapy
Additional Ongoing Narrative Analysis
Positioning of self, positioning of audience, influence of audience, core narratives, comparative narrative, historical contexts (inclusions/exclusions) Narrative language, wider narratives and change



On-going analysis of factors related to Experience Centred (Squire 2010). Dialogical/Performance (Reissman 2008) approaches


Write Up
Theme 4
Theme 8
Further reading on Narrative Theory and formation
Further literature review on themes identified eg 'time running out", illness narratives
Th 1
Th 2
Th 5
Th 3
Th 4
Initial Write Up
Themes contextualized back to literature but remain interrelated
Reflexivity
Reflexive journal, progress reviews, Telephone tutorials
Writing up of reflexivity
Mental Health
Family Life
Ageing
Th 1
Th 5
Th 3
onset
burden fear
distancing
Interactions highlighted in write up
Interrelations noted
Clinical experience
Reading of literature relating to clinical work
Clinical implications

APPENDIX 9: DESCRIPTION OF THE ANALYTICAL PROCESS LEADING TO INCLUSION AND EXCLUSION OF FINDINGS

Description of Analytic Process

Example of a theme included in Write Up

Being a good mother

This theme was identified early on in the transcription and analysis process. For example in the first interview and transcription Participant 1 highlighted this theme in relation to past mothering.
"I was what I think was a very good mother caring you know still am I think 'erm....."

And present mothering of a grown up son.
"I wouldn't say much at all because I suppose it is ***protecting*** *my son"*

This theme was then noted as I transcribed and analysed other transcripts.
Participant 3 *"I am a very very observant mother....I helped her in a way a mother should help her (daughter)"*

As more examples then emerged from transcripts the theme was felt to be related to having been a good mother through protecting children from potential effects of MH difficulties and seen as related to all three areas of interest.

Participant 3: *"she (daughter)* ***couldn't see anything*** *so she didn't know what I was going to do (attempt suicide)"*

Participant 9: *"erm I don't think the girls realised we tried to keep it from them as much as we could erm"*

Participant 1: *"I've always put on the "no way would he (her son) know that I was down in the dumps or just had a couple of valium" no nothing like that"*

Given the form of NA applied in this study this theme was also considered in relation to the influences of audience, coherence and relation to wider cultural narratives. For example with regards to wider cultural narratives, the following excerpt was felt to be indicative of the influence of the stereotype that elders are burdensome to their families if they ask for help.

Participant 6: *"She (daughter) had really enough to cope with and I'm very wary...."*

The connection of this theme to other theories of narrative construction then thickened its potential significance and influenced the decision regarding its inclusion in the write up. Further literature review around areas of mothering, mental health and audience then took place, highlighting current research interest in this area and illuminating meanings of this study's findings. For example Gunnerson and Hyden's (2009) findings of parents' narratively constructing self with "moral accountability" to audience.

These findings were then taken back into participants' whole narratives to ensure their contextualisation within individual life long narratives. For example Participant 1's narration of being a protective mother was felt to be related to a repeated theme within her whole narrative of wanting to be approved of by others.

Participant 1: *"...There was about twelve of us in the group I was referred to and I thought "Gosh everybody there was crying and I was trying to ...I suppose I was acting really you know.."*

This relation back to the whole narrative allowed links to be made back to the clinical field. For example, how therapy might help identify negative aspects of this belief to family relations.

Participant 1: *"Until my psychologist started coming* ***the family*** *really didn't know I had these anxiety problems I didn't tell anybody"*

Reflexive processes then allowed identification of my own personal narratives and life circumstances and how they might relate to my identification of the themes. For example in relation to this theme it was felt significant that I was (at the time of analysis) myself a new mother and struggling with my decision to return to work in the face of wider conflicting narratives of mothering. It was felt this might increase my focus on this theme.

Decisions regarding where this finding might be included in write up were difficult. Initially, this theme was planned to be included in a section on wider cultural narratives. However, when decision to divide the findings section into the three areas included in the narrative question was made the dilemma shifted to which of these three sections it should be included within. This theme could potentially have been included in all three and it was eventually decided it connected most strongly to familial relationships. Acknowledgement was however also made of its connection to the chapters of ageing and mental health.

Examples of Themes not included within Findings

In Laws

One example of a theme not included within the findings was participants' relationship with in laws. However, some participants did include this subject within their narratives.

Participant 1: *She would never call me mum or anything like that I would never expect her to but with my husband's mother she would be mum .....I have a different relationship with my daughter in law than I had with my husband's mum and I suppose that's (2 secs) the generational gap really and how things work"*

Participant 8: *"...I do the shopping. She (daughter in law) will pick me up from here....."*

Participants narrated relationship with their grown up children and grandchildren. However, very little reference was made to in laws or relationship with them. For example, Participant 3 narrated her relief when her daughter married the father of her grandchild and how important this was to her but included nothing of her relationship to this son in law. Participant 9 narrated going on holiday with her daughter and children but included no reference to her son in law.

In retrospect this was might have been noted as a potentially significant finding through its absence and more asked of it at the end of interview. However, because the relationship was not narrated in detail by participants it was not identified as a theme in initial analysis of whole narrative transcripts nor as a cross narrative theme.

Retirement

Retirement was also a theme which might have been (but was not) focused upon since it was included in narratives of some participants.

Participant 6: *"Whereas I was doing everything well not everything but the majority of things erm my husband took over some of it (at retirement)...it changed ..."*

"...he's (pause) needs a push sometimes now I mean he never did before ....he seems to have lost all incentive since he has retired that is worrying in itself ..."

Participant 2: *"... I was mainly alright whilst I was working I said to the psychiatrist "What am I going to do for the rest of my life"..."*

Participant 9: *"He didn't want to retire he didn't retire at the normal time ....I wanted him to and be with me. Well to sort of do a different kind of life and I felt it was rejecting me I think because he would not retire"*

A theme of retirement by participants and their partners could have been included as a stand alone finding. However, retirement was felt to be included within and related to other identified themes such as the impact of mental health, relationship with spouse and physical illness. For the majority of female participants, working lives had been disrupted by childbirth and culturally gendered restrictions of that time. Working and retirement were not narrated as pivotal nor mentioned by most female participants. Furthermore, since most participants had struggled with MH for many years working careers had for many men also occurred earlier than expected on the basis of ill health.

Connection of references within and across narratives of retirement to create a separate theme would have involved, either repetition of the excerpts within which they were embedded and related to other themes, or the removal of these from other sections. The latter choice would have led to lower contextualisation of this issue to other life events. Further, it was felt important to keep a focus on issues participants themselves were emphasising. That is, if retirement was included as an example of strained marital relationship the emphasis was given to the marital relationship rather than retirement.

Reflexive consideration of this theme highlighted how retirement was not an issue I was not facing. However, had I been older this may well have been a theme more focused upon and possibly identified further in transcripts analysed.