



3

Making Sense of Grief

How people make sense of grief has salience in contemporary cultures with conflicting understandings of the meaning, role and value of grief. In the opening chapter, I stated my concern with the contradiction between the increasingly public face of grief and the persistent belief in grief as a social taboo. In this chapter, I discuss the psychological, political, and cultural framing of grief and recovery, resisting the idea popular in literature on death that with the decline of religion people are left with no resources with which to make sense of grief. Instead, I explore the discourses that continue to shape grief, albeit in different forms, where competing definitions of grief and recovery reflect the ambiguity over what constitutes the normal course of grief and recovery. Howarth (2000) has described how, with the destabilisation of religious narratives and a diminished belief in the afterlife, life and death have become separated so that death is no longer a continuation of life, but a threat to life. Grief too in its expression of loss and death is out of place in a society oriented towards life rather than death. It is thus unsurprising that the concept of recovery with its allusions to rebirth and revival of the individual has been embraced by mental health care, and in models of grief, where recovery serves to rescue the individual from the polluted

boundaries of death and depression. How grief is made meaningful, whether drawing on medical, rational, ritualistic, or symbolic explanations, provide justifications that enable grief to become governable or calculable. The existence of these, at times, contradictory discourses, reveals how making sense of and defining grief is an ongoing public and private endeavour.

The chapter begins with the ongoing debate concerning the establishment of psychiatric diagnostic categories of grief, to discuss how certain forms of grief have come to be considered problematic. Following on from the previous chapter, I explore the ways grief has become a psychological object of study through detailing political reforms in mental health that have encouraged a contemporary political and economic climate focused on individual happiness and well-being. Through government-driven initiatives, improving one's well-being and recovering from mental illness are understood as a matter of individual choice and responsibility, as continues to be the trend in public health. A thriving economy is key to many mental health reforms due to the huge financial costs of mental health within the National Health Service (NHS) budget, estimated in 2016 at an annual cost of £105 billion: the biggest item of expenditure. In such a climate, focus on improving happiness and human flourishing, 'negative' emotions like grief, and mental disorders like depression, became not part of life and something to be accommodated but something to overcome, not only in the name of individual health but also for the economic stability of the nation. Put simply, unlimited grief is constructed as a 'burden' in a society that favours happy emotions, time-efficient mental health services and continued productivity through employment.

While the acts of government and psychologists certainly have consequential effects, in literature and the arts grief is prized with a special human value. In the second section of this chapter, I consider the portrayal and presentation of grief, in texts such as memoirs, novels and poetry. I contrast the ways in which grief appears, on the one hand, to be increasingly a matter of medical concern with, on the other, the literary uses of grief, in memoirs, fiction and poetry. The grief memoir or narrative is set within a broader growth in non-fiction writing,

specifically autobiographical writing or writing that narrates personal experiences. The emergence of what has been described as the 'autobiographical novel,' epitomised by contemporary writers such as Karl Ove Knausgaard and Rachel Cusk, has served to blur the boundaries between what is considered fiction or non-fiction. While it can be argued that it certainly is not new for authors to depict their own lives in their work, the autobiographical novel poses new questions over not only how narratives are constructed, but how they come to be categorised and consumed, and further how work comes to be judged as fiction or not. In terms of the grief memoir, the blurring of boundaries between fiction and non-fiction suggests a fluidity in the 'truth claims' made about grief. The grief memoir is viewed as an acceptable medium within which to make experiences of bereavement public and as such blurs simple distinctions between the 'public' and 'private' expressions of grief.

In the third section of this chapter, I present findings from the bereaved participants I interviewed and discuss the different discourses participants drew upon to narrate their experiences. These discourses were both rational and traditional ones, offering symbolic meaning in pain and bereavement through signs, superstitions, and metaphors but also reliant on more established ideas such as grief models and bereavement counselling to make sense of grief. This suggests that for the bereaved participants drawing on rational and symbolic types of explanations was not necessarily contradictory, though could appear ambiguous in trying to make sense of the event of bereavement. How people utilised these different discourses problematised not only the understanding of individual choice within policy on recovery but also the ways in which the personal or private modes of explaining grief can adhere to and reject dominant narratives in ways that are not clear cut. In closing, I explore and challenge the understanding that grief needs to be made sense of or found meaningful in order for people to successfully 'recover.' I reflect on what happens when there is a failure to make sense of grief, drawing on the understanding within counselling and therapy that being unable to find meaning from grief causes a lack of recovery from grief.

Public Narratives of Grief and Recovery

Grief as a Disorder

In 2013, the publication of the DSM-5 (American Psychological Association) caused considerable debate across the field of grief and bereavement research, in particular the proposal of a new diagnostic category ‘Persistent Complex Bereavement Disorder’ (PCBD) to be considered for inclusion in future editions of the manual. Controversy over the proposed diagnosis of PCBD was centred on internal disputes between two well-researched categories of abnormal grief: ‘prolonged grief disorder’ (PGD) proposed by Prigerson and colleagues (Prigerson et al. 2009; Boelen and Prigerson 2012) and ‘complicated grief’ (CG), the category described by Shear and colleagues (Shear 2010, 2012; Zisook and Shear 2009). PCBD was in effect a faulty compromise, a product of criticisms of over-medicalisation in the preparation stages of DSM-5. The two respective research groups continue to disagree over which category—prolonged grief disorder or complicated grief—is the most robust, leading to a back and forth commentary in the pages of medical journals including the *British Medical Journal* and *JAMA Psychiatry*, highlighting the shortcomings of the others research and claiming the superior scientific validity of their own (Maciejewski and Prigerson 2017; Reynolds et al. 2017; Prigerson and Maciejewski 2017).

The scientific rigour of the work on prolonged and complicated grief is much flaunted, however, not enough criticism has been directed to the inconsistencies of each diagnostic category. Boelen and Prigerson (2012) provide a comparison of the symptoms of PGD, CG and PCBD highlighting both the similarities and marked differences between diagnostic categories. The most notable difference is the length of time a person is expected to demonstrate symptoms before diagnosis. For example, PGD requires symptoms to be present for six months before intervention, while a diagnosis of PCBD is recommended only if symptoms are present at least 12 months following bereavement. There are also varying opinions on how many people are affected by these disorders; from seven to ten per cent of bereaved people claimed by Shear

(2010, 2012) to a much higher 15% of all bereaved people by Bryant (2012) who remarked ‘there are over a million new cases of prolonged grief in the USA each year, representing a public health issue’ (10). Although the use of the categories of prolonged or complicated grief is currently less prevalent in bereavement care and practice in the UK, as I detail in Chapter 4, initiatives such as the ‘Early Intervention Project,’ run by Cruse Bereavement Care and funded by the Department of Health, reveal how complicated grief is becoming a prominent focus of concern.

While proponents of complicated grief argue that the growth of research into the area is merely the recognition of a disorder that already existed and experienced by bereaved individuals, there appears to be some ambiguity around why complicated grief develops in some people and not others. The ICD-11 defines PGD as a:

[P]ersistent and pervasive grief response characterised by longing for the deceased person or persistent preoccupation with the deceased accompanied by intense emotional pain.

The grief response is defined as prolonged if it has persisted for:

(...) an atypically long period of time following the loss (more than six months at a minimum) and clearly exceeds expected social, cultural or religious norms for the individual’s culture and context.

It is the ‘atypically long’ time period, which most clearly demarcates complicated from normal grief, and yet as I argued in Chapter 2, the meaning of ‘normal’ grief, is still under considerable debate. Despite this lack of clarity, this has not prevented the creation of diagnostic categories based on the assumption of a normal course of grief.

Brown (1995) suggests there is a need to ask of medical diagnosis: why is it that conditions get identified at certain times? And why is action taken—for whose benefit and at what cost? Indeed, receiving a diagnosis has direct practical implications for the person’s social status and standing. A diagnosis can help people to access treatment; it can

legitimise contested conditions and provide coherence and a narrative to its sufferers. As Hacking (1986, 1999) has argued, psychiatric diagnosis is not merely the recognition of an illness already present but one that is socially produced. In other words, mental illness and disorder are made 'visible' in an individual body through the clinician's 'gaze,' using labels, diagnostic categories, and other tools of psychiatry. These tools, that emerged with the birth of modern medical practice as Foucault (1973) and Rose (1985) have described, sought to localise illness in the body, or more specifically in this case, in the mind or brain. As I describe further in the following sections, the locating of illness inside the mind meant both the cause and management of mental disorder became largely a responsibility of the individual.

The way in which such medical rituals are used suggests the danger a complicated griever might pose to what are considered to be normal, healthy emotions and behaviours. Therefore, to understand why prolonged grieving poses a risk and has become problematic for many requires a wider analysis in the realm of political, economic and societal concerns. While a time limit is important in distinguishing complicated from normal grief and time-limited mourning is present in a number of mourning rituals, it takes on new relevance when considering time limits in the treatment and recovery of mental disorders. Further, these time limits, established in the creation of a psychiatric diagnosis of complicated or prolonged grief, might be considered as a 'technology of temporalisation' (Foucault 1975) that serve to contain mental distress or unhappiness. As I will discuss below, such time limits on grief take on renewed relevance in a political and economic climate where maintaining happiness and well-being and being a productive worker are primary markers of the good citizen.

No Health Without Mental Health

The second half of the twentieth century witnessed a shift away from disease prevention located at the level of public health to an emphasis on individual responsibility. This trend was captured in policy such as the White Paper *Choosing Health: Making Healthy Choices Easier*,

published in 2004 by Blair's Labour government, which set the tone for policy decisions that followed with an emphasis on individual choice and responsibility over one's well-being. This was also followed in David Cameron's 'Big Society,' the ethos of which was to give people more control over their lives, in the belief that when people are made to feel as if they are the 'authors of their own destiny' their sense of self-worth and well-being increases. More recently the Health Secretary Matt Hancock has encouraged people to take more responsibility for their own health and make better health choices, reaffirming the government policy on public health (*BBC News* 2018).

In *No Health Without Mental Health* (Department of Health 2011a) the Conservative-Liberal Democrat coalition government set forth an improved policy to tackle mental illness. While the principles underpinning the report were individual 'freedom,' 'fairness,' and 'responsibility,' there was also a great deal of focus on the economic impact of mental illness. Commonly described as the 'burden' of mental health (Department of Health 2011a; Wittchen et al. 2011), the report quantified the cost of poor mental health in 2011 as £105 billion, accounting for 23% of the total illness burden in the UK. The same figures were featured in a government-commissioned report published in February 2016 by the NHS England independent mental health task force (chaired by the MIND charity CEO), which proposed a five year forward plan for mental health care (The Mental Health Taskforce 2016). The report coincided with Prime Minister Cameron's announcement of nearly a billion-pound investment in mental health care, adding to the estimated 34 billion pounds spent on mental health each year (Department of Health 2016).

Wittchen et al. (2011), in their review of statistics across the European Union (EU) countries, concluded that one-third of the EU population suffers from mental disorders: a finding that revealed a much greater burden of disease than previously considered. Disorders of the brain, they stated, are the core global health challenge of the twenty-first century. *No Health Without Mental Health* was preceded by a number of other government-directed reports such as the Foresight Report (Jenkins et al. 2008) that focused on ways to create 'positive

mental capital.’ The report described the ‘important societal value’ of positive mental health as:

(I)ncluding overall productivity. It is an important resource for individuals, families, communities and nations, contributing to human, social and economic capital. (Jenkins et al. 2008, 15)

The ways in which ‘positive’ mental health and mental disorders were positioned was clear: mental illness is a costly burden, and well-being is productive, most crucially in economic terms. The way to remedy the burden called for the introduction of accessible psychological therapies. Lord Layard’s report, entitled *The Depression Report* (The Centre for Economic Performance’s Mental Health Policy Group 2006), provided an in-depth proposal of a psychological service that would reduce the costs of absenteeism and incapacity benefits caused by mental ill health by aiding people to recover more quickly and return to work. The Improving Access to Psychological Therapies service (IAPT) was thus born, with the 2011 government mental health policy including many of Layard’s proposals. The IAPT service was set up to provide nationwide access to evidence-based therapies in accordance with the National Institute for Clinical Excellence (NICE) guidelines, including therapies of different ‘intensity’ levels. The therapy of choice in IAPT was cognitive behavioural therapy (CBT) approved by NICE for its evidence-based success rate, and favoured for its brief treatment time. IAPT was thus targeted largely at mild depressive and anxiety disorders where the delivery was lightweight with a maximum of six sessions of CBT and, in some instances, merely referral to other services or provision of leaflets.

Addressing mental health in 2011 was particularly poignant in what might be considered the lowest point in the economic recession. In the supplementary document to *No Health Without Mental Health* which focused on the introduction of talking therapies, Paul Burstow, then Minister of State for Care Services, made explicit this connection when he wrote: ‘Following the recession, it is clear we need to heal emotional wounds, which means we are looking for a psychological recovery outside our economic recovery’ (Department of Health 2011b, 2).

The therapy IAPT provided was seen to benefit not only the individual 'but also the nation by helping people come off sick pay and benefits and stay in or return to work' (5). Ehrenreich (2010) in her book *Smile or Die*, attacked the 'Pollyannaism' of a political agenda focused on individual well-being, arguing it was the delusion of positive thinking that caused the financial crash to occur in the first place. Halting economic progress was not in question, even if it had been the cause of misery for many. The answer to the economic recovery was not a restructuring of the type of neoliberal economics that arguably created the problem but a psychological recovery of the citizens bearing the brunt of its aftermath.

A Happiness Agenda

It was not only those considered to be mentally ill who required assistance. In late 2010 Prime Minister David Cameron announced that the coalition government would begin measuring the nation's happiness (Cabinet Office 2010). The Office for National Statistics (ONS) was directed to include a set number of questions in their Household Survey that sought to gauge the happiness levels of the population. The establishment of a 'happiness index' emerged out of a series of events both in the UK and internationally; the central one being the revelation that more money and increased gross domestic product (GDP) did not make people happier. What became known as the 'Easterlin paradox' derived from a number of studies by Easterlin (Easterlin and Angelescu 2009), revealed that in developed countries after reaching a certain level of wealth, happiness and well-being plateaued. The identification of an inverse relationship between money and happiness led economists and politicians to seek out new measures of progress alongside GDP. Cameron's announcement marked the beginning of the peak of political and economic interest in happiness and well-being. It also tapped into what had become an established sub-field of psychology that focused on the fostering of positive emotions. The new field of positive psychology, stemming from the former chair of the American Psychological Association Seligman's (2002) seminal text *Authentic Happiness*

provoked a wave of interest in happiness, an emotion Seligman claimed had been historically neglected in psychology with the discipline's over-emphasis on the melancholy. The goal of positive psychology was not only to stop people being ill but help them 'be well' by building the 'enabling' conditions of life. As Seligman (2002) described, it was about getting people from zero to 'plus five.'

While some thought the plans for a happiness index 'woolly' and 'impractical' (Duncan 2010; The Midlands Psychology Group 2007), Cameron's announcement was met with considerable support. The organisation 'Action for Happiness' founded by Layard, Geoff Mulgan (formerly Director of Policy in Blair's Labour government) and Anthony Seldon (the historian known for his biographies of British prime ministers) was re-launched with the goal to make a happier society. Meanwhile, the New Economics Foundation (NEF) created well-being as one of its key themes, formulating a Happy Planet Index (HPI) which aimed to show where the happiest and healthiest place was to live, and instructing people of the 'five ways to well-being'.¹ The media interest in Cameron's announcement sparked what Davies (2015) has described as a 'happiness industry.' From the BBC's 'Happiness Challenge,' to laughter coaches and happiness phone apps, happiness was at its peak.

The ability to measure happiness provided the tools to define happiness in objective terms, but as a consequence of the discovery of the 'Easterlin paradox' happiness has been defined not as something dependent on the structures of society but on individual thoughts and feelings. Happiness has thus come to be framed as something within the individual's reach, if only he or she could learn to make the right choices about their health and well-being. Yet the research into happiness had revealed that, even when presented with accurate information, people did not always make the 'right' choices about their health. In order to address these 'toxic biases' a government policy unit called the 'Behavioural Insights Team' (BIT) was formed. The BIT was quickly dubbed the 'nudge unit' referencing Thaler and Sunstein's (2009) book *Nudge* that put forward the idea that people would make better choices for themselves if only their behaviour was 'nudged' the right way. While

standard economic analysis had been based on the assumption that humans are rational and behave in their own self-interest, behavioural economics rested on the belief that people repeatedly make mistakes about what brings them well-being (Cromby and Willis 2013). The happiness agenda and behavioural economics appeared to be utilising different types of subjectivities: one that was resilient, self-motivated and in control of their well-being, and one that was simultaneously at the whim of unconscious drives and government nudges. Mol described how this contemporary 'logic of choice' within health care services in western societies promises a level of mastery over one's life but hides what it costs to reshape the world in a way that 'situations of choice' are created (2008). Along the same lines Borgstrom (2015; Borgstrom and Walter 2015) illustrated the limits of the choice agenda within end-of-life care where choices over a 'good death' are not always possible.

The political and economic agendas within the happiness agenda were, I suggest, hidden within a discourse that revitalised an Aristotelian view that happiness is what all people desire. From how it is thus defined, happiness is perceived as a neutral term, flexible to the subjective views of the individual. Yet Ahmed (2010) identified how the idea of happiness that has evolved is a limited and restrictive one, specifically critiquing the way in which the rise and emphasis on happiness is at the exclusion of certain individuals, groups and ideas. The history of happiness, Ahmed argues, is not one of inclusivity; the criteria for happiness has discounted certain individual and groups and affected how 'negative' emotions are socially perceived and acted upon.

The move towards classifying complicated forms of grief can be considered as part of this broader political and economic imperative to alleviate the 'burden' of mental disorder and create happier more productive citizens. Within the happiness agenda, happiness is an object, both individual and collective which all are encouraged to obtain. When happiness and positive emotions are viewed as the endpoint of all endeavours, unhappiness registers as something that gets in the way. Instead, Ahmed posed the argument that unhappiness should be treated as more than something to overcome. Yet, as I will go on to discuss, recovery from unhappiness and mental distress is precisely the goal that

individuals, governments and health care services are orientating themselves towards.

The Journey to Recovery

Alongside the proliferation of government policy, psychological research and public interest in happiness and well-being, was the popularising of a 'recovery model' in mental health care. The move towards recovery sought to bring acceptance to living with a mental illness and to broaden the notion of recovery outside of medical requirements in an attempt to remedy what was considered the 'epistemic injustice' at the heart of the way health care services have been administered (Carel and Kidd 2014). It is not an understatement to note that recovery is one of the most significant transformations in mental health care policy in recent times. NHS mental health services now declare themselves as 'recovery-orientated' or 'recovery-focused'; 'recovery colleges' have been set up around the UK, numbering 76² at the time of writing, and recovery is a central focus in psychiatric research (Roberts and Wolfson 2004; Slade et al. 2012, 2014; Summerfield 2002). In this section I shed light on what recovery means for mental health care policy and suggest why recovery has captured the imagination of policymakers and service users alike.

Establishing what recovery means is no straightforward task and most policy, articles or books on the topic will begin with the preface that no one definition of recovery exists. This is in part an intentional consequence as mental health service users and survivors first embraced the term recovery as a way to describe ways of living fulfilling and meaningful lives with their mental illness. Oft-cited definitions of recovery include that of Anthony (1993), who described recovery thus:

[Recovery is] a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Recovery from mental illness involves much more than recovery from the illness itself. (1993, 11)

Another popular definition is provided by Deegan (1996) who, in her book *Recovery as a Journey of the Heart*, described that the goal of the recovery process:

(...) is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human. (1996, 92)

Policy and research papers such as *No Health Without Mental Health* detailed above frequently cite these two definitions. In these definitions of recovery, the unique and self-defined nature of recovery is emphasised. This reflects the radical beginnings of the recovery movement made possible by the anti-psychiatry of the 1970s and the rise of a psychiatric survivors' radical movement that demanded change to the paternalistic and often oppressive mental health care of the past. Recovery thus began as a liberatory message of resistance against the medical model of understanding mental illness and what were considered the normative goals of psychiatric care, yet has since permeated mainstream mental health services. The official introduction of recovery into NHS mental health services was heralded with the New Labour government's 'vision' for mental health care in 2001 entitled *The Journey to Recovery* (Department of Health 2001). In this document, the government laid out their plans for modernising the 'defective' and 'chaotic' mental health care services of the past, where it was claimed people with mental illness were not expected to recover. In the 'services of the future' recovery will be spoken about as much as illness, after all 'the vast majority have real prospects of recovery' (Department of Health 2001, 24). The contemporary model of recovery, however, has also incorporated the consumer movement in health care as well as applying the insights of positive psychology where choice, hope, and responsibility are terms commonly found in descriptions of recovery. This theme was illustrated in the emphasis on enabling and empowering citizenship as closely tied to recovery, acknowledging a need to aid service users

into engaging with ‘ordinary social activities’ and finding a ‘meaningful occupation’ (25).

By 2010 recovery had been well-established in mental health care policy as demonstrated by *No Health Without Mental Health*, where one of its six main objectives was that ‘more people with mental health problems will recover’ (Department of Health 2011a). In many respects, the New Labour vision could be considered a noble one, wanting to ‘foster the understanding that mental illness is no more to be frowned at than breaking a leg’ (25). Yet the ‘mainstreaming of recovery’ (Rose 2014) was not without its problems. Service users began to express their dissatisfaction with a notion of recovery that had come to be shaped by government-directed outcomes rather than being individually defined. Recovery came to be defined by policymakers and service users in two ways: clinical and personal recovery. What was being established were two dividing notions of recovery, one that could be decided from a clinical perspective, and that had to be proved to have universal application; and one that was defined individually and that could reaffirm, resist or be completely detached from normative beliefs around recovery.

This distinction, argue Harper and Speed (2012, 13), ‘functions to effectively locate “personal recovery” as an adjunct to clinical recovery, and this complementarity avoids recovery being seen as inherently contested.’ This somewhat distorted the definitions of those like Anthony and Deegan, which policymakers and NHS services were themselves referencing. Recovery then was provided with outcomes, such as the ‘recovery star’³ rather than being a unique self-defined exercise. Arguably, as recovery began to be co-opted and incorporated into mainstream practices, radical demands coincided with, or indeed were diluted by, a government agenda of autonomy and individual responsibility (Braslow 2013). This was perhaps a result of the ‘plastic’ nature of recovery that was designed to be inclusionary unlike the exclusionary nature of the health care of the past. However, neither of these definitions of recovery incorporated a socially informed model of recovery, for instance one that emphasised how recovery was achieved by being in relation to certain ideas, people, organisations, rather than simply being a matter of individual choice and will.

A Culture of Trauma

The state intervention into recovery approaches to mental health is a recent development but one that can be traced to a longer history of 'moral treatment' (Rose 1985). Accounts of the rise of the recovery model often highlight the description of the York Retreat written by Tuke in 1813 as a turning point towards the humane treatment of mental disorder (see, for example, Carson et al. 2010) away from the Victorian asylums, now written about with much disdain as 'overcrowded,' 'awful' and 'appalling' places (Department of Health 2001). More significant, perhaps, was the development of thinking about the causes of mental illness that allowed for the changes in the provision for and care of people with mental distress. Rose (1985) has documented the rise of psychology as a discipline and its incorporation from the fringes of experimental pseudo-science to a domain of knowledge that increasingly came to influence and govern different populations from the military to children and families. The First and Second World Wars seem to have provided a catalyst for change over the twentieth century in the shifting perceptions of the cause and treatment of mental disorders. The emergence of the shell-shocked soldier has become a poignant figure that signalled this shift from understanding the causes of mental distress as moral and hereditary to a physical phenomenon (Leese 2002; Shepard 2002). Shell shock was remarkable in its indiscriminate reach, presenting as a cluster of symptoms previously viewed as specific to female hysteria (Appignanesi 2008; Leys 1994). The sheer quantity of cases of this non-physical trauma of war posed an interesting problem to the medical profession, which arguably paved the way for the first wide-scale intervention into the mental health of the population.

The treatment of shell shock was a key instance of mental illness becoming a matter of 'social hygiene' (Rose 1989). Mental disturbance produced from the experience of war rather than an inherited trauma based in family history, stimulated the experimentation with new behavioural therapies at places such as the Maudsley hospital (Marks 2012) that dispensed with Freudian heavy psychoanalytical approaches. With a strong need to get soldiers fit enough to return to the front line, behavioural therapies emerged amid an interest in treating

the symptoms instead of the mind, an approach that had a more materialistic understanding of mental distress. During and following the First World War, society witnessed the creation of specialist hospitals such as those at Maghull, the Maudsley, and Craiglockhart (Jones and Wessley 2005), the latter made famous by the *Regeneration* Trilogy by Pat Barker. Other notable developments included the opening of 'recovery homes' by the Ministry of Pensions and the formation of a national network of psychotherapy clinics in 1919–1920 (Leese 2002). Many of the doctors who treated shell shock during the war worked across the UK afterwards, so the new ideas in the relatively new specialism of psychiatry spread. It also cemented a new relationship between psychology and the military, where recruits had to undergo psychological screening for vulnerability (Jones and Wessley 2005; Shepard 2002). As Shepard (2002) has documented, this was rediscovered during the Vietnam War, giving rise to the establishment of Post-Traumatic Stress Disorder (PTSD) as a psychiatric disorder in the DSM III in 1980.

By the end of the twentieth century, through the impact of war and the growth of psychological expertise, understandings of mental distress had undergone a process of re-categorisation, witnessing the creation of legitimised categories of mental disorder. While there were obvious advantages to the recognition of PTSD, for Shepard, from this 'rediscovery' of trauma emerged a whole 'culture of trauma' that saw for example debriefing by counsellors after traumatic events as common practice (Seeley 2015) and a rising interest in real-life trauma stories as a form of media entertainment. This culture of trauma involved not only a reconfiguration in clinical and academic understandings of mental distress but also promoted particular modes of recovery, significantly that of talking therapies, setting the appropriate environment for notions of psychological recovery that proliferate today.

Glyde (2014) described the 'recovery industrial complex' embodied in the powerful ethos of Alcoholics Anonymous (AA), established by recovering alcoholic Bill Wilson in 1935 originally with an evangelical Christian and overtly masculine overtone, where the solution was for religion to replace addiction. Central to the recovery industrial complex is the telling of individual stories of trauma, underlined by the

therapeutic belief that the narration of stories enables one to heal and recover from trauma. Trauma has been described as marking the disjunction between the event and a belated incomplete understanding of the event (Caruth 1995). It is implied that the cause, or perpetuation of, mental trauma is not having a coherent story and so cures of mental distress are often directed at enabling people to find a story (for example in the treatment of PTSD). This is demonstrated in psychodynamic treatment where the construction of case histories is used to provide meaning and comprehension of events and thus recovery (Goody 2006). This ethos of psychological recovery, a recovery made possible through the telling of trauma, is evident from self-help recovery groups such as AA to the industrial complex that is Oprah Winfrey promoting her own brand of self-help and empowerment through her talk show and various books (Travis 2009). Psychological notions of mental distress and recovery in turn permeated popular culture influencing the way people publicly expressed and managed emotions such as grief, as I describe next.

A Private Vocabulary for Grief

Narratives of Grief

A culture of trauma encouraged the expression of individual stories and developed a captive audience for accounts of traumatic experiences such as grief. In this section, I juxtapose the modern rationality of medicalisation with the burgeoning creative use of grief in literature, a mode of making sense of grief that embraces a sentiment more reminiscent of the Romantic period. Hockey et al. (2001) have documented the influence of romantic ideology on mourning practices, where responses to death were increasingly understood through an emotional paradigm. If the modern 'rationalisation' of grief, which has given rise to psychiatric classifications, can be understood as a product of enlightenment thought, the popularity of the grief memoir might be viewed as a continuation of the romantic individual and emotional expression through literature.

In 2015, several of the most prestigious book awards were won by autobiographical accounts of grief and bereavement. *The Iceberg* written by Coutts (2014) who won the 2015 Wellcome book prize and Macdonald (2014) who won both the 2015 Samuel Johnson prize and the Costa book award for *H is for Hawk*, received critical acclaim for their depictions of grief over the loss of a husband and father, respectively. The success of these titles evidences the continuing popularity of grief as a theme for literature. These titles are not anomalies; the bereavement memoir remains a consistent bestseller. Lewis's (1961) *A Grief Observed*, first published in 1961 was republished in 2016 as a new edition and has been adapted for film and theatre. Other popular titles include Didion's (2006) *The Year of Magical Thinking*, Wild (2012) by Strayed (and accompanying film) and *The Long Goodbye* (O'Rourke 2011). As well as fictional work like *Grief is the Thing with Feathers* (Porter 2015), the post 9/11 grief of *Extremely Loud and Incredibly Close* (Foer 2005) and classic depictions of grief in Shakespeare's *Hamlet* and Bronte's *Wuthering Heights*, and even the place of grief in J. K. Rowling's *Harry Potter* series. Not to mention the great canon of elegiac poetry which serves to provide consolation from grief through its accurate expression of the emotions.

Why might people be drawn to writing about grief? In her memoir describing the death of her mother, O'Rourke (2011) wrote her 'pervasive loneliness' was the result of 'the privatisation of grief.' To write about the experience of grief is both to find a way to express the 'unsayable' of death (Watkin 2004), and to make public what is felt to be private. Arguably, the popularity of such written accounts of grief fills the gap left between the modern divide of life and death, a gap that the authors such as O'Rourke (2011) claims are not adequately fulfilled by professional grief literature. When the understanding that grief is a 'taboo' persists, then writing openly about an experience like bereavement enables people to connect to otherwise hidden and silenced stories: they offer guidelines to recovery. Dennis (2008) in his analysis of contemporary bereavement memoirs described how grief accounts become 'vehicles of information and instruction for fellow citizens in the community of grieving' (802). The autobiographical account thus acts to provide a map for others in their navigation through the liminal

space of grief, arguably offering some form of consolation in learning that someone else has also endured a similar sense of pain. Dennis outlines six narrative dimensions of the grief memoir: restitution (trying to fix things), evaluative (positive reappraisal), interpretive (making sense of it), affirmation (of deceased, of continued relationship), affective (emotional disclosure) and transformation. The well-established narrative outline provides a ready format for the reader to make sense of their loss.

Grievers also turn to language, metaphor and the imagination to find expression for their emotions. Metaphors are often utilised in writing about grief, for example Porter (2015) in his short novel *Grief is the Thing with Feathers* conjures the image of the Crow, famously the talisman of choice for the poet Ted Hughes. In his story of a bereaved partner and father and his two young sons Porter draws on the idea of the crow as 'stronger than death' and the echoes of Hughes' 'Crow,' who becomes the healing force in the story. A bird also plays the healer, in this case a literal bird, in McDonald's memoir of grief in which she decides to train a Goshawk. In explaining her actions, she remarked: 'You can't tame grief, but you can tame hawks' (Willoughby 2015). In both books, the birds, whether fictional or real, become symbolic of the grief which they cannot express but also provide a model of being; McDonald explained: 'The hawk was everything I wanted to be: solitary, self-possessed, free from grief, and numb to the hurts of human life' (Macdonald 2014, 85).

In the grief memoir, the author and their feelings are made prominent, and so rather than a 'death' of the author (Barthes 1967), the biographical details of the author are especially relevant. The grief memoir plays a cathartic role for its author. The drive to write about one's grief is not always made explicit, more often it is assumed that writing and claiming one's narrative is automatically healing. Finding the words to tell one's story has a central role in the politics of, and recovery from, trauma. Grief is widely believed to be an event that disrupts an individual's 'self-narrative' (Neimeyer 2005). This is a belief that rests on a further assumption: that each individual possesses his or her own 'narrative-identity.' Creating a story about illness or grief, remedies the disruption of personal self-identity caused by traumatic experiences.

Coutts described the process of producing *The Iceberg* as one of ‘writing against annihilation’ (Law 2014).

What has been described as a ‘narrative turn’ in the social sciences sought to acknowledge how telling stories is ‘universal’ and that human beings understand and make sense of their lives in narrative (Bury 2001; Clandinin and Connelly 2000; Frank 2010; Squire 2005). Gilbert (2002) states that humans are ‘naturally orientated’ to storytelling and use narrative and stories to organise, bring order and structure experience. Constructing narratives is considered to be a ‘characteristically human’ process; the ‘narrative parsing and organisation of experience are rooted in our biology,’ claim Neimeyer et al. (2014, 487–489). The healing properties of narrative have been especially highlighted in studies of illness, and increasingly in grief and bereavement, where constructing a narrative is believed to repair disrupted identities and enable people to reconstruct their biographies (Bury 2001; Frank 2006). The emerging field of ‘narrative medicine’ (Charon 2006) has embraced the importance of narrative to understanding illness, placing emphasis on listening to the story of the patient as a means of producing a more humane and ethical medical practice.

Within the excitement about narratives there is a tendency to overstate the power of narration. Frank (2010), for example, enthusiastically describes the ‘exceptional’ nature of narratives, listing the functions of narrative: narratives connect people and enable membership of social groups; narrative is the means through which humans learn who they are and learn between good and bad actions. For ‘without stories, there would be no sense of action as ethical’ (Frank 2010, 665). Neimeyer et al. (2014) make a further leap inferring from a rather preliminary study using fMRI scans on people who had been bereaved (O’Connor 2005) to suggest that: ‘[t]he human penchant for “storying” events, to organise temporal experience in terms of plot structures with meaningful beginnings, middles, and ends, appears to be anchored in brain structures’ (Neimeyer et al. 2014, 487). Similar claims exist in support of the healing act of writing, where it is contended that ‘unresolved’ trauma can ‘easily spill over ... into our emotions and into the very way our immune system interacts with disease’ (Watts 2011, 8).

However, in his essay on oral and written storytelling, Goody (2006) demonstrated how narrative is not a predominant characteristic of adult intercourse in purely oral (non-literate) cultures. Contrary to beliefs that narrative is a universal form of expression, Goody argued narrative is less a universal human trait and more something promoted by literacy and the advent of printing, which introduced the fictional novel as a narrative form. In his essay 'The blob' Bloch (2011) described how humans possess a 'narrative level.' This narrative level is not an inherent mode of cognition as some psychologists might claim, but a form of learnt expression. Tilly argued that westerners (1999) acquired standard story packaging, causing individuals to organise experience in standard story form. He described a standard story structure as composed of a limited number of interacting, independent and self-motivated characters that make deliberate actions and possess specific motives, with the story located in time and place. Tilly and Goody both point out life histories do not just emerge automatically but are heavily constructed by the culture in which they are situated. The proliferation of narratives of grief is not merely the freeing of the truth about grief but the production of particular types of stories about grief. Moreover, it naturalises a type of self that demands personal and emotional expression.

The resistance of a standard story structure is also, then, a resistance to an easily classifiable identity. Ramazani (1994) has described how modern forms of elegy diverge from the late romantic tradition of death poetry as one of self-definition to an 'unmasking' of the poet. The modern elegist attacks the dead or themselves and refuses orthodox consolation in God or rebirth. Modern elegies tend not to achieve but to resist consolation, not to heal but to reopen wounds of loss. This melancholic form of elegy provides no answers or solace but is purposely resistant and recalcitrant. For example, Ramazani drew on a variety of poets including Seamus Heaney and Wilfred Owen who both refused to see any consolation in the deaths in the many victims of war, or indeed place faith in the recuperative effect of poetry. For Ramazani modern elegies are 'a compromise-formation in response to the privatisation of grief' (1994, 15–16). However, it would seem that in the act of refusing consolation, the modern elegy provides a different form of 'refuge from

the social denial of grief.’ The popularity of grief memoirs could be seen in a similar fashion in that even if written in the act of refusing recovery the act of writing provides its own refuge from the ‘impact of the thing’ itself, as Lewis (1961) described. Yet for writers or poets to find consolation in the act of writing is hardly surprising. The question remains as to how accessible such a vocabulary is and what ways people might use such vocabularies to make sense of their grief.

Telling stories and giving voice to one’s pain is a commonly accepted tool to provide liberation from suffering and oppression (Charmaz 1999; Charon 2006; Smith and Sparkes 2008). Yet, not all stories get to be heard and the act of storytelling reduces the forms of expression into ‘standard’ narratives, excluding those unable to articulate their stories. Creative writing and literature potentially provide a privileged site where grief and different expressions of grief are accepted, though access to this site is not available to all. Furthermore, the expression of grief through literature can be used not only as a source of consolation but as a form of ‘resistance’ to assumed notions of appropriate grieving.

Rational and Symbolic Explanations

Science and literature within modern society are divided along the lines of the public and the private and the two realms have served to reflect a divided face of grief. While science utilises psychiatric manuals and literature uses metaphor, I suggest that neither one should be seen to be filling a gap left by the other. Rather they both produce explanations about the same thing: grief. In this section, I present excerpts from interviews with bereaved people to address how people often draw on both rational and symbolic explanations, and at times inconsistent ideas, to make sense of their own feelings of grief.

I begin by exploring how participants retold the story of the death of their partner or family member and what explanations—both rational and symbolic—they drew on to make sense of their experiences. In their accounts, participants included descriptions of events and activities and also emotions and metaphors. The participants strove to narrate

a chronological and comprehensive story of the death and the character of their partner or family member, including fine details of dates and events. On the one hand, there was a need to confirm the truth of what happened when the person died, and yet on the other hand participants referred to signs and metaphors to help them make sense of the death and their feelings of grief. While most of the participants competently narrated their stories to me by drawing on narrative features such as plot, characters and metaphor, finding meaning in their experiences was a different activity to telling a story about it.

Many of the participants in their interview accounts addressed three key areas: the process of a partner or family member dying, the event of the death and the subsequent response to the death and feelings of grief. Following the setting up of the scene of death, participants continued to describe events that happened after the death and which were interspersed with their own feelings and often biographical information about themselves, their partner or family member that died and even other family members and friends. In line with Árnason's (2000) discovery, I argue the participants were constructing not so much a 'durable biography' of the deceased person, argued by Walter (1996), but a story of themselves and their relationship with their deceased partner or family member.

Most participants narrated their experiences using this structure with little prompting from me, the interviewer. Typically, I would begin the interview with a question that referred to a detail the participants had shared with me prior to the interview, such as, 'You mentioned your husband died four years ago?'. This led in the majority of cases to a description of the death; for example, Laura relayed to me how her husband died in this way:

He needed his medication so the two paramedics took him into the ambulance ... when I came down the ambulance was closed up and rocking and it was at that point he'd collapsed and he had, it turned out, a ruptured aorta ... Very traumatic. Massive shock. Went into shock for I would say six months. I functioned, I went, I was back at work, because we buried him, well cremated him on 6th January and he died on 22nd December.

The participants followed a largely chronological order starting with the story of the death and for some, the illness that may have preceded it. Rose, for example, wrote me a timeline of her life with her husband, that she emailed to me prior to our interview. ‘A compressed history’ she described it, which presented a chronology from when they met up to the year of his death. This sense of a need to be thorough in their accounts was common. At the close of the interview, Anne reached for some notes she had written beforehand to ensure she had told me all the details. For Anne, the death of her husband became a matter for a police investigation, of which she spoke at length. The question over the cause of her husband’s death propelled Anne into a search for the true sequence of events, as she explained:

He fell out of an office window. It was an accident. That’s what happened. He was closing it, and he fell four floors ... Now in fact what happened was he had fallen out of window, at his work, at quarter to seven at night. ... Your head—in the absence of information your head grabs at anything it possibly can to make it work, to make sense.

Following the death of her husband, Anne described the task of reconciling what she thought to be true about her husband with the alternative options suggested by the police investigation. In this excerpt from Anne’s account, it is possible to see how important it was for Anne to locate the story in time and place, as well to clarify the truth of what ‘in fact’ happened. In both Anne and Laura’s accounts, there was a reliance on—or need for—the ‘truth’ where the emphasis was on the maintaining the accuracy of the date, time and sequence of events. However, participants also readily drew on more symbolic means of making sense of death. For example, Rose, whose husband died 26 years prior to the interview, narrated the account of his death by drawing on signs and symbolic references:

37, both of us were 37. He was born on a Saturday, died on a Saturday. Born on third of the month, died on the third of the month. Born at

4.30, died at 4.30. And I even added to that, he was breech birth and the first thing I saw when I was coming down the stairs was his feet ... [W]hen we swapped the house and when we moved in, there was this vase of flowers on the table, now I don't know if you know of the, there's a superstition do not have lilac in the house because they'll be a death in the family, but there was lilac in this arrangement and I remember saying oh we shouldn't have, but I adore lilac so I left it and we got home and he died, there's a death in the family. It's not logical but you can't help but sort of go, it's weird.

Like Anne and Laura, Rose focused on the details surrounding the death, which she recalled even 26 years later. Yet this emphasis on the factual detail was given a symbolic meaning, so that in her narration Rose's husband's death appeared somewhat fated. In her description, Rose highlighted details such as the lilac in the house and endowed the superstition with meaning, even as she acknowledged, 'it's not logical.' 'Signs' from Rose's husband were present too after his death, and as I discuss in Chapter 6, her husband's presence remained very much alive in Rose's life.

While understanding and knowing the 'truth' of what happened was one part of the process of being able to narrate the story of bereavement and grief, it appeared that describing the internal experience of grief within a rational framework posed difficulties. Participants remarked that they found it hard to describe the feeling of loss, saying how 'complex,' 'ethereal' and difficult to 'quantify' grief was. Participants, therefore, often drew on metaphors to describe their feelings. Grief was described as a place of darkness where the 'light had gone out,' feelings felt 'dark' and 'black' and it was a place that people would move 'down' into. Spatial metaphors were present as Laura described widowhood as a 'very strange land' with 'no map.' Anne too explained her experience of navigating grief as being lost at sea:

I needed to try something, to catch at some sort of straw because I did feel like a little rubber duck in the most amazing storm at sea, no land, no light, just waves and lightning and thunder and no shore.

While grief was described as a place in which the participants had unwillingly entered, the individual bodily effects of grief were described as physical pain. For example, the pain of grief was described using physical descriptors such as ‘spiky’ and ‘stabbing’ and ‘raw.’ Anne detailed in visual terms the experience of grief and how she once thought it was just a ‘metaphor’ but discovered the bodily ‘affects’ of grief:

I always thought that was a metaphor, it’s not, it’s physical. My whole body cavity just screamed in pain and even now, when I’m stressed, my sternum feels like all my tendons are pulling off it physically. I just had to this view of the inside of my body being this black and splattered cavity where my heart and soul had just splattered into a million soggy pieces. And there’s an awful lot of, trying to stick pieces back together, and it’s still a right old mess.

The almost violent imagery conjured up by Anne portrayed a vivid picture of the embodied experience of grief. In the interview Anne drew on metaphors quite often to describe her feelings, acknowledging that she liked to use metaphors. However, I suspected that not all participants were as able to convey the embodied experience of grief through language, moreover in an interview setting. In Chapter 4, I describe the importance of safety the bereavement counsellors and support workers emphasised in the counselling setting, where the client was made to feel they were in a relationship that could hold the ‘unbearable’ pain of grief. When participants would state things such as: ‘It’s just awful’ or ‘the worst experience of my life’ I imagined they were referencing this ‘unbearable’ pain that was hard to quantify and articulate. Further, this was a pain the participants described as embodied, evidenced in a physical impact on the body causing symptoms such as sleeplessness, difficulty eating or as Anne described, a pain located around the sternum.

Therefore, the use of metaphors was one strategy that enabled participants to convey the experience of grief, yet there could be a limit to how much meaning could be made from the experience of grief. In Chapter 6, I discuss further the limits of language (and my chosen method of interviews) in expressing the ‘unbearable’ physical and emotional pain

of grief. While the participants would narrate what had happened, they also remarked how they had not quite understood what had happened. As John remarked over his wife's death:

Still can't understand why it's all happened, I still don't. I find it difficult to accept it, you know, when I'm daydreaming in a way. It's only when I think to myself, come out, snap out of it.

Speaking about the sudden death of her husband Tania told me:

Yeah it's a bit strange. I sometimes think now did all that actually really happen?

Listening to the participants' accounts of grief it was as though the rational—or at least those explanations that were available—had reached their limit when it came to explain the event of bereavement. Therefore, participants would use rational and symbolic explanations interchangeably, as demonstrated by Rose's statement above 'it's not logical but.' For Anne it was the nature of her husband's death for which she struggled to find any meaning:

It just doesn't make sense and, it shouldn't happen. We're in a first world country, we can do all sorts of things and yet we can't keep people safe in office buildings ... I never imagined that he wouldn't make it out the front door of the office.

As Anne highlighted, the death of her husband felt nonsensical in a 'first world country' where she felt accustomed to the idea that she and the people around her were relatively safe from immediate threats to life (at least in office buildings). The experience of her husband's death thus challenged Anne's whole belief system, her sense of ontological security. Anne went on to explain how she had lost her faith as a result, unable to 'compute' the death of her husband:

The thing is through this process, well, I lost all my faith. The point is whether you suddenly start seeing signs in everything that drops from

the clouds or every rainbow, you either go one way or the other. You either talk about people looking down from heaven and meeting you again or you say no-one could allow that to happen it can't be ... And there is, even four years later I can say to myself what? How on earth? That can't be right, that does not compute.

Anne's 'assumptive world' (Parkes 1972) following the death of her husband, had been transformed. Anne was then left to search for a new sense of meaning. In doing so, she referenced the use of signs and heaven that she acknowledged other people might use to make sense of death but found them unsatisfactory. Yet Anne still relied on some wider meaning to the universe even as she described she no longer believed in the idea of God. Instead she found some meaning in the idea of 'multiverses,' which enabled her to believe the energy and soul of her husband was not destroyed but potentially existing in another dimension.

Despite the individuality of grief, it was interesting to see how the narration of the experience of grief was situated in relatively few 'domains.' Rosenblatt (2000) in his study of parents' narratives of grief found that what the parents talked about fell within a limited number of domains including the moment of death and events following the death and finding meaning and managing feelings. Participants did find various meanings, some of which I have described above, for example, Rose's signs and superstitions and Anne finding comfort in science and multiverses. As I described earlier, the growing medicalisation of grief that seeks to provide a scientific rationale for grief has left individual expressions of grief the preserve of literature and autobiographical accounts. Bennett and Bennett's (2000) study of bereaved participants who experience the presence of deceased people found that the participants interpreted their experience of the presence of a deceased person through both a scientific and supernaturalist interpretive framework, opting for a different discourse depending on the circumstance in which they provided their account. These accounts of bereavement suggest a disjuncture in the public narration and private experiences of grief.

In this section, I have discussed how bereaved people used a mixture of both rational and symbolic explanations to describe their experiences

of bereavement and feelings of grief. For instance, Rose described the signs that suggested her husband's pending death, signs not of a medical nature but of a vase of lilac and how it symbolised death in the family. Anne made reference to the story of Harry Potter by J. K. Rowling to symbolise the transition of her husband to another world. Further, Anne told me that although her original religious faith had diminished following bereavement, she believed in multiverses, and that her husband's spirit lived on in a different dimension. For some, the grief theories resonated, others found comfort in spiritual ideas. So, while the public narrative of grief appears to give a clear outline of stages and tasks, in the daily experience of grief people used a variety of discourses to make sense of grief. This creative exploration of meaning-making reaches its limit however when one fails to make sense of grief. In the next section I want to draw further attention to this struggle to piece together a satisfactory story through the account of John, to consider the effects of being unable to find the right story.

Failing to Make Sense of Grief

As alluded to earlier, telling stories and giving voice to one's pain is a commonly accepted tool to provide liberation from suffering and oppression (Charmaz 1999; Charon 2006; Smith and Sparkes 2008). Yet, not all stories get to be heard and the act of storytelling reduces the forms of expression into 'standard' narratives, excluding those unable to articulate their stories. Creative writing and literature potentially provide a privileged site where grief and different expressions of grief are accepted, though access to this site is not available to all. Furthermore, the expression of grief through literature can be used not only as a source of consolation but as a form of 'resistance' to assumed notions of appropriate grieving.

What struck me about John's account was his need to find coherence in what happened and the struggle he encountered in living in the face of incoherence. Rather than viewing this necessarily as a biological need to narrate, I suggest the dominance of certain narrative forms in western cultures can serve to isolate experiences and events that lack a resolution and

cannot be easily assimilated into a linear pattern, as anomalous or problematic. Here I present John's search for coherence and his need to find a satisfactory line of reasoning for his wife's death. John's wife died after a short period of illness of terminal cancer. Due to the speed of events, John found it was six months after her death, at the point of interview, that he was going over the details of the death and questioning things:

I'm finding it harder to accept that than I did straightaway. But it was very quick, it was literally from October, 30th October to the 5th March so it was, barely four months ... and I just feel that it's hard that someone who's looked after herself so well, she didn't smoke, hardly drank, kept herself fit, ate the right things and wallop done completely, completely wiped out in four months.

John highlighted details about his wife's lifestyle such as being fit, eating well and being a non-smoker that did not fit with the broader narrative of dying of cancer. John reflected on the things his wife could have done differently saying he felt 'let down' that, as a nurse, she failed to look after herself like her patients. In retrospect, John could see the signs of his wife's stomach pain and how they 'missed' them. He described how now he had the urge to go over the details of his wife's death to solve the puzzle of why she died:

I keep on looking at it from the point of view that we should've been able to see it coming you know. There should have been some indication that, what did we miss, what did I miss, what did my wife miss ... And I kept everything at home, I've kept all the paperwork and we tried to make notes about what people were telling us. ... I did think about trying to write it all down and try to do some sort of putting it all in chronological order and try to make some sense of it all ... At other times I think to myself well would that do me any good in a way, would it just all bring it, bring it up again and then I'd be left with, what would I do with it then you know. So, it's a bit of a conundrum really.

John appeared to oscillate between the two plans of action: to sit down and make sense of it or to accept he could not do anything about

it. It was clear though, evidenced by his wrestling over this conundrum that living with uncertainty was not a comfortable place to be. I asked John how it felt to potentially live with and accept things might not be resolved, he replied:

Well, I'd rather be clear in my mind where things stood, well you know what the problem was, how it came to be, all those issues. But I just think they're all, well a lot of them are beyond, beyond resolving in effect. You can't do that now. So, I'm just, it's something that I'm pretty certain that I'm just going to have to live with really. Have to sort of say well that's it I just can't take that any further and sort of try and get on with life.

Without an acceptable story of what happened John found he was lacking a resolution that had forced him into what I have called a (liminal) space where it was not clear where 'things stood.' In this liminal space, as John ruminated on his recent past, he was unable to go forward and 'get on with life.' He explained how without this resolution about what had happened he could not make sense of the present or the future:

It's when you start looking back isn't it, when you, you can put some sort of picture to it all and I think that's probably one of the problems at that moment is that I can't do that. Because my life has changed so much with my wife passing away that until I've got a little bit of history that I can look back on and sort of judge where I am at that, whatever, time. Whereas at the moment I can't do that.

I argue that the absence of a 'little bit of history' meant John could not locate himself in the present and make sense of his life without his wife. Living with unanswered questions John was left with a tenuous attachment to the present where, on the one hand, he recognised he had to just accept and live with it and yet, on the other, the desire to know and make sense remained strong. This sense of ambivalence however was not easy to overcome. John acknowledged the only resolution was then to settle for the absence of an answer:

And I suppose I'll have to get over that because there's no way round it, I can't, I don't, it'll never be solved that question. I'm never going to resolve it, it's just a feeling I've got and I'm going to have to live with it. Can't, I can't, no-one's going to say, no-one's going to come up with an answer to that problem, I'm just going to have to accept that it's happened and just get on with it really. Hard. Very hard.

It seemed that not having a coherent story placed John outside linear time where he could not rely on a past and a history that made sense from which to locate himself in the present. Instead, John was in a cyclical mode of time, taking each day as it came. This was the only way to manage living on where the past was unclear, and the future was uncertain. Without a story, settling for uncertainty and liminality was the only option. Crafting a clear story about the death was one mode of bringing coherence and understanding to an incomprehensible event. However, the focus on narratives hides the struggle to find a story as described through the account of John, and disadvantages those that lack the language, ability or desire to construct a narrative and allow it to be heard. Living outside of this linear narrative structure meant the need to build familiar structures in daily life through routine and physical activities became increasingly important, as I describe in the next chapter.

Public and Private Narratives of Grief

This chapter has covered a variety of cultural, political and personal factors that frame the meanings of grief and recovery. The space of grief and recovery is a terrain mapped by changing guidance and discourse, from the role of psychiatric diagnosis of mental disorders, the politics of happiness and the transformation of mental health policy, to autobiographies and individual narratives. In this enquiry I have sought to delineate two themes shaping notions around recovery, emotions, and grief. The first is the appearance of an increasing medicalisation of mental distress and an unprecedented intervention of the government

into the private and emotional lives of the population. The second is the acknowledgment that alongside this there is a celebration of the individuality and diversity of grief experiences through the proliferation and consumption of individual stories and narratives.

Making sense of grief is a public enterprise, and grief is framed within a modern post-enlightenment discourse that values scientific understandings of health and the emotions. The need for a meaningful story relies on an understanding of the world and the self that is always coherent and comprehensible. In this view, people need to find meaning or be assisted to find meaning; there is no option to decide that grief and death are without meaning. Not finding meaning in grief thus becomes problematic to the public narrative of grief where there is little space for unhappy emotions or stories without a resolution. Further, while making sense of grief is both a formalised activity and increasingly about individual choice and creativity, not all stories are permitted in the public narrative. Grief stories are then categorised into genres where those who fail to recover, or otherwise grieve in a way that could be described as complicated, become worthy of features in newspapers that highlight how certain stories of grief are disagreeable (McQuire 2015; *The Mirror* 2017; Moore 2014; Parris 2009).

The complicated griever, the wealthy but unhappy, the traumatised soldier, are some of the figures discussed in the first section of this chapter. These figures, through the discourse of recovery have found themselves bound to new authorities in the name of freedom, a relationship all the more subjectifying because the guidance offered appears to emanate from their individual desires (Rose 1989, 17). There is, however, the echo of resistance against this 'obligation to be free,' a resistance often voiced through stories and narratives. However, this is a resistance that embraces the forms of individuality and self-expression produced by the type of governmentality against which it is reacting. The privileged site of literature provides a platform for a variety of grief expression but arguably, it is a platform gained by learning how to tell the right stories.

Taking into account Frank's (2010) argument that narration is a moral impulse, not having a narrative or story about oneself and

one's experience apparently has a high price. In this line of argument, the refusal to narrate one's experience of suffering is a refusal of the moral implications of what counts as 'fundamentally' human. Within the recovery model of mental health, the experiences of service users are increasingly presented by mental health services as stories of recovery (Carson et al. 2010; Central and North West London NHS Foundation Trust 2014). However, a growing number of service users have argued that their stories have been sanitised of elements of resistance and incorporated into a neoliberal agenda (Costa et al. 2012; Rose 2014). For these mental health service users, the truly radical move now is to remain silent about one's 'story' and refuse to narrate one's life and experiences (Costa et al. 2012).

This resistance to storytelling has resulted from the realisation that telling one's story can have limited reach in producing change. I argue too that for the bereaved participants the ability to narrate their experiences of bereavement was different to finding meaning and resolution, or to producing tangible changes, either internally or externally. Grief posed a problem that could not be resolved, offering only an ongoing and never-ending process of adjustment. Grief was an experience and feeling particularly resistant to the format of the linear narrative, even as the bereaved participants worked within those structures in their attempt to provide an account of their experience in the interviews.

This need to make sense of grief in order to recover was presented in John's account, where the obligation to make sense was somehow at odds with his desire to remain mulling over the events of his wife's death. John felt the need to write down the timeline of his wife's illness and death in the hope that in doing so he would have a clearer understanding of, and perhaps an answer to, what had happened. Similar sentiments appeared in bereaved participants' accounts; disbelief at the death and dissatisfaction with the medical or other authorities to effectively manage, prevent and make sense of the death. As they described it, it was the apparent failure of such external authorities that hindered their ability to make sense of the death. The authorities that people might turn to in order to make sense of death, such as medical professionals, had failed to provide a satisfactory discourse that enabled the participants to make sense of death. In a modern culture where death

cannot be left without a medical cause, the failure to find meaning in grief, and resistance to fitting experience into a meaningful narrative, produces the same outcome of ‘non-recovery.’

Notes

1. The five ways to wellbeing: connect, be active, take notice, keep learning, give. Further details available at: <https://neweconomics.org/2011/07/five-ways-well-new-applications-new-ways-thinking>.
2. List of Recovery College providers available at Mind Recovery Net: <http://mindrecoverynet.org.uk/providers/>.
3. Triangle Consulting Social Enterprise Limited. 2008. “Recovery Star: The Outcomes Star for adults managing their mental Health.” Further details available at: <http://www.outcomesstar.org.uk/using-the-star/see-the-stars/recovery-star/>.

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