Remarkable lives: Caitlin Jenkins in conversation with Jerome Carson.

Abstract

Purpose – The purpose of this paper is to offer a profile of Caitlin Jenkins.

Design/methodology/approach – Caitlin gives a short biographical account and is then interviewed by Jerome. Areas covered in the interview include her interest in psychiatric diagnosis, the helpfulness of counselling and personal narrative.

Findings – Caitlin believes that her recovery was only really possible when she was allowed to tell her own story, to be allowed the time and space to talk about events in her life. She mentions how psychodynamic therapy and CBT prevented her from truly exploring her personal story.

Research implications/implications – While this is of course one person’s account, it will find resonance with many others.

Practical implications – Reinforces the central role of narrative and its role in personal recovery.

Social implications – It stresses the importance of a truly therapeutic relationship. As Caitlin states, this enabled her to begin “joining the dots of my experience to construct a meaningful personal narrative.”

Originality/value – Counselling is often undervalued in contrast to more established therapies. This account demonstrates that what really matters to many individuals recovering from mental health problems, is being listened to and being helped to make sense of their experiences.

Keywords Recovery, Psychiatric diagnosis, Counselling, CBT, Narrative, Compassion

Paper type Viewpoint

Introduction

I met Caitlin after I had given a lecture to first year undergraduate Psychology students. She asked whether having lived experience of mental health problems would prevent someone from embarking on a career in Clinical Psychology. I immediately thought of the published stories of clinical psychologists like Rachel Perkins, Rufus May and Emma Harding (see Davies et al., 2011 for their individual stories). While years ago I would have thought this to be very difficult, because of the bravery of many psychologists and other mental health professionals in
coming out about their own mental health problems, I now see this as in many ways an advantage. I am sure Caitlin will go on to become an exceptional Clinical Psychologist.

**Brief biography of Caitlin Jenkins.**

Last month I walked into one of the meeting rooms at *MhIST*, a mental health charity in Bolton. The eclectic assortment of chairs arranged in a circle was immediately familiar, bringing to mind any of a number of similarly furnished rooms set up to accommodate the mixed bag of professionals likely to attend a Care Programme Approach (CPA) review.

I have lost count of the number of CPAs I attended as a patient, occupying the uncomfortable focal point in a room full of experts. On some occasions—I realise now—I sat through meetings that I wasn’t aware were CPAs. This wasn’t because I was too ill to comprehend the meaning of these gatherings but because nobody told me that’s what we were all doing there. When I did know I was attending a CPA review I was initially baffled by—but quickly became resigned to—the number of professionals in attendance that I had never seen before—and might not see again! Sometimes these people were introduced and sometimes they weren’t but it didn’t really matter either way as far as I was concerned. Inside my bell jar (Plath, 2001) I had long relinquished any sense that I might have some say in my own destiny.

I was introduced—and introduced myself—to the collection of people in the meeting room at *MhIST*. We were not there for anybody’s CPA review, but to discuss possible research collaborations between *MhIST* and the *University of Bolton*, where I have just finished the second year of a Psychology degree. One of the topics on the agenda was my final year project. I was surprised to hear myself talk easily and with some confidence about my planned research in which I propose to explore lived experiences of psychiatric diagnosis from the perspectives of the people being diagnosed.

Diagnosis plays its part but is certainly not the whole, or most important feature, of my personal journey into mental illness and beyond. For me diagnoses—to quote Sinatra: “I’ve had a few”—tended to feel a bit arbitrary and at least partially dependant on which psychiatrist happened to be treating me at the time, and when and where I was being treated. While I don’t doubt that there was a *sense* to my symptoms (Freud, 1991) in terms of *DSM/ICD* diagnostic categories, my symptoms didn’t entirely make sense.

From my teens onwards low mood, fluctuating motivation, intense feelings of hopelessness, guilt, self-loathing and thoughts of suicide all pointed to a depressive disorder. As an undergraduate Literature student at Oxford, anxiety and obsessive compulsions took hold, suggesting OCD might accompany—or have usurped—depression. At their worst these frightening and invasive symptoms bordered on psychosis: I recall sitting on the lawn with a friend at New College trying to communicate something about my peers by tracing letters on the grass with my finger rather than speaking aloud because people could see, hear and were watching me. Talking of bordering on something, my recurrent self-harm and episodes of
dissociation were thought by more than one professional to signify possible Borderline Personality Disorder (BPD) or Post Traumatic Stress Disorder (PTSD). At least I think that’s what they thought—my understanding of my ever evolving diagnosis is retrospective. I don’t think anyone ever sat me down and told me what they thought was going on. My notes tell a story of their own that at times (I feel) bears little resemblance to my own experience. Regardless of what was surmised by others, I experienced this failure to fit neatly into any single diagnostic box as just another in a long series of failures that were coming to define me. I and some—but by no means most—of the professionals I encountered began to suspect that I might be difficult, awkward or unhelpfully complex. This intensified my feelings of guilt, self-loathing and hopelessness. More than anything I didn’t want to be any trouble.

From my current vantage point I understand that my confusing array of symptoms was never going to make complete sense until I was allowed to tell the story of the events of my life to someone who wanted to listen without judging me or rushing to fix me. The sense to my symptoms lies in a much fuller biography which I have no desire to share—it’s too personal. What I can say is that following my third and most serious suicide attempt—and penultimate admission to an acute psychiatric ward in 2008—things finally began to change.

I count myself incredibly lucky to have been offered individual counselling—of no particular denomination—to continue for as long as I needed it. This time and space proved crucial to my recovery. I couldn’t begin to make sense of the things that had happened without recounting them as events—this is what happened, and then this, then this—joining the dots of my experience to construct a meaningful personal narrative. My counsellor Sue wasn’t especially interested in what my symptoms signified diagnostically but was concerned about how I felt and the sense we could make together of the knotty thread of my life experience. By telling my story I was able to simultaneously own it and let it go. I began to find space in my head to start thinking about living.

I didn’t really live between the ages of 19 and 30. My identity during that time was entirely bound up in the role of psychiatric patient. Another professional I am lucky to have met was Lindsey, an Occupational Therapist. By asking me about my roles—I couldn’t identify a single meaningful role for myself in 2008—Lindsey gently alerted me to the fact that my life had become unbearably small and without purpose. With her support I started voluntary work, just half a day a week at my local Age Concern shop. It was more than enough to start with but by taking small steps—sometimes backwards, often forwards—I have forged a life for myself so that I can now identify multiple roles. I am a student, an employee, a partner to Julie, a friend, a daughter, a sister, an auntie and—recently—a godmother. I am more than a survivor; I am luminescent.
Caitlin in conversation with Jerome.

Jerome. You are studying for a Psychology degree. What do you hope to do after you graduate?

Caitlin. I would like to train as a Clinical Psychologist. I realise that’s a tall order—starting with just getting a place on a course—but I’ve already come so far. When I returned to HE after 13 years away I questioned whether I would be able to manage the pressures of full-time study—but I’m doing it. I’ve also been getting plenty of work experience as a support worker which at times has been more challenging than my degree course: engaging with service users in a way that both supports and enables is no mean feat! I’m particularly enjoying working with people with profound learning disability who cannot communicate verbally. There’s something about non-verbal communication that feels very special. It requires imagination, patience and persistence—and the underrated ability to stop talking!

Jerome. For your Final Year Project you have chosen to interview people with lived experience about their perspectives on psychiatric diagnoses. What has made you decide to focus on diagnosis?

Caitlin. Nothing very mysterious—my own experiences of diagnosis have been painful, confusing and traumatic. Psychiatric diagnosis is a prime example of someone else’s choice of words having huge power over an individual’s life. I’m not sure whether clinicians are fully aware of the impact diagnosis can have. My research also suggests that diagnostic categories—or dimensions—are typically founded on expert consensus about what constitutes a mental illness. I find this alarming—too few people have too much power in this area—and the stories that doctors tell can suppress the stories of patients (Cohen, 2008).

Jerome. You found counselling to be helpful in coming to terms with your problems? What do you feel is especially helpful about counselling as opposed to say CBT or psychotherapy?

Caitlin. Counselling worked because it started with me and the events of my life. To make sense of where I was I needed to understand where I had been. I am wary of approaches that impose too much theory on a person who is struggling. I experienced psychodynamic therapy as a teenager and found it quite baffling. Nothing was as it seemed—or that’s how it seemed to me! I felt tangled up in knots. In contrast CBT seemed to want to make me better without wanting to know why I had become unwell; the focus on maladaptive thought processes felt presumptuous. My faulty cognitions made a great deal of sense in the light of the things I had experienced and proposing to remove or reshape them without considering their origin felt invalidating and reckless. I needed someone to hear, believe and acknowledge the things that had contributed to my fractured sense of self and to allow me the time and space to talk about and begin to recover from them.
Jerome. You talked about constructing a meaningful personal narrative. Why do you feel this is so important?

Caitlin. Stories are clearly important—we can’t help but shape narrative whenever we meet, talk and write. Stories have helped us to make sense of who we are for centuries. But my experience of psychiatric intervention was—typically—that my personal story didn’t really matter and that dwelling on the past was part of my problem; there was something self-indulgent about my wanting to tell my story. Actually I didn’t want to dwell, I didn’t want to linger in the past but I needed help to acknowledge that who I was in the present had indeed emerged from previous experiences. I needed to tell my story because despite my best efforts to move forward, unvoiced my story kept coming back to haunt me. It really bothers me that the treatments of choice today—medication and/or brief CBT—so neatly sidestep such stories.

Jerome. What changes would you most like to see in mental health services?

Caitlin. Services are overstretched and even the best practitioners do not have the time or resources to offer consistently comprehensive, individually tailored support. I don’t know the answer to this problem which, at least ostensibly, is a financial one. Peer support is an important alternative and offers something special and unique, but should complement rather than replace good quality professional input. Clarity of information matters too: so often during my mental health journey I didn’t know what was happening or why and my own care felt shrouded in unnecessary mystery. Better communication generally—and I mean listening as well as talking—support should consist of dialogue.

Jerome. What are your views on the use of medication for mental health problems?

Caitlin. I’m glad you asked that because I’m in something of a quandary with this one. I firmly believe that the combination of psychotropic medicines I take—and have been taking for some time—have improved my mental health. But why are they working now and when many others didn’t? And why do I still experience symptoms sometimes? My own experience aside, the actual evidence for the therapeutic effects of psychiatric medication is—at best—debateable and the influence of pharmaceutical companies on prescribing habits extremely concerning (see Davies, 2013 for an overview). The best I can say is that medication may have a place for some people at some points but like any other treatment should be considered carefully and in relation to individuals.

Jerome. Have you been inspired by any mental health professionals?

Caitlin. Many-while being appalled by others! Several people come to mind immediately, all nursing assistants on the front line of acute inpatient care. I have met wonderful nurses too and my current psychiatrist is a gem but this is not an Oscar’s speech! During my first hospital admission in Oxford I was cared for by a gentle giant called Geoff. Withdrawn from a world I hated and feared Geoff convinced me to walk round the hospital grounds with him (I drew the line at the game of Ping-Pong he suggested initially!) Refusing my own shoes and without my glasses on (what was the point in either?) he insisted that I wear his own enormous flip-flops when the path petered out. Geoff embodied compassion.
Jerome. In terms of people with lived experience, which individuals have impressed you?

Caitlin. My partner is a survivor of serious mental illness and so are some of my closest friends—all women that I admire greatly and who share qualities like resilience, intelligence and wit as much as a psychiatric diagnosis. Sometimes hearing people talk about schizophrenia in hushed terms as the most devastating and debilitating mental illness frustrates me: this just is not the whole story! Like any serious illness schizophrenia can be devastating and debilitating but the people I know who have been thus diagnosed are so much more: friends, partners, mothers, volunteers—people who achieve so much.

Jerome. What challenges lie ahead for you? What do you most want to achieve in the future?

Caitlin. Getting onto a postgrad clinical psychology training course! I keep hearing about the bottleneck—lots of jobs but very limited scope for training. I will just have to continue to work hard and hope that my three pronged plan of attack—first class degree, plenty of work experience and my own lived experience—will be enough. My other ambitions are more personal: stay well, manage the times when I am unwell as best I can, sustain authentic and meaningful relationships with the people I love, try to be kind, fair and wise, read lots...I think that’s enough to keep anyone busy for a lifetime!

Jerome. What would you most like to be remembered for?

Caitlin. I saw Eddie Izzard perform in Manchester a few years ago. He quoted somebody—I can’t remember who—as saying that if at the point of death you can look back on your life and feel that the world was better for you having been in it than not, then yours was a life well lived. What matters is what I do now; after that I am quite happy to be forgotten!

Conclusion

Caitlin’s story is testament to the power of personal narrative, though in parts shows the lack of power many service users feel. As she states, “Inside my bell jar, I had long relinquished any sense that I might have some say in my own destiny.” As with many accounts key individuals helped Caitlin recover, from Geoff the mental health nurse, whom she describes as a “gentle giant,” to Lindsey her occupational therapist and probably most importantly, her partner. I somehow doubt that Caitlin is someone whom we will forget. Rather I suspect she is an individual who will touch the lives of many.
References:


About the authors

Caitlin Jenkins is in the final year of her Psychology degree at the University of Bolton, Bolton, UK.

Jerome Carson is Professor of Psychology in the Education and Psychology Academic Group at the University of Bolton, Bolton, UK.

Corresponding author

Professor Jerome Carson can be contacted at: J.Carson@bolton.ac.uk