Department of Psychology

The Practice of Mental Health

Class Habitus, Discourse and the Symbolic Framing of Subjectivity

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Submission Date: February 26, 2026

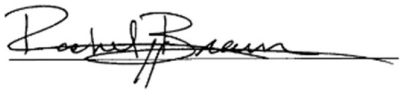
Thesis submitted to the Department of Psychology, Faculty of Science and Engineering, in fulfilment of the requirements for the degree of Doctor of Philosophy.
Maynooth University, Ireland

Table of Contents

List of Tables and Figures

Declaration of Originality

I declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university or other institution of tertiary education. Information derived from the published or unpublished work of others has been acknowledged in the text, and a list of references has been provided.

Signature: 

Date: February 26th, 2026

Acknowledgements

First and foremost, I would like to express my sincere gratitude to my supervisor, Dr Michael Cooke, for his enduring support in all aspects of my PhD. From our very first meeting, I was struck by his breadth of knowledge and expertise as an academic, and it was with him that my true education began. He has challenged my intellect and, at times, my patience, but always did so with kindness and civility, guiding me to reach my full potential. Dr Cooke is the highest character of a human being with unwavering integrity and is a true gentleman. Not only has he been more of a supervisor than I could ever have hoped for, but Michael is now my mentor and friend. For his guidance, encouragement, and kindness, I will be forever grateful.

I would also like to acknowledge the staff of the Maynooth Department of Psychology, who provided me with the foundation of knowledge and skills on which this thesis was built. From my undergraduate studies to completing my master's degree and throughout my PhD, the lecturers and support staff were always supportive and provided kind words of encouragement. In the same vein, I must thank my post-graduate peers, who, like no others, understood the pressures I was enduring and, with humour and hugs, made this a very enjoyable endeavour. Their kindness and camaraderie will be missed.

A very important thank you goes to my family, my husband, Sean, and my two daughters, Eva and Claire. They had no idea that when I returned to education ten years ago, they would be coming along for the ride, and they have been by my side the whole time. I dedicate this PhD to them for their love, patience, and support. I would also like to thank my family in California, my parents and siblings, who sent encouragement across the miles. I know I have made all my family proud, and their pride in me touches me deeply.

Finally, I would like to show my appreciation to the participants of this study. They generously gave their time and shared their experiences with me, and I am honoured that they trusted me with their stories. Throughout the interviews, many of the participants expressed that what this PhD was about was important and needed to be researched. More than that, they wanted their stories to be told and heard, and that, in doing so, change may occur. Without their generosity, this PhD wouldn't have happened, and I hope that what I have produced, what this research means, honours them.

Abstract

A substantial body of research indicates an inverse relationship between social class and mental health outcomes, with lower SES groups more likely to be diagnosed with a mental health condition. Yet, the dynamics of this relationship remain unclear, as despite social mobility and mental health interventions for marginalised populations, research suggests a continuation of class-related inequality relating to accounts of mental health, indicating that this relationship cannot be explained by socioeconomic conditions alone. This study explores how class habitus, understood as the embodied and durable dispositions, tastes, and manners of acting, thinking, and feeling, acquired through classed socialisation and conditioning, operates as a key factor shaping mental health experiences. A qualitative study was conducted using semi-structured interviews with participants (N=14) from distinct social class backgrounds, producing in-depth qualitative data. Analysis was initially carried out using reflexive thematic analysis to identify key themes. A more in-depth critical discourse analysis informed by Bourdieusian and Lacanian theory was done, focusing on the role of language and key signifiers in the construction of these themes. The analysis indicated that class habitus was critical in shaping how mental health services are experienced in relation to other elements of practice, such as social fields and capital forms. This led to a conceptualising of mental health as a dialogically organised *practice* corresponding to a cycle of resilience, recovery, and subjectification, distributed across three levels: intra-psychological, interpersonal (social), and structural (societal/institutional). Across all analyses, these practices were organised through authoritative (Master) signifiers that structured symbolic identification and desire for recognition by the Other, binding subjects to performative ideals whose maintenance frequently entailed psychological cost. This thesis reframes how we understand the experience of mental health from an individualised defect-focused and reductive biomedical model towards a socially situated, symbolically mediated dialogical practice with implications for policy addressing clinical practice and structural inequality within mental health services.

Preface

This preface aims to "set the stage" as to what the reader can expect from this thesis. This includes the research questions as well as the aims of the study and outlines the evolution of the research process. It introduces the motivations for adopting a critical approach and pursuing particular methods, and my own subjective positionality, which was a central tenet in this thesis. What follows is a very personal piece of work that I hope makes a meaningful contribution to our understanding of what is commonly referred to as mental health. It is personal, as my own experience of social class and mental health has been a key motivation for conducting this study. I come from a low socioeconomic background and witnessed the damaging effects of class-based inequality and marginalisation on the mental health of those around me, but also experienced them myself.

As I returned to education in attempts to gain social mobility, I began to understand the structural and cultural influences that shaped these experiences. My studies focused on the knowledge that frames human experience, that of anthropology, sociology and psychology. Yet I often felt disappointed at the discrepancies in my own experiences and observations, as what was presented to me as knowledge and truth seemed incomplete, if not inaccurate. I became dissatisfied and even disillusioned, as I knew that mental health was more than biological abnormalities or maladaptive psychological functions of the individual and class was more than just how much money you had. Even the more holistic bio-psycho-social model of mental health provided little insight into how and why these factors combined to make complex class-based mental health experiences.

As I continued my studies, the combination of knowledge from sociology and psychology constructed a dualistic picture, each discipline only capturing part of two distinct but obviously intertwined phenomena. Thankfully, during my master's degree, I was introduced to the philosophical and critical approach to psychology. This was the perspective that not only addressed the complexities of the psychological and social, but did so with the aim of social change. Thus, I embarked on a PhD that took a critical psychology approach to address my interests as a researcher motivated by my subjective experience, the mental suffering derived from the social realm. It is fair to say that this PhD has been highly personal, if not a passion project. I am very grateful that I can do a PhD that is so meaningful to me and to have a supportive supervisor who recognises and shares in that meaning.

Yet my passion for this thesis does not mean that it has been an easy journey. If anything, it has been more difficult due to the self-inflicted pressure to do this research accurately and give these topics justice. Topics that are not quantifiable, but complex, dialectical and dialogical, and require the development of a complex theoretical and methodological framework to investigate. As such, the research needed to evolve, exploring multiple theories and methods requiring interdisciplinarity while always maintaining the critical approach. Consequently, I employed a theoretical framework that incorporates the disciplines of psychology, psychiatry, sociology, anthropology, philosophy and linguistics. What started as a simple qualitative exploration of the relationship between mental health and internalised social class (habitus) became something far more in-depth, complex, challenging and important.

The original research question, "Does social class habitus affect the lived experience of mental health, and if so, in what ways, amongst a sample of participants identifying as lower class, working class and middle class?" aimed to explore interview data collected from a diverse range of participants and to analyse the texts using critical discourse analysis. Yet, as the project progressed, my original methods seemed unable to capture the complexity that I observed in the participants' accounts. In this regard, the original research question was too limited, as what was present in the data went beyond habitus to the overarching concept of practice. This led to a further research question: "How does language shape the experiences of mental health described in the participants' accounts?" As a result, I adopted and even developed new methods that gave deeper and broader insights, a key strength of this study. This iterative and explorative approach, common in qualitative inquiry, enabled me to freely immerse myself in the data, but also develop the study in a manner that captured the "messiness" of such complex phenomena.

Due to the interdisciplinary and theoretical nature of this thesis, it is structured in what could be described as a narrative style, as it follows the development of the research process, but also unfolds a cycle of mental health that led to the findings and theoretical contributions. The narrative style also accounts for reflexivity and allows space for subjectivity in the voice of the researcher. Yet it also follows the APA 7th ed guidelines for the structure of a psychology research report with eight distinct, yet interrelated chapters. Chapter 1 reviews the literature on mental health and social class and highlights the knowledge base and gaps on these topics. It also provides the research questions, aims and objectives, positioning this study within the existing research on mental health. While it is traditional to have a singular method chapter

with a section that covers the theoretical framework, that was so central to my approach that it deserved its own chapter. Thus, Chapter 2 covers the philosophical, ontological, epistemological and methodological framework and the usefulness of applying these to research on mental health and social class. Chapter 3 then is a detailed description of the methods of data collection and analysis used in this study and includes coverage of the ethical protocol and methods to achieve reflexive rigour.

Chapter 4 presents the results of the initial level of analysis, reflexive thematic analysis, where a cycle of mental health was observed in themes. Chapters 5, 6 and 7 cover the results from the combined analytic approach of socio-cognitive critical discourse analysis, Bourdieusian analysis and Lacanian discourse analysis. Each chapter briefly introduces the topic with relevant supporting literature and then provides a description of analytic findings with examples of interview extracts. Chapter 5 focuses on resilience, Chapter 6 on recovery and Chapter 7 on subjectification. Chapter 8 is a discussion of the findings in relation to the literature and theory on mental health. It also reports the implications and recommendations, but also notes the limitations of this study and states the conclusions. Following the main content of the thesis, there is a reference section of supporting literature and an appendix section providing supplementary materials.

My intention with this thesis was not to make claims of truth regarding what mental health is or how it is impacted by social class. Instead, I offer one possible understanding, one that accounts for the multifaceted nature of mental suffering. I present this thesis with the hope that it may broaden the knowledge within psychology and mental health research by acting as an alternative to hegemonic discourses about suffering that generate biases and sustain inequalities. Within the clinical field, this research may provide greater insight into the diversity of mental health experiences and critically how they are shaped by social phenomena outside the individual's control. To all readers, I hope that, as it has for me, this thesis brings a greater understanding of their own mental suffering, subjectivity and relationality to the social realm. I would like to end this preface with a quote from Jerome Bruner (1961) that I believe captures the essence of this PhD and my experience as a researcher.

> *The study of the human mind is so difficult, so caught in the dilemma of being both the object and the agent of its own study, that it cannot limit its inquiries to ways of thinking that grew out of yesterday's physics. Rather, the task is so compellingly important that it deserves all the rich variety of insight that we can bring to the understanding of what man makes of his world, of his fellow beings, and of himself. That is the spirit in which we should proceed (p. xiii).*

1. Mental Health and the Context of Social Class

1.1 Introduction

This chapter introduces the topics that are the focal point of this thesis, mental health and social class. It presents a critical review of literature on mental health and related issues, such as mental health inequalities and the lived experience of mental health. The empirical and theoretical literature on social class and associated concepts, such as socioeconomic status (SES) and subjective social status (SSS), is also explored. It covers interdisciplinary theories that address social class, power inequalities and constructions of mental health norms, shining a critical lens on these topics. This introductory chapter presents an overview of the current state of affairs, providing the empirical and theoretical foundation for the substantial content presented in this thesis. Importantly, it highlights that despite consistent and enduring research linking mental health experiences to social class inequalities, the *mechanisms* through which social class influences mental health are unclear, suggesting that the mental health-social class relationship remains insufficiently theorised.

1.2 Mental Health

1.2.1 Concepts and Definitions of Mental Health

How mental health is conceptualised or defined strongly influences how it is understood in the public domain (Foucault & Dreyfus, 1987). Definitions of mental health influence our understanding of what constitutes normal or healthy psychological functions and behaviours as opposed to abnormal or pathological ones (Frances, 2013). Mental health definitions come with implied normality frames, containing inferences beyond the initial meaning, as mental health discourses around these conceptualisations and definitions have implications for how mental health is experienced, but also how it is addressed within clinical realms, as well as in mental health and social policy (Foucault & Dreyfus, 1987).

It's important to consider that conceptualisations, definitions and related diagnostic criteria are derived from theoretical underpinnings framing the nature of human functioning and experience. For example, the Diagnostic and Statistical Manual, currently in its fifth edition (DSM-5) (Cooper, 2017) and the International Classification of Diseases in its eleventh revision (ICD-11) (World Health Organisation, 1992) are derived from biomedical theories

suggesting mental health has biological correlates of abnormal neurochemical presentations of genetic origins (Szasz, 1979). This frames mental health like a physical illness that is treatable through physical means, such as medication and electroconvulsive therapy (ECT) and is currently the dominant approach in research, policy, practice, and consequently public knowledge.

However, other theoretical conceptualisations and approaches sit in contradiction to the biomedical model (Cohen, 2017). For example, the Power Threat Meaning Framework (PTMF) views mental health as a non-diagnostic system in which the adversity that a person experienced, how they managed it, and the meaning derived from it are the basis of mental health. The PTMF also considers the social elements and power structures that influenced the adversity and the meanings derived from the experience. (Johnstone & Boyle, 2025). Another example is the psychoanalytic approach, which views mental suffering arising from a link between the social world, including power structures, and the individual psyche mediated by language (Parker & Cuéllar, 2021). While there are variations to psychoanalytic approaches, language is core to this conceptualisation. In the Lacanian approach, there is no normal measure of humanity to compare against, only individuals bound to the collective social realm (the symbolic order) through language. Mental suffering is not only psychological but also arises from exposure to inequalities within the symbolic order, as these inequalities are internalised in the unconscious by the vector of language (Parker & Cuéllar, 2021).

It is important to consider these various concepts of mental health, and they are linked to various diagnoses and treatment approaches that can also have a significant impact in terms of mental health experiences. While Frances (2013) stresses that diagnosis can be life-affirming when someone can attribute their distress to a classified illness and consequently access appropriate treatments and supports that hopefully bring recovery, he also stresses the substantial consequences as a diagnosis produces an evaluative and determinative mental health status. Below, Francis (2013) highlights just some of the implications that this diagnostic status can have on people's lives, as it determines

> Who is considered well and who is sick; what treatment is offered; who pays for it; who gets disability benefits; who is eligible for mental health services, school, vocational and other services; who gets to be hired for a job, can adopt a child, or pilot a plane, or qualifies for life insurance; whether a murderer is a criminal or a mental patient; what should be the damages awarded in lawsuits; and much, much more (p. XII).

This highlights how a concept of mental health and associated diagnostic criteria can determine an array of circumstances that affect people's lives, and consequently how they view themselves (Ahmedani, 2011). Through the process of subjectification, individuals evaluate their mental processes and behaviours around a defined normality often associated with mental health definitions and diagnosis, forming identity around these concepts of normal or abnormal presentations of self in relation to the discourse of mental health (Foucault, 1961; Foucault & Dreyfus, 1987). This has implications in terms of self-stigma (Horsfall et al., 2010), limiting the formation of a subjectivity that encapsulates the dynamics of individual social and cultural experiences, and instead strives to align with mental health norms set by these definitions.

According to Galderisi et al. (2015), definitions must "overcome perspectives based on ideal norms or hedonic and eudaimonic theoretical traditions" (p. 5). Concepts and definitions of mental health should be inclusive of social and cultural differences as well as biological and genetic characteristics, individual differences of personality, intelligence and cognitive functions, as well as learned behaviours (Kiesler, 2000). For example, culture has been shown to produce significant variations in how mental health is understood, evaluated and experienced (Marsella & Yamada, 2000). To understand the mental health of the individual, the social and cultural ecology of the individual must be taken into account, as, according to Marsella and Yamada (2000), "cultural factors act as a major determinant of the onset, expression, course, and outcome of mental disorders" (p. 3).

Cross-cultural studies found that conceptualisations of mental health and mental illness are culturally specific, with presentations of mental health conditions, and the interpreted meaning made by the individual and the community strongly impacted by cultural norms, beliefs, and values (Bass et al., 2007; Bhugra, 2006; Tse & Haslam, 2023). For example, coping strategies are found to be related to cultural variations in individual versus collectivist orientations (See & Essau, 2010), impacting knowledge and beliefs about mental health as well as attitudes towards help-seeking (Sheikh & Furnham, 2000), including stigma (Ahad et al., 2023). Critically, culture, both of the mental health worker and the service user, has been found to influence the perceptions of the mental health worker regarding evaluations of mental illness, having an impact on diagnosis and treatment (Biswas et al., 2016).

These externally oriented factors, such as culture, but also family and personal relationships, stress levels, access to supports, physical health, leisure activities, living conditions, employment status and occupation type, also influence the quality of mental health

and should also be considered (Kiesler, 2000). This highlights the need for an interdisciplinary approach when researching mental health, as doing so will form a conceptualisation of mental health "as close as possible to human life experience, which is sometimes joyful, and at other times sad or disgusting or frightening, sometimes satisfactory, and at other times challenging or unsatisfactory" (Galderisi et al., p. 5).

Regardless of how mental health is defined and the conceptualisations that surround those definitions, what we understand as mental suffering, how it is spoken about and therefore how it is perceived and experienced, is shaped by these definitions that are generated by others, linked to theoretical frames, and mediated by language. In this regard, what is understood as mental health may not reflect what is being experienced as mental health. Instead, these theoretical conceptualisations of mental health are a socially constructed form of knowledge, bound temporarily, socioculturally and economically to their conception and cannot be taken as truth in terms of capturing the lived experience of mental suffering (Foucault, 1961).

1.2.2 The Social Construction of Mental Health

The previous discussion outlined some of the conceptualisations and definitions common to the understanding of mental health. It also highlighted the contextuality of these conceptualisations and the effects that they may have on individual and social experiences. Therefore, what is understood as mental health, and what accounts for good or poor-quality mental health, arises from social, cultural, and temporal contexts. Thus, mental health can be considered a socially constructed concept (Walker, 2006).

Social constructionism views knowledge as socially, culturally, and historically derived, and the language of these contextualities contributes to the reality or experience of such phenomena (O'Reilly et al., 2017). Language that bears knowledge is contextual to a specific society and culture at any given point in time (Foucault, 2013). The language, discourses, and rhetoric that a society or culture uses at a given time to communicate about mental suffering frames how it is experienced (Lacan, 2007). This is because the realities of what it means to be mentally well or ill and what the boundaries are for acceptable mental functioning and behaviour within a given society are socially constructed (Walker, 2006).

In this way, the concepts of mental health and mental illness are not *discovered* through research but brought to life as they are *constructed* by the language used to describe mental states and behaviours (O'Reilly et al., 2017). The immediacy of experience, the individual's signifying chain that expresses the experience, is lost by the prevailing language of the social

realm in what Lacan (2007) referred to as symbolic mortification. Language can never capture what is truly experienced, and therefore, only accounts of that experience can be shared that are framed by the socially constructed system of meaning that is carried by language.

1.2.2.1 Power and the Social Construction of Mental Health. However, these social constructions are not neutral, but are embedded with the power structures derived from the society in which the social construction of knowledge occurred. In terms of social constructions of mental health, Walker goes on to explain how "psychology, like psychiatry, has found ways of linguistically contorting, convoluting, and confusing lived experience with essential 'truths' of its own" (p.6). In this way, an individual's immediacy of the experience of mental health in itself, how they experience and evaluate their own behaviours, thoughts, and feelings, as well as how they are perceived by others, is inevitably tied to the versions of "truth" arising from socially constructed knowledge, if not silenced by it. As such, only accounts of mental health that align with the socially constructed knowledge are considered legitimate (Foucault, 2020).

Knowledge and discourses can be constructed to exert dominance and control over those in subordinate positions by "limiting the freedom of action of the others, or influencing their knowledge, attitudes, or ideologies" (van Dijk, 2013, p. 84). This dominance is legitimised morally and legally through an ideological state apparatus (Althusser, 2024). The institutions of the judiciary, education, health care, media and even the traditional family unit maintain and reproduce the social structure that maintains the established hierarchy. van Dijk (2013) emphasises that the dominance of discourses has a key cognitive element of control, shaping the minds of both the oppressed and the oppressors, influencing how they perceive others and themselves. Yet, this is not brought about by force, but through a hegemony of knowledge that is gradual and subtle, creating discourses that suggest the ruling ideology is the natural order and is accepted as the status quo, the only reality and the only truth (Gramsci, 2007).

For example, the knowledge which underscores the biomedical approach arises from research conducted on a relatively small sample of the population, known as WEIRD samples or western, educated, industrialised, rich, and democratic cohorts (Henrich et al., 2010). Research is also often conducted in university settings where students act as a convenient, yet highly classed sample (Grossmann and Huynh, 2013). While some research may focus on the effects of social inequalities on mental health, findings are often framed as deviations from psychological and behavioural norms which are emblematic of societal power (Hansen et al.,

2014). In this way, what is presented as truth in terms of mental health is often a skewed and biased picture, not only in terms of culture, but also in terms of social class.

The above discussion outlined some of the definitions and conceptualisations of mental health through a social constructionist lens. However, what is not being implied here is that mental health disorders do not exist, or that experiences of psychological and behavioural variations do not cause distress, suffering and impaired function. These experiences are real for the individual, with real consequences and outcomes for themselves, their families and friends and for society generally. As such, it is vitally important to question how these socially constructed conceptualisations, definitions, and diagnostic criteria shape mental health experiences differently, particularly in relation to the individual's social positioning.

As this thesis takes a critical ontological positioning, it views inequalities of social positioning, such as social class, as real in terms of the material conditions and socioeconomic consequences experienced at different status levels. In terms of mental health, categories and experiences are socially constructed and symbolically mediated. Mental distress, as understood here, is neither reducible to biological dysfunction nor a purely discursive construction. Rather, it arises as a psychological experience dialectically emergent from the interplay of material conditions, social relations, and symbolic processes. However, we can see the occurrence of suffering, regardless of how it is framed in the quantified statistical data on mental health, which stresses how widespread the occurrence is and the importance of conceptualising mental health in a manner that reduces these occurrences.

1.2.3 Mental Health Statistics

The global occurrences of mental health conditions are on the rise, with a 13 per cent increase in reported occurrences in the last decade (WHO, 2022). Recent statistics from the Institute for Health Metrics and Evaluation (2025) show that in 2023, fifteen per cent of the world population were diagnosed with a mental health condition. According to the WHO (2022), 264 million people are diagnosed with depression, now the leading cause of disability worldwide, with a further 45 million diagnoses with bipolar disorder and 20 million psychoses, while many others are experiencing mental health conditions such as anxiety, PTSD, personality and eating disorders. Yet, those are only the recorded statistics, with many more struggling with mental distress who, often due to stigma or lack of resources, do not or cannot access services or receive a diagnosis and remain uncounted.

For those experiencing mental health conditions, it can substantially impact their quality of life, with reported reductions in well-being and poorer quality of physical health (WHO, 2020). On average, individuals with mental health conditions die two years earlier than those without mental health conditions. In addition to reduced life span, suicide, often but not always linked to mental health conditions, is the fourth leading cause of death for those aged 15 to 29 and accounts for 1 in 100 deaths globally. Beyond the personal distress and consequences for individuals and their families, there are wider implications for society generally (Cosgrove et al., 2020). Economically, depression and anxiety alone cost the global economy 1 trillion US dollars per year from a combination of lost earnings, illness benefits, and publicly funded interventions such as hospitalisations and medication (WHO, 2020). Yet, even with this obvious economic burden, only two per cent of the global expenditure goes towards mental health services (WHO, 2020). Significantly, 76-85 per cent of those experiencing mental health conditions go without interventions due to income inequality, inequality of access and other barriers such as stigma (Collaborators GDP, 2018).

1.2.4 Mental Health Inequalities

Mental health inequalities are the unequal presentation of the exposure to risk factors, such as adversity, but also in the prevalence and diagnosis of certain mental illnesses, access to appropriate services and associated mental health outcomes (Henderson et al., 1998). Research has shown that mental health inequalities relate to contextual phenomena that increase the likelihood of a person experiencing a mental health condition, the diagnosis type, and the severity and duration. Inequalities relate both to personal circumstances and social determinants, but these are often interlinked and reciprocal. This includes, but is not limited to, social, class, age, gender, sexuality, race, ethnicity, marital status, employment status, urban or rural location, accommodation type, immigration status, poverty, social isolation, social disorientation and exposure to various forms of violence. However, individuals don't fall neatly into one marginalised group and will often have multiple forces of marginalisation due to the intersectionality of multiple social categorisations. McAllister et al. (2018) highlight the role of macro-level social structures associated with social inequality, particularly those of SES that pose as risk factors and protective factors associated with class inequality or affluence.

1.2.4.1 Exposure to Risk Factors. Risk factors are characteristics and circumstances that make it more likely for one individual to develop a mental health condition than someone without them (Haggerty & Mrazek, 1994). Risk factors can be biological, psychological, social, and environmental and often vary in their effect throughout a lifetime. Some risk factors, such

as genetic biological markers or childhood trauma, on their own do not always result in poor quality mental health. For example, a person's DNA can be influenced by epigenetic processes resulting from exposure to adversity, such as low SES and associated trauma in early life, creating changes in the genotype expression as phenotypes, increasing the likelihood of developing a mental health condition (McGowen & Szyf, 2010; Uddin et al., 2013). Yet, Haggerty and Mrazek (1994) suggest there is a complex interplay of risk factors responsible for the likelihood of experiencing a mental health condition and that no individual risk factor can be suggested as causal.

While there is a complex interplay between risk factors, it is clear that certain circumstances and conditions contribute to poor quality mental health through increasing the likelihood of risk factors (Haggerty et al., 1994). These circumstances and conditions are often linked with inequalities relating to socioeconomic status, but can also have intersectionality elements (McAlister et al., 2019). For example, there is an association between socioeconomic status and levels of economic stress (Businelle et al., 2014; Liem & Liem, 1978), socioeconomic deprivation (Faris et al., 1939), urban violence (Mari et al., 2008), and deprivation (Faris & Dunham, 1939), as well as employment status and occupation (Cox et al., 2004). Additionally, the suffering and mental burden of inequality, marginalisation and low social power in itself can increase the risk of poor mental health (Charlesworth, 2005). However, these risk factors can be mitigated with exposure to protective factors.

1.2.4.2 Access to Protective Factors. Protective factors are any conditions, behaviours or variables that "modify, ameliorate or alter a person's response to some environmental hazard that predisposes them to a maladaptive outcome" (Rutter, 1985, p. 316). Protective factors mediate the risk of developing a mental health condition and aid and sustain good quality mental health (Mrazek & Haggerty, 1994). They can be biological, psychological, community, family or institutional support and can vary in their effect for each individual. Protective factors do not guarantee that a person will have good mental health. Rather, access to these protective factors increases the likelihood of having better mental health and less severe presentations of mental health conditions with better outcomes. For example, access to mental health services is one of the protective factors that can reduce the effects from risk factors of developing a mental health condition, its duration and severity. However, not everyone has equality of access to these protective factors, such as supportive services (Mrazek & Haggerty, 1994).

1.2.4.3 Barriers to Services. There are many circumstances which affect access to mental health services, with findings suggesting SES is the strongest indicator (Kirkbride et al., 2024). Socioeconomic inequality of access is both structural, in the ability to afford services, but also attitudes toward services and acceptability or appropriateness of services (Sareen et al., 2007). Along with financial issues of accessing services, the acceptability of services was less likely in lower social class groups with issues presenting around language barriers, family and work commitments, lack of knowledge of services, lack of confidence in services, a preference to cope with issues themselves and a fear of stigma (Sareen et al., 2007). In this regard, barriers to services that relate to social status go beyond direct material barriers such as affordability, accessibility, and availability of services, but also to attitudes regarding services and levels of mental health literacy (Kohn et al., 2004).

1.2.4.4 Diagnosis. The diagnosis of a mental health condition is commonly based on diagnostic criteria set out in the DSM-5 as well as the ICD-11. The diagnosis generally requires the presence of a specific set of symptoms as well as impairment and disruption to life over a period of time, and a person can be diagnosed with multiple mental health conditions concurrently or successively (Cooper, 2018). The responsibility to assess and diagnose mental health conditions is primarily left to psychiatrists and psychologists, and some general practitioners with varying degrees of diagnostic accuracy (Andersen & Harthorn, 1989). A diagnosis of a mental health condition often comes with implications, both positive and negative and can have effects on identity, self-worth, relationships, the ability to work, as well as potential legal consequences (Frances, 2013). Yet, a diagnosis can be life-affirming and empowering when the diagnosis allows people to make sense of their experiences and leads to treatment and recovery (Slade, 2009). The potential for positive and negative outcomes based on the diagnosis of a mental health condition highlights the importance of accurate diagnostic criteria and clinicians who conduct their diagnosis in a non-biased and ethical manner (Frances, 2013).

Yet, even with the best intentions of accurate and non-biased diagnosis, many individuals will find that their behaviours, thoughts, and emotions will be incorrectly diagnosed or misdiagnosed as pathological when no pathology exists (Frances, 2013). Disparities in diagnosis have been linked to biases associated with social class (Garb, 1997; Lee, 1968). While there is evidence of the inverse relationship between SES and mental health conditions (Businelle et al., 2014; Das-Munshi et al., 2012; Faris & Dunbar, 1939; Muntaner et al., 2000; Muntaner et al., 2004), Lee et al. (1968) highlight that not only are there causal links, but this

also occurs with diagnosis in itself and the type of diagnoses received. Social bias among clinicians leads to differential diagnoses, but also to the type of interventions that are recommended to different class groups (Gard, 1997).

1.2.4.5 Interventions. The mental health treatment gap is often referred to as the difference in those who require mental health care compared to those who receive it (Evans-Lacko et al., 2018). Socio-economic indicators have been found to have a significant effect in preventing those in need of mental health services. Globally, those who are of low SES will face significant barriers to accessing mental health services (Kirkbride et al., 2024). This occurs on multiple levels, including affordability and accessibility (Kohn et al., 2004), but also individuals' ability to recognise the need for treatment, their perceptions of stigma and consequences of accepting treatment and attitudes about the efficacy of treatment (Andrade et al., 2014). Furthermore, those who may need mental health services may not have the social or financial supports, such as childcare or supportive relationships and may also have literacy or language barriers that also relate to SES (Smith et al., 2019).

In addition to the affordability, accessibility and acceptability, when individuals do avail of treatment, there are variations in recommendations of treatment options and quality of care (Cohen, 2016). A study by Buhagiar et al. (2019) showed that those from lower SES neighbourhoods were prescribed more antipsychotic medications and were prescribed first-generation antipsychotics with substantial side effects, while those from higher SES neighbourhoods were more likely to be prescribed second-generation antipsychotics with fewer side effects and high efficacy. Low SES individuals were also found to be prescribed medication more often, particularly antidepressants, rather than talking therapies offered to higher SES individuals (Holman, 2015). However, this could also relate to class distinct preferences in terms of treatment as well as clinical bias and SES contextual factors such as availability of financial means and the time to devote to mental health concerns, as well as stigma (Holman, 2015).

1.2.4.6 Stigma. The stigma of mental health conditions can be considered as either a mental health inequality in itself or a contributory factor. Stigma exists in society and institutions in the form of prejudice and discrimination and is reproduced through the media and socialisation of negative attitudes relating to specific presentations of mental health (Ahmedani, 2011). This often creates barriers, not only within institutions but also socially, such as acquiring employment or forming relationships. Stigma can be externally experienced

as from negative attitudes, treatment and discrimination from others or negative connotations displayed in the media and society broadly (Teachman et al., 2006). It may also be self-stigma with the negative perception of one's own mental health from internalisation of social stigma (Horsfall et al., 2010). Whether the stigma is experienced externally or internally, stigma impacts the experience of mental health and one's well-being.

The preceding section outlined just some of the mental health inequalities that are reported in the literature. However, research needs to go beyond reporting of statistics on inequalities, but needs to look deeper into the mechanisms of inequality functioning in the relationship between mental health and social class. What is clear is that not only does SES, and the associated cultural distinctions of social class impact the quality of mental health, diagnosis and services, but it is also reported to impact the lived experience of mental health (Charlesworth, 2000, 2001, 2005). These mental health inequalities of class need to be viewed as more than an individualised experience associated with class status, but an ethical and human rights issue (Freeman & Pathare, 2005; Ngui et al., 2010; Puras & Gooding, 2019).

1.2.5 The Lived Experience of Mental Health

The lived experience of mental health encompasses the "contextual understanding of a person's daily experiences, encountered difficulties, coping approaches and available support networks" as well as the "internal component of thoughts and emotions" relating to day-to-day life (Morris, 2016, p. xiii). Considering the temporal nature of lived experience, the lived experience of mental health is not only the processing of current mental health states, but the evaluations of experiences of mental health based on past ones, always as a contextually situated understanding (Mossis, 2016). Many contextual factors influence the lived experience of mental health (Sartor, 2023). Influences can include past exposure to others' mental health states, such as family, friends or peers, how it is portrayed in the media and how mental health is addressed in government policies and institutions (Morris, 2016). Furthermore, lived experiences of mental health are influenced by broader societal forces such as social and cultural norms, as well as political and economic circumstances (Cohen, 2017). As such, there is a link between the contexts in which mental health is experienced and the quality of that experience (Morris, 2016).

One example of how the lived experience of mental health is influenced by broader societal factors is how people from different societal positionalities experience resilience. Viewed as a valuable attribute of individuals, relationships, communities, cultures, and even

entire nations (Manyena, 2006), resilience should enable everyone to experience adversity, such as inequality, stress, trauma, and illness, with minimal negative effects on their well-being and mental health (Fletcher & Sarkar, 2013). Marketed as an essential psychological attribute needed to thrive in modern society, a plethora of books, workshops, seminars, and mobile phone apps (Gill & Orgad, 2018), therapeutic interventions such as resilience training, mindfulness, meditation, and CBT promise resilience to overcome a multitude of challenging experiences. Yet, these interventions focus on failures of the individual to cope as opposed to the inequality of resilient demands that are structurally or institutionally exploitive (Joyce et al., 2018).

However, inequalities of adversity and the spectral nature of resilience suggest that in terms of the lived experience of resilience, these are often not equal (Stepleman et al., 2008; Smyth & Sweetman, 2015). Further arguments have been made suggesting the use of resilience to justify an exploitive and unequal society and suggest it is a matter of human rights and social justice (Joseph 2013; Gill & Orgad, 2018; Schwarz, 2018). Central to this critical perspective is the unequal exposure of adversity for minority and marginalised groups whose characteristics are typically based on class, race, sexuality, gender, and disability (Stepleman et al., 2008). Furthermore, adversity often occurs on an intersectional basis in multiple settings and circumstances, resulting in magnified resilient demands (Chisty et al., 2021). This is not due to failures or maladaptive behaviours of the individual, but from structural inequalities experienced both on an individual and group level (Smyth & Sweetman, 2015).

This example of resilience is just one facet of the lived experience of mental health that can only be understood as an experience within context, where sociocultural and socioeconomic factors, such as social class, are the forces behind what Charlesworth (2005) refers to as "social suffering" (p.296). It functions by the disempowerment of populations that is embedded in their experience of mental health on a social and psychological level, bound to the generative conditions that formed distinctions in terms of social class (Charlesworth, 2001). In this way, contextual factors influence how someone evaluates their own thoughts, emotions and behaviours or their subjective mental health and how this in turn affects their subjectivity and identity (Cohen, 2017). Considering this contextual embeddedness, it is necessary to investigate the lived experiences of mental health in tandem with the generative contexts. Critically, it is in the lived experience accounts of mental health where class habitus and symbolic mediation become analytically essential. As such, class-based lived experience accounts of mental health are the focus of this study.

1.3 Social Class

As previously stated, there is a significant relationship between an individual's place in the social class hierarchy (whether indicated by SES or SSS measures) and their mental health (Businelle et al., 2014; Das-Munshi et al., 2012; Dougall et al., 2024; Eisenberg-Guyot & Prins, 2022; Evans, 2025; Faris & Dunbar, 1939; Muntaner et al., 2000; Muntaner et al., 2004). Therefore, it is essential to examine the class structure that hierarchically stratifies society, influencing both the material and social conditions (Kraus, 2015). Social stratification occurs when groups with similar characteristics (such as class, age, gender, sexuality, race, etc.) are hierarchically stratified in terms of their power and status within society (Grusky, 2019). This generates experiences that are not only hierarchical but also spectral and contextually driven by multiple macro and micro experiential planes (MacLachlan & McVeigh, 2021). As such, stratification happened on an intersectional level, with various socially constructed and valued characteristics shaping experiences. In capitalist societies, social class is the primary basis of social stratification and has the greatest effect on quality of life (Bourdieu, 1987a), including mental health (Muntaner et al., 2000, 2004) and thus is the focus of this study.

1.3.1 Concepts and Measures of Social Class

Mental health research has not ignored the influence of social class. Yet, often only controls for its influence and moderating or mediating effects of socio-economic status (SES), and less so subjective social status (SSS) measures as opposed to investigating it directly (Diemer et al., 2013). The rationale for the gap in direct research within psychology relates to debates around how social class can accurately be measured. Consequently, measurement often focuses on material and social resources that can be operationalised as SES (income, employment type, level of education), or self-identification with social groups with SSS measures (self-identified class identity). Using only these measures risks missing crucial elements that may lead to deeper insights into the effects social class has on psychological phenomena such as mental health. For example, SES can only capture access to material and status resources and not the effects of social relationships. While SSS indicators may be too subjective to capture the objective reality of the individual's material conditions, they can be biased to inflation or degradation of subjective evaluations of status (Diemer et al., 2013).

Due to these limitations in SES and SSS measures, and to gain a deeper understanding of how social class operates psychologically, this study uses dispositional and relational concepts of class, such as those of Bourdieu (1977). This not only captures the cultural elements of class that are outside of SES and SSS measures, but also allows access to aspects of class

such as habits, tastes, dispositions and practices. It also allows access to that which may escape SES measures when social mobility is a factor.

1.3.2 Social Mobility

Social mobility poses a particular challenge for researchers who attempt to account for social class status impacting psychological phenomena (Rubin et al., 2014). Social mobility can be described as the upward or downward improvements or decreases in the quality of material and social resources and is generally measured by SES indicators (Islam & Jaffee, 2024). However, social mobility does not account for the cultural facets of social class status, such as values, norms and practices (Bourdieu, 1977; Bottero, 2013). For example, Islam and Jaffee (2024) suggest that social mobility has a significant impact on mental health experiences and outcomes, with social mobility in either direction resulting in deteriorations in the quality of mental health. Yet not as significantly compared to those who remain in low SES positions, while those who maintain high SES had better quality mental health than all other SES groups, despite other groups' gains in social mobility.

This aligns with previous research from Das-Munshi et al. (2012), Bottero (2013), Simandan (2018) and Kim et al. (2023), who all found that social mobility may bring initial benefits to mental health, but it is often followed by reductions. Simandan (2018) points to social isolation and loss of support networks, the challenge of fitting in with new social groups, new social norms, struggles with identity and sense of self as the complicating factors that prevent social mobility from having long-term benefits to mental health. The data suggest that social status in Western capitalist societies has elements beyond the measures of SES or SSS. In this regard, social class may be more holistically captured by theoretical conceptualisations of social class that can account for the presence of dispositional characteristics beyond SES conditions and reflect how social class operates on a psychological level.

1.3.3 Definitions of Social Class

Kraus (2015) argues that research on social class is important to understand the link between social inequalities and psychological phenomena as “class contexts guide psychological experience because they shape fundamental aspects of the self and patterns of relating to others” (Kraus, 2015, p.643). While social class is often more associated with sociological research than psychological, it is increasingly becoming an area of focus as evidence suggests that mental health inequalities are linked to SES and SSS. Thereby,

examining the practices associated with social class may illuminate the mechanisms of class-based experiences that impact mental health (Muntaner et al., 2000).

The classic theoretical concept of social class is most commonly understood as relating to the theories of the philosopher Karl Marx, who posited that the capitalist economic system generates two classes. Those who own the means of production or life-sustaining resources, the Bourgeoisie, and the workers or Proletariat, who sell their labour to gain financial capital to purchase resources from the Bourgeoisie (Marx & Engels, 2002). However, a Marxist theory of class seems less valid with the dynamic and spectral nature of social stratification in our modern, complex and constantly developing society (Bourdieu, 1987a). As society and the economy have changed, various concepts of class with a multiplicity of categories have developed (U'Ren, 2011). Under class, criminal class, lower class, lower-middle and upper working class, lower and upper-middle class, rich, super-rich, elite, new money, old money, super class, and the self-actualised X class are just some of the titles now given to groups that in one context or another meet criteria for group classification (Rossiter, 2012). Class groupings can be based on income, assets and material wealth, level of debt, educational attainment, employment status and occupation type, as well as values, consumption patterns, tastes, activities and practices (Bourdieu, 1987b).

The multiplicity of theories, measures and categorisations attempting to capture and quantify social class often fail to recognise the temporal, social and cultural changes that have arisen due to the development of information technology, and the flexibility, globalisation and multiculturalism of contemporary neoliberal capitalist economy (Gil-Hernández et al., 2024). Not only have these changes affected material conditions and the environments in which we live and work, but also the societies and cultures themselves (Fisher, 2009). In turn, social norms, cultures, values, ideologies, knowledge, and discourses of contemporary society are in constant flux, and traditional concepts and measures of class have become less applicable and even arbitrary (Bourdieu,1987a). Contemporary classed experiences are more diverse and exist on a spectrum of multiple domains where class groupings and identities are less defined (U'Ren, 2011). Weber (2018) argued that the complexity of class not only exists between class groups, but within them as different members of individual groups have different interests and levels of power, which are negotiated within group dynamics and not between.

However, while class experiences are fluid, Bourdieu (1987a) argues that the "homogenization of society" (p.3) of late capitalism does not dissolve social class but that it is

"possible to deny the existence of classes that are homogeneous sets of economically and socially differentiated individuals objectively constituted into groups, and to assert at the same time the existence of space of differences based on a principal of economic and social differentiation" (p.3). To do so one only need to view class as existing in what Bourdieu refers to as "social reality" in which class exists "not with substance, but with relationships" (p.3). So, while on the one hand, measurements that attempt to make class a quantifiable phenomenon are arbitrary, on the other, there is the phenomenon of socially distinct groups that exists in real and tangible forms, yet only in the realm of the dynamic social space of social relationships (Bourdieu, 1987a). As such, Bourdieu defines class as

> A set of agents who are placed in homogenous conditions of existence imposing homogenous conditionings and producing homogenous systems of dispositions capable of generating similar practices; and who possess a set of common properties, objectified properties, sometimes legally guaranteed (as possession of goods and power) or properties embodied as class habitus (and in particular, systems of classificatory schemes) (p. 101).

It is worth noting here that Bourdieu's concept of social class is what will be used in this study and will be discussed in detail further on. According to this conceptualisation, social classes are defined by their similarities in the conditions of existence formed by the social hierarchy, yet at the same time, they are classes due to the conditioning effects of these conditions of existence. Collectively, individuals of similar SES have similar ways of living, as their perception of the social world is bound to the class conditions which are formed by social relationships occurring in social space (Bourdieu, 1987b). In this way, class functions in the material world via the relationships of the social world. For example, access to resources such as food and housing is not based on physical barriers that prevent people from obtaining these essential resources, but the social relationships that exist within society, where social norms, values, laws and rules are established through social relationships, which state who controls access to housing and food and create legal barriers which allow or restrict access. This is just one example of how the social relationships of social classes affect real material aspects of people's lives.

Below Lubrano (2005) highlights the predominant effect the phenomenon of social class has on daily existence as it acts on material, social and psychological levels.

> Class is a script, map, and guide. It tells us how to talk, how to dress, how to hold ourselves, how to eat, and how to socialise. It affects whom we marry; where we live; the friends we choose; the jobs we have; the vacations we take; the books we read; the movies we see; the restaurants we pick; how we decide to buy houses, carpets, furniture,

> and cars; where our kids are educated; what we tell our children at the dinner table (conversations about the middle east, for example, versus the continuing sagas of the broken vacuum cleaner, or the halfwit neighbour); whether we even have a dinner table, or a suppertime. In short, class is nearly everything about you. And it dictates what to expect out of life and what the future should be. (p. 9)

What is clear is that people who have similar access to resources, both materially and socially, often have similar experiences in society, values, normalised practices, and lifestyles (Uren, 2011). Critically, the grouping of people based on their access to resources and the valuing or devaluing of the associated practices is not neutral or naturally occurring (Bourdieu, 1987b). It is an intentional act of the capitalist class structure, which requires people to be hierarchically stratified in order to increase power and access to resources for some and limit them for others to maintain a system (Bourdieu, 1987a). As such, social class is a more complete concept of social inequalities that comprises economic structures and the associated social and power dimensions (Wagner & McLaughlin, 2015). Furthermore, when researching inequalities, it's vital to utilise a macro approach that encompasses more than the economic indicators, but an approach that captures the influence of macro social processes on the micro individual processes of psychological phenomena (MacLachlan & McVeigh, 2021).

1.3.3 The Psychological Effects of Social Class

Social class affects the conditions in which one lives as well as the day-to-day experiences and practices, and is a determining factor in overall life outcomes (Kraus et al., 2012). Yet, the effects of social class on psychological functioning have largely gone unresearched, at least in the realm of mainstream psychology (Day et al., 2020). However, research has found that social status produces the social class differences in psychological functions (Argle, 1994; Bruner & Goodman, 1947; Grossman & Varnum, 2011; Kraus, 2015; Kraus et al., 2009; Kraus et al., 2010; Kraus et al., 2011; Kraus et al., 2012a; Kraus et al., 2012b; Kraus et al., 2017; Kraus & Park, 2017; Piff & Moskowitz, 2017; Piff & Robinson, 2018) as well as differences in development of neuroanatomy (Brito and Nobel, 2014) and neurocognitive performance (Ursache et al., 2016). Social class has also been found to effects perceptions and evaluations (Bruner & Goodman, 1947) cognitions such as attention (Grossman & Varnum, 2010; Kraus et al., 2009; Kraus et al., 2012a) emotional occurrences and regulation (Argle, 1994; Jacoby, 2016; Piff & Moskowitz, 2018) self-concepts, self-esteem (Kraus & Park, 2014) perceived sense of control (Kraus et al., 2011), and prosocial behaviours (Korndörfer et al., 2015; Kraus et al., 2010; Piff & Robinson, 2017).

As these psychological functions are key elements to mental health, social class is likely a factor that mediates psychological processes central to experiences of mental health. Consequently, all experiences would be influenced by social class as the underlying psychological composites of experience are shaped by the social and economic conditions that affect brain development (Brito and Nobel, 2014) and psychological processes (Ursache et al., 2016). Furthermore, social class in terms of material and social conditions, as well as identity, norms and values associated with the experience of social class, has an impact on experiences of mental health (Charlesworth, 2005). As individuals experience society differently based on their positionality in the social structures, this shapes class group distinctions and is the internalisation of the lived experience of social class (Bourdieu, 1987a).

1.3.4 The Lived Experience of Social Class

As social class has a substantial effect on material and social conditions in which people exist, and the psychological processes of perceptions and evaluation (Kraus, 2015; Manstead, 2018), it consequently affects people's everyday experiences (Bourdieu, 1987b). These experiences are not equal in their effects as the content of experience varies depending upon levels of wealth, affluence and privilege or poverty, exploitation, and subordination to which individuals are exposed (Charlesworth, 2001). Essentially, from birth, and possibly even before (Currie & Goodman, 2020; Lu et al., 2021), we are experiencing life through a filter of class (Bourdieu, 1987b). Every aspect of our experience is saturated with class contexts due to the class position we are born into, which we occupy throughout our lives and the class structures of society in which the experiences take place (Bourdieu, 1987b).

The experiential effects of social class are not equal, as those of the higher classes often benefit from their experience of class, while those in the lower classes often have a diminished quality of life and have more negative class experiences (Billings, 2021; Kraus et al., 2017). As diminished quality of life and negative experiences are contributory factors for mental health conditions, those who are of the lower classes will experience the negative effects of their social class more. This is not to say that those experiences of the upper classes are always protective and never result in poor mental health. However, the prevalence and strength of findings regarding the inverse relationship between social class and mental health suggest that those of the lower classes experience more negative effects of their position in the social class hierarchy (Charlesworth, 2000, 2001, 2005; Cohen, 2017; Kraus et al., 2017).

Once again, it is useful to consider the lived experience of resilience, this time in the context of social class. As discussed in Section 1.3.4, the lived experience of resilience is strongly influenced by contextual factors (Chisty et al., 2021; Unger 2008,2011). According to Vyas and Dillahunt (2017), those experiencing financial hardship demonstrate resilience to mitigate the effects of adversity daily. Calado et al. (2020) stress the relationship with social structures, such as social class, that shape the resilient demands that are distributed throughout society. Additionally, not only are the mechanisms of inequality that generate resilient demands of adversity different for different social class groups, but also how resilience is valued and understood and how it affects individual mental health, differently dependent on their social positionality on multiple levels of experience (Taanman et al. 2020).

This research adopts the position that social class is more than socioeconomic status, but distinctions in practices that reflect class-based culture (Bourdieu, 1987a). MacLachlan (2006) suggests that there are variations in how cultures perceive and deal with adversity and distress, and that psychological concepts such as hardiness (resilience) and their associated meanings often come from westernised perspectives. For example, research has traditionally focused on marginalised groups who experience greater adversity and require high levels of resilience, shaping how resilience is valued and understood, as it is associated with marginalised groups' sociocultural characteristics (Botrell, 2009). Bottrell (2009) argues that the assessment of behaviour and psychological functions as healthy or maladaptive is strongly embedded in socio-cultural and historical expectations, influencing how we understand adversity, distress, and resilience.

Charlesworth (2005) highlights the suffering associated with the lower class's experience and the profound effect on mental health and refers to Bourdieu's (2000) "social recognitions" and states, "there is no worse deprivation, no worse privation, perhaps, than that of the losers in the symbolic struggle for recognition, for access to humanity" (p. 242). In this way, social class acts on the individual beyond material resources and conditions, but in the social realm, which has a profound effect on the individual's sense of identity and how they value themselves, a reflection of how they are recognised and valued in society (Charlesworth, 2000). The links that Charlesworth (2000, 2001, 2005) makes between the social experience of class, its impact on identity and valuing of oneself, and relations with mental health suggest that social class is experienced on a much more profound level than just material and social conditions, and must be addressed on a deeper level.

1.4 Addressing the Relationship between Mental Health and Social Class.

A substantial body of research has established an inverse relationship between mental health and social status, most often using SES measures (Businelle et al., 2014; Das-Munshi et al., 2012; Dougall et al., 2024; Faris & Dunbar, 1939; Muntaner et al., 2000; Muntaner et al., 2004; Muntaner et al., 1012). This inverse relationship suggests that those with lower SES have a greater likelihood of experiencing a mental health condition than those with higher SES. Critically, some research suggests that one's social status (a measure by SES) is the strongest determinant of the quality of mental health (Ganie et al., 2026; Tanarsuwongkul et al., 2025; Wilkinson & Pickett, 2020). Furthermore, as discussed in section 1.2.4, the effects of this inverse relationship go beyond the quality of one's mental health, but impact the entire experience of mental health with inequalities in the access and acceptability of services (Sareen et al., 2007), whether you receiving a diagnosis and what diagnosis you receive (Muntaner et al., 2005), the treatment and interventions you are offered (Holman, 2015) and their effectiveness (Finegan et al., 2018), as well as the severity and disability experience (McAllister et al., 2018), and overall outcomes (Ng et al., 2014).

According to a systematic meta review by Dougal et al. (2024), studies examining mental health outcomes as measured by SES suggest that the effects are related strongest to low SES and depression, with factors including sense of control, stress and trauma associated with economic insecurity and neighbourhood deprivation. There were also indications that social and economic capital associated with higher SES acted as a buffer (or protective factor) in minimising the effects of trauma. Dougal et al. (2024) also found that social capital had positive effects on mental health despite community deprivation and low SES position. Barnett et al. (2023) also found this inverse relationship, but expanded it to the relationship with mental health services, finding that the mental health interventions are not only less accessible for those of lower SES backgrounds, but are also less effective, which was previously reported by Sareen et al. (2007) and Finegan et al. (2018). Barnett et al. (2023) suggest this is related not only to the lack of resources to access services, but also the effectiveness as interventions often do not focus on social status-associated adversity, stress and trauma and recommend psychosocial interventions that address risk factors, such as reducing unemployment.

This inverse relationship between SES and mental health suggests that the psychosocial interventions could be the resolution to the mental health issues suffered by lower SES groups, as they facilitate social mobility. However, as discussed in Section 1.3.2, social mobility was

found to have a significant impact on mental health, with either direction resulting in deteriorations in the quality of mental health (Islam & Jaffee, 2024). While research from Das-Munshi et al. (2012), Bottero (2013), Simandan (2018) and Kim et al. (2023) found social mobility gives initial benefits to mental health, but it is often followed by reductions, particularly for those who have gained social mobility from lower SES to a higher SES. Simandan (2018) suggests that while moving out of abject poverty accounted for the initial improvements to mental health, non-financial factors contribute to further mental distress, such as social isolation, loss of support networks, new social norms, and struggles with identity and sense of self. In this regard, the concept of social class as opposed to SES measures may provide greater insights into the inverse relationship, as it accounts for the presence of dispositional characteristics beyond SES conditions and reflects how social class operates on a psychological level, and gives insights into how social status impacts mental health.

The review of literature above highlights the empirical evidence showing a relationship between two distinct phenomena, social class and mental health. Despite literature indicating this relationship, the frameworks explored explain this relationship either in structural terms (through material, risk exposure, and service inequalities) or in individual terms (through psychological vulnerability, stress, or coping processes) with the vast majority of empirical studies using SES measure and very few using a conceptual framing of social status as social class, and with the review of literature done for this study, very few using Bourdieusian concept of social class. Veenstra's (2007) study highlighted the usefulness of the Bourdieusian concept of social class in identifying health inequalities (including those of mental health) that are active outside of SES measures. Other notable studies include Doblytė (2019) using Bourdieu's theory of fields to understand help-seeking practices and Saadati's (2022) analysis of the role of economic and cultural capital in contributing to mental health conditions.

The studies using SES indicate correlates and contributing factors in the inverse relationship, while the studies employing Bourdieu's concepts of class highlight the influence of cultural, social and financial capital as well as the influence of class-distinct norms and social fields. Yet, these studies lack a sufficient and critical theorisation regarding the mediating processes by which SES conditions contribute to and shape experiences of mental health. Critically, there is still limited conceptual clarity in terms of how social positioning becomes internalised as embodied states, how value-laden symbolic hierarchies of recognition shape evaluation of the self in relation to distress, and how these processes become enacted in mental health practices.

This thesis will address this gap by conceptualising mental health not simply as a result of material inequality, but as a socioculturally and symbolically mediated practice structured by the internalised features of social class, or social class habitus. By integrating key concepts from Bourdieusian and Lacanian theory, this study will explore how classed conditions of material and symbolic life become transformed into subjective experiences through language and other signifying forms, symbolic recognition, and embodied dispositions of suffering. An in-depth discussion of the theoretical framework of this thesis is presented in Chapter 2, and the application of these approaches within the analytical framework is presented in Chapter 3. For now, it is worth noting that this interdisciplinary and critical approach addresses the research gap that arises in the literature that has yet to examine the social class mental health relationship by an approach that captures the dynamic and dialogical relationship of both phenomena.

1.5 This Research

The preceding review of literature on mental health and social class highlights the substantial empirical findings that suggest a relationship between mental health and social class. The details of this relationship, the why, and the how social class impacts mental health seem less clear, and providing further insight into this relationship is the intention of this study. While theoretical and methodological approaches from disciplines of psychiatry, psychology and sociology have often addressed this relationship in disciplinary isolation, this study's interdisciplinary approach provides deeper and holistic insights, beyond those that could have been achieved through the application of psychological theory and methods alone. The theoretical offerings from a synthesis of Bourdieu and Lacan pose a dynamic framework that not only addresses the knowledge gaps that pertain to the mental health-social class relationship but also provides for a critical investigation that goes beyond the simple observation and reporting of class-based accounts of mental health, but investigates the mechanisms and processes that underlie these experiences. This further insight is central to the aims and objectives of this study.

1.5.1 Research Questions, Aims and Objectives

The initial research question for this study was "Does social class habitus affect the lived experience of mental health, and if so, in what ways, amongst a sample of participants identifying as lower class, working class and middle class?" The initial aim was to investigate

this research question through critical discourse analysis of interview texts from participants of various social class backgrounds and their accounts of mental health. Its objective was to gain insights into the operation of social class habitus on mental health experiences, broadening the understanding of the relationship between mental health and social class. However, as the study progressed, it was clear that habitus was impacting mental health not in isolation, but as a facet of practice. As such, this required not only the additional research question "How does language shape the experiences of mental health described in the participants' accounts?" to address the congruencies and complexities that appear in the language of the participants' accounts of mental health. This led to a further conceptual analysis of mental health, which became essential to fully grasp how and why social class impacts mental health by viewing it through the lens of social practice.

1.6 Chapter Summary

This chapter introduced substantial content in terms of a review of literature, both empirical and theoretical, on the topics of mental health and social class and associated mental health inequalities. It also addressed related topics, such as measures of SES and SSS, as well as the psychological effects of social class and covered the lived experiences research of both phenomena. While this review of literature also provided valuable foundations for this study, it also highlighted a gap in knowledge pertaining to the mechanism of the relationship between mental health and social class, one which this study aims to explore further.

I also introduced the various concepts and methods of measuring social class, and outlined the rationale for adopting the Bourdieusian concept of social class, which focuses on distinctions of practice rather than objective measures such as SES. In combination with the Lacanian approach to language, this study aims to gain deeper insights by examining the language of class-based accounts of mental health on the level of symbolic mediation, that of the signifier. This theoretical positioning best addresses the gaps seen in the literature, as well as the research questions, aims and objectives of this study. The following chapter covers the ontological and epistemological premises of this study, as well as a more detailed account of the methodological framework, providing the rationale for the research methods used in this study.

2. Theoretical Framework

2.1 Introduction

The previous chapter highlighted a knowledge gap regarding the relationship between social class and mental health. To address this gap, this study draws on certain philosophical underpinnings to explore the complexity of this relationship. This philosophical positioning is more than an ontological or epistemological guide relating to how decisions are made about methods, but why they are appropriate and useful for meeting the aims of this study, including doing so with a critical perspective. All research frames the nature of how we understand and relate to reality, but these frames are always aligned to certain ontological beliefs (Moon & Blackman, 2014). Thus, an exploration of these beliefs is invaluable to understand the inferences made by the researcher and how these guide the epistemological approaches and corresponding methods. Moon and Blackman (2014) stress the importance of transparency regarding ontological and epistemological positioning to ensure validity in terms of the "methods of acquiring knowledge, such as, with what constitutes a knowledge claim; how knowledge can be produced or acquired; and how the extent of its applicability can be determined" (p.6).

Considering this, the following chapter outlines the philosophical framework of this study, drawing on social constructionism, hermeneutics, and the interpretation of meaning, as well as the mediating role of language. It then focuses on the relationship between language and power, as well as the role of discourse. Next, there is coverage of the theoretical framework that supports the analytic framework of this study, and the rationale for its use. The theoretically grounded methodological framework covered in this chapter highlights its usefulness for investigating the complex relationship between mental health and social class and addressing the research questions and aims of this study. It also provides a grounding in terms of the ontological and epistemological positioning it takes to the analysis of accounts of mental health in the following results chapters, and the rationale for the focus on language.

2.2 Social Constructionism and Constructivism

This study holds certain positions in terms of the nature of what accounts for the experience of reality. Reality exists only within mental constructs bound to time and space, or what is known as "bounded relativism" (Moon & Blackman, 2014, p. 1167). As such, the

mental constructs of those who interpreted “reality” are social constructions of that “reality”. Meanings derived from such realities are purely subjective and only “exist within the subject: imposing meaning on the object.” (Moon & Blackman, 2015, p. 1169). This corresponds with the position of social constructionism, “in that reality is socially defined, but this reality refers to the subjective experience of everyday life, how the world is understood rather than to the objective reality of the natural world.” (Andrews, 2012, p.40). This is not to say that reality does not exist. The material conditions relative to social class, the instances of trauma and the psychological manifestation of distress are real, but the meanings attributed to these experiences are mediated by language, and thus are socially constructed. In this regard, this study focuses analytically on how these realities are apprehended, narrated, and negotiated within classed discursive contexts.

The social constructivist position views “realities” as bound to sociocultural contexts, and that knowledge derived from these contexts is contextually derived (Kim, 2001). Bruner (1990) argues, “our knowledge, then, becomes enculturated knowledge, indefinable save in a culturally based system of notation.” (p.21). This study follows the ontology position that reality is a social and cultural activity where meaning is created by social learning and the internalisation of sign systems, predominantly language (Kim, 2001). As such, I have approached the phenomena of this study, mental health and social class, as a product of cultural activity and is accessible through the mediating vector of culture, language. However, this social cultural product can be explored only because of the intersubjective nature of language.

2.2.1 Intersubjectivity

Knowledge constructs are generated and mediated by context-specific language and are specific to those who are equipped with the intersubjectivity to understand the associated social meaning. Zaner (1961) refers to Schutz’s work on intersubjectivity, which captures the abstractness and complexity of the relations between the individual and the social.

> How, that is to say, does it come that in spite of the fact that I, being "here” and the center “O” for a system of coordinates defining my surrounding world, and you, being "there" and the center "O" for a similar set of coordinates defining your surrounding world (you forming a part of my surrounding world, and me forming a part of yours) how do *we* come to have something in common (an object, a project, ultimately a common world)? How is it possible that although I cannot live in your seeing of things, cannot feel your love and hatred, cannot have an immediate and direct perception of your mental life as it is for you, how is it possible that I can nevertheless share your thoughts, feelings, and attitudes? (p. 76)

Intersubjectivity, then, is an activity intersection of the mental and social in which culturally group-specific "common interests and assumptions that form the ground for their communication" are the basis of their shared sociocultural knowledge and associated meaning-making as mediated by their shared language (Kim, 2001, p.3). Individual meanings are shaped by the intersubjectivity of their community or group membership, with sociocultural meaning-making based on group sociocultural histories. In this way, language acts as a vector of sociocultural historical knowledge from the group to the individual (Kim, 2001). Gillespie and Cornish (2010) argue that intersubjectivity is essential for understanding human social behaviour and requires a dialogical analysis of talk and texts as well as ethnographic engagement with contexts in which the intersubjectivity is derived. This study's analytic framework adopts the recommendations of Gillespie and Cornish (2010) as it is dialogical in the analysis of discourses, as it includes individuals' contextual social positioning as ethnographic engagement to illuminate the sociocultural intersubjectivity guiding the interpretation of the meaning of the accounts explored here.

2.3 Hermeneutics and the Interpretation of Meaning

According to Bruner (1990), "Our culturally adapted way of life depends upon shared meanings and shared concepts and depends as well upon shared modes of discourse for negotiating differences in meaning and interpretation." (p. 13). Research that focuses on these shared meanings, such as the study presented here, takes this hermeneutic approach. Hermeneutics views "interpretation in the context of fundamental philosophical questions about being and knowing, language and history, art and aesthetic experience, and practical life." (George, 2020, p.1). In this regard a hermeneutic approach is necessary as "all of the ways that people understand the world are filters through systems of meanings making, so the researcher scrutinise the data for evidence of discourses, paradigms, meaning repertories, values and attitudes which construct knowledge, talk and practices" (Ryan, 2005, p.100). Here I use the hermeneutic circle of language, as described by Smith et al. (2021), as a framework of inquiry in which "the part" can only be understood as an element of the "the whole" and "the whole" holistically from "the parts" that compose it as displayed in Table 1.

Table 1

Relationships of language and context: the Hermeneutic Circle (Smith et al., 2021, p.28)

The Part	**The Whole**
The single	Sentence in which the world is embedded
The single extract	Complete text
The particular text	Complete oeuvre
The interview	Research project
The single episode	Complete life

However, Bruner (1990) argues that language is more than just a mediator of meaning, but is meaning-making that is the foundation for human culture. The meanings we make of our experiences are what Geertz (1973) refers to *as culture in itself*. Culture is semantic in nature due to the language-generated sociocultural and temporal meanings. The dependence on language for mediating and generating meaning suggests that language is central to the formation of the cognitive schematic structures of knowledge and the conscious mind (Vygotsky, 2012). In terms of the analysis here, particularly the Lacanian discourse analysis, interpretation is viewed as limited, as the meaning attributed to signifiers is bound to the individual, and there is a semblance of language, where the truth of what the subject intends can never be interpreted by the receiving agent (Lacan, 2007). According to Parker (2010), it is with the analysis of discourse that we can see what speaks for the subject, that of language and gain insights beyond those of intersubjectivity. Yet, as both the subject and agent are within the same symbolic order and the same structuring principles of language, which can be analysed to give insights into the subject's truth. In this way, an intersubjective interpretation of accounts can be achieved, yet one that must always be accounted to the meaning-making of the analysing agent's Imaginary (Cuéllar, 2018).

2.4 Language and Meaning

So far, I have provided a rationale for the focus on language in this study in the context that it formulates sociocultural phenomena and the meaning derived from it. What is crucial to this approach is that meaning is generated by broader contexts and mediated by language, which is a psychological process (Gadamer, 2013). Baily (2009) stresses that language is the "distinguishing characteristics of human beings" (p.95) and the act of generating meaning that is derived from signifiers does not need to be learned, but is a natural human ability to engage

in the meaning-making of the sociocultural history that is language. Language then acts as a "medium that shows us the being, of meaningful order, of the world and the things we encounter in it" (George 2020, section 4.4), operating in a hermeneutic conversation. The meaningfulness that arises from language is not within language itself, but the sociocultural significations that are attributed to the sign (De Saussure, 1985). These significations are sociocultural in nature and allow for meaning-making that is structured by and on the signifier (Lacan, 1955). Sociocultural significations then account for the very nature of the mind and of consciousness as argued by Vygotsky (2012).

> Thought and language, which reflect reality in a way different from that of perception, are key to the nature of human consciousness. Words play a central part not only in the development of thought but in the historical growth of consciousness as a whole. A word is a microcosm of human consciousness (p.153).

2.4.1 Language and the formation of Mind

According to Vygotsky (2012), the semiotic culture of the social world becomes that of the psychological through processes of internalisation. He states,

> Thought development is determined by language, i.e., by the linguistic tools of thought and by the sociocultural experience of the child. Essentially, the development of inner speech depends on outside factors; the development of logic in the child, as Piaget's studies have shown, is a direct function of his socialised speech. The child's intellectual growth is contingent on his mastering the social means of thought, that is, language (Vygotsky, 2012, p.51).

In this way, the very nature of mind changes from biological to sociohistorical and is governed by the "general laws of the historical development of human society" (Vygotsky, 2012, p.51). This premise originates from the Marxist theory of historical materialism, which posits that the formations of "human nature and development based on the empirically knowable material conditions of human existence" (Baur, 2017, p.2) and takes a dialectical view. This makes language fundamental to the study of mental health, as language and the signifiers of mental normality are socioculturally, contextually and temporally situated. This study takes language as the means by which we can investigate accounts of mental health as situated in their sociocultural class positioning. As this study is interested in the cultural features of social class as opposed to a socioeconomic positionality, it examines the cultural aspects of social class that operate psychologically through language.

However, to understand how a semantically formed and functioning culture operates on psychological processes that constitute mental health, it is necessary to have a method that focuses on processes and not outcomes. As such, this study has used Vygotsky's (1980)

developmental method and focused on qualitative features of psychosocial processes of mental health and the qualitative features of social class that are accessible through language as opposed to objective measurable outcomes. The details of this method are covered in Chapter 3, and for now, I will only explore the philosophical and theoretical position of this method and how it links to the phenomenon under investigation. Here, I consider language as a constructing agent which does not just mediate on neutral terms but is laden with meanings that hold significant power (Foucault, 2020).

2.4.2 Language and Symbolic Power

According to Fairclough (2013), there is no "external relationship between language and society, but an internal and dialectical relationship. Language is part of society, linguistic phenomena *are* social phenomena of a special sort, and social phenomena *are* (in part) linguistic phenomena." (p.23). It is in this dialectical relationship in which language operates, carried by discursive events (Parker & Cuéllar, 2014). Discourses are part of social processes in which text is only a medium or a function of the "transpersonal systems of language" that mediates shared sociocultural knowledge, ideologies, beliefs, values and social norms (Rivkin & Ryan, 1998, p 190). Foucault (1961) uses the example of mental illness and the associated behavioural norms, which have temporally and culturally shifted. He stresses the role of discourse for shaping the acceptable spectrum of mental and behavioural phenomena, from "touched" to "mad," "insane," "mentally ill" and "mental health conditions." Language gives a sociocultural and temporal evaluative quality to mental states. This is not an obvious process, as power is legitimised in language and operates invisibly, carried on talk and texts, shaping the schematic structures of knowledge (Bourdieu, 1991)

Discourses of those who form these schematic structures of knowledge that reproduce and maintain the social order are what Foucault (1976) refers to as biopower. Yet, the effects of biopower are only influential for those who have first the linguistic intersubjectivity, or what Bourdieu (1991) refers to as a linguistic habitus, to recognise the meanings of the discourse, even if subliminally, and recognise the power that employs the discourse. Discourse alone cannot produce power but operates through "a given relation between those who exercise power and those who submit to it, i.e. in the very structure of the field in which *belief* is produced and reproduced." This symbolic power that produces and maintains the social order is only achieved when there "is a belief in the legitimacy of words and those who utter them" (Bourdieu, 1991, p.170).

As such, discourse maintains this social order with power embedded in the legitimacy of language, which we communicate with and think about events, others and ourselves in these discursive events that pass off daily as ordinary talk and thought of what at times may appear as unimportant (Parker & Cuéllar, 2014). Yet, the symbolic power of language makes discourses more than mere words as "discourses are composed of signs; but what they do is more that use these signs to designate things. It is the *more* that renders them irreducible to the language (*langue*) and to speech. It is this "*more*" that we must reveal and describe." (Foucault, 1961, in Rivkin & Ryan, 1998, p.191). It is this *more* that is the focal point of this study that provides insight into how mental health and social class are dialogically relational. To investigate this more, I needed to deconstruct the discursive events that are accounts of mental health described by the participants of this study.

2.4.3 Post-Structuralism

According to post-structuralist theory, discourses function as a mirror to the symbolic power structures that shape social reality (Moon & Blackman, 2014). Critically, due to this embeddedness of power, the meaning of discourses cannot be taken at face value, as when they signify one thing, they exclude another operating in binaries and contextual multiplicities (Derrida, 1970) with multiple significations and chains of signifiers that are contextually specific (Lacan, 1955). De Saussure (1989) states,

> In the language itself, there are only differences. Even more important than that is the fact that, although in general a difference presupposes positive terms between which the difference holds, in language there are only differences, and no positive terms (p. 118).

Derrida (1970) states that due to this difference in meaning and the ability of language to defer, which he refers to as "différance", we must *deconstruct* the text in a double reading. The first reading is to interpret the text's concepts, assumptions and arguments, and the second is to view the undercurrent of the text, or the repressed and excluded arguments. By doing so, a discursive analysis allows access to the signifiers that shape the meaning and thus the subject (Parker & Cuéllar, 2014). This study follows this poststructuralist position, and takes an approach to discourse where language is embedded in and formulates the social order, shaping minds, activities and practices, and by the analysis of discourse, insights can be gained.

2.5 Bourdieusian Theory of Practice

In the context of this study, it is the social order that is made up by and operates through discourse is based on a capitalist economy and society (Parker & Cuéllar, 2021). Not only in terms of the traditional Marxist structuring of society around workers and owners of the means of production, but in terms of the ever shifting and evolving capitalist social and economic system that centres more so than ever around knowledge capital carried on language. As this research pertained to accounts situated not only within contemporary capitalist society but specifically within the class structure of society, a theoretical and analytic framework that accounts for this contextuality and the interactions between psychological and social factors within these contexts is crucial.

As introduced in Chapter One, Bourdieu's (1987b) theory of class suggests an interactional effect between society and individuals and the categorisation of classes through transient behavioural distinctions rather than objective stagnant measures. His theory of class is an expansion on his previous work, namely the theory of practice (Bourdieu, 1977). The theory of practice goes beyond objective measures of socioeconomic status, as they failed to capture the qualitative distinctions of the activities associated with the material and social conditions of class.

While this study initially focused on internalised social class (social class habitus), as the study progressed, it was clear that all elements of practice had relevance. Furthermore, Bourdieu (1977) warned of isolating the habitus from the other elements of practice and that doing so risks fetishising it as an analytical tool as opposed to a dialogical element of practice. Doing so abstracts habitus from sociocultural and historical contexts and the power structures where practice is performed. This leaves any analysis that solely focuses on habitus incomplete and arbitrary, and no more than the observational reporting of qualitative features, which misses the holistic nature of class. During the research process, I observed the arbitrariness of habitus as a standalone concept, and that the other elements of practice were too relevant to disregard. As such, I shifted my analytic focus to include all elements of practice and account for the interactive and dialogical activity in participants' accounts of mental health.

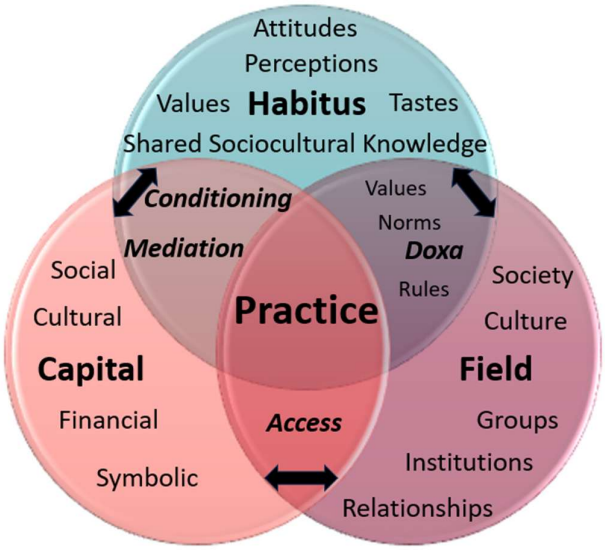
2.5.1 The Activity of Practice

As stated above, the habitus operates only in conjunction with the other elements of practice. Habitus arises as a result of different conditions of capital and the acquisition of doxa from social actors from various social fields. The social fields and recognition of different

forms of capital can only arise from the habitus, the distinct, shared sociocultural class-associated knowledge and practices. As such, the activity of practice that occurs on psychological, social and structural levels is iterative in its action (Bourdieu, 1977). Bourdieu (1990) uses the mathematical equation, [(habitus) (capital)] + field = practice, to illustrate the *logic* of the activity of practice. In Figure 1, I have used a Venn diagram to illustrate the three elements of practice and their interdependent and dialogical relationship.

Figure 1

Bourdieu's (1977) formula of practice, illustrated as a Venn Diagram.



Jenkins (1992) describes Bourdieu's practice as distinguished from other theories of class-based activity, as it is based on the

> Establishment of a statistical pattern of 'reality' as a basic datum, upon problematising what people say as something other than either simply a reflection of 'what is going on in their heads' or a valid description of the social world; upon the improvisatory and strategic nature of practice, as opposed to viewing behaviour as governed by rules; and upon the necessity for a diachronic analysis which situates the ebb and flow of social life in time and space (p.68).

Considering the holistic nature of Bourdieu's approach of viewing class as activities, relationships and practices in process rather than objectified static measurable outcomes, it

moves beyond the arbitrary conceptualisations of class commonly used in psychological studies (Wagner & McLaughlin, 2015) and proves very useful in this study as it aligns with the developmental method employed here that investigates mental health as processes rather than as a fixed state. Below each element of practice is described, illustrating the dependent relationship between habitus, fields (doxa) and capital that results in practice, but also links to its application in this study.

2.5.2 Social Class Habitus

For Bourdieu (1987a), class functioned beyond the material conditions of monetary capital and the individual's relationship with production and consumption, but within complex social relationships operating in social reality and the structures of society. Importantly, individuals and groups are social actors based on their relative position within social space. One's relative position is determined by the level of forms of capital they possess, concurrent with the social fields they occupy and relative to others within those fields. This shapes the activities and dispositions by the conditioning effects of social actors' relative positions and levels of capital (Webb et al., 2001). Bourdieu (1977) labelled these behavioural dispositions as social class habitus, defining it as "a subjective but not individual system of internalised structures, schemes of perception, conception, and action common to all members of the same group or class" (p. 86). Habitus exists on multiple planes of consciousness, both on an individual and group level as an intersubjective class consciousness (Bourdieu, 1977).

Habitus explains why individuals from social class groups appear homogeneous with similarities in their activities, accents, language, tastes and the values, attitudes and opinions they have (Bourdieu, 1984). The habitus is a "generative principle of objectively classifiable judgements and a system of classification" (Bourdieu 1984, p. 170) and the relationship between these functions that produces the practices, lifestyles and culture associated with class groupings. Bourdieu (1987b) found that those from similar socio-economic conditions statistically had a higher likelihood of having similar tastes, dispositions, and practices. In essence, the habitus is the internalisation of the social hierarchy, which produces class conditions and shapes how people live their lives, how they perceive the world, and the meaning they derive from their experiences (Bourdieu, 1984).

In this way, the habitus of an individual reflects the norms and practices of the collective class group, and while variations arise from differences in experience, generalised similarities in daily practices, tastes, and dispositions reflect the class of the individual as well as

intergenerational class backgrounds (Bourdieu, 1990). Importantly, this "systems of durable, transposable dispositions" (Bourdieu 1990, p. 72), while on the one hand is bound to class position, on the other it is to some extent malleable to experience and the fluid and temporal nature of society (Costa et al., 2019). Later in his research, Bourdieu (1981) posed that life experiences, particularly those brought about by social mobility, formed a cloved habitus (*habitus clíve*) where the shared sociocultural knowledge, norms and practices from new social fields' doxas' intersect, and often conflict, with the generative habitus.

The habitus functions for the most part, beyond consciousness (Bourdieu, 1977). The practices of the habitus, both external behavioural and cognitive dispositions, establish norms that are,

> Objectively regulated and regular without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them and, being all this, collectively orchestrated without being the product of the orchestrating action of a conductor (Bourdieu, 1977, p.72).

In this way, the internalisation of class conditions results in a cognitive schematic or "structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations" (Bourdieu, 1977, p. 72). This is how the habitus operates below conscious awareness, as it is in the very cognitive structure of the mind and operates as normal or regular psychological functioning (Lizardo, 2004). In this study, the habitus is perhaps the most useful of Bourdieu's concepts as it captures the psychological facets of social class, which is unmeasurable but observable in the language of the participants' accounts. Here, I view class through this Bourdieusian lens, as distinctions in habitus. Yet, as Bourdieu warned, my use of the habitus as an analytic tool can only be used effectively if it accounts for the other elements of practice it has a dialogical relationship with, that being capital and social fields.

2.5.3 Social Fields

For Bourdieu (1977), habitus is shaped by and operates within the bounds of social fields, which Bourdieu describes as

> A network, or a configuration, of the objective relations between positions objectively defines, in their existence and in the determination they impost upon their occupants, agents or institutions by their recent and potential situations…in the structures of the distribution of power (or capital) whose possession commands access to the special profits that are at stake in the field, as well as by their objective relations to other positions" (Bourdieu in Wacquant, 1989, p.39).

Social fields can intersect, interact, and overlap, functioning in different and multiple social realms concurrently (Bourdieu, 1989). Fields can exist as institutions or within them, in social or cultural groups and even families. In the accounts explored here, social fields provide the key contexts in which language performs. A signifier in one social field will have no relevance or power in another. Critically, where they do have power, they shape the activities of social actors within those fields. Yet, norms and practices of different social fields interact and are layered to produce complex sets of rules or norms of behaviour, or doxa.

2.5.3.1 Doxa. The regularities and legitimisation of specific behaviours in a given social field are known as a field's doxa (Bourdieu, 1990). Doxa are the taken-for-granted and normalised system of discourses, implicit beliefs, values and ideologies specific to a social field. They can intersect or have commonalities with other fields' doxa, and are continually shaped and reformed based on temporal and social changes, as well as diverging social actors' habitus, both within the field and in concurrent fields. Knowledge of the doxa of a social field can be a powerful asset as it allows actors to negotiate the field to gain access to resources, power and prestige. This knowledge of the "rules of the game" is a form of capital. For those who deviate from these rules, lack the knowledge of a doxa or do not possess the capital to adapt to them, they face consequences such as ridicule, disassociation and marginalisation, or what Bourdieu (1989) refers to as symbolic violence.

2.5.4 Capital

Capital, the other element of Bourdieu's formula of practice, is explicitly tied to fields (and doxa) and strongly impacts habitus (Bourdieu, 1986). Where one form of capital has symbolic or material value to one social field's doxa, it may have little or no value in another and may change within a field with time and circumstance (Webb et al., 2001). As such, capital can be anything that holds value for a social field at a given point in time (Bourdieu, 1977). Various forms of capital shift and are in constant flux, dependent on social fields, social actors and temporal changes within social fields. Importantly, capital presents in various forms such as financial capital, cultural capital, and social capital, as well as symbolic capital, which functions as respect and prestige gained through the former forms of capital, but is also a form of capital in itself (Bourdieu, 1986). For the analysis presented here, capital is again a key element in which we see participants' activities manoeuvring. As such, it is vital to differentiate between the different forms of capital so that they are recognisable in the texts.

2.5.4.1 Economic Capital. Economic capital comes in the form of monetary assets such as money, property, businesses, investments, stocks, bonds, collateral, and any valued material goods that can be sold (Bourdieu, 1977). Economic capital gives power by direct access to the purchase of goods, services and resources such as housing, food, education and medical care, but also culturally valued goods and activities such as designer clothes or attending the symphony. Economic capital in itself can hold great power within social fields as the economic resources and material possessions of such wealth are culturally recognised signs of status, acting as cultural capital and are strictly controlled within the social class hierarchy (Bourdieu, 1987b).

2.5.4.2 Cultural Capital. Cultural capital is anything, material items or social activities, which holds value and prestige within a field and is present in three states (Bourdieu, 1986). Cultural goods, such as material goods which have symbolic but not material value, or goods that are the product of cultural knowledge, such as books, engineering, or machinery. Embodied states of cultural capital, such as a position or role within a field that holds authority, power, respect, or prestige, as well as a class habitus that is valued. Finally, cultural capital can come in an institutionalised state, such as a qualification or an occupation that is held in prestige, relevant to the social field's doxa. Importantly, what is cultural capital in one field may not be in another, and it is strongly linked to social class, functioning as a class distinction (Bourdieu, 1984).

2.5.4.3 Social Capital. The third form of capital is social capital and exists purely in relationships that foster access to resources and power (Bourdieu, 1989). These relationships may be between individuals, or affiliations with institutions, families or groups (Bourdieu, 1986). Key to social capital, as with other forms of capital, these relationships are only a form of capital in the given field that recognises them as such. Additionally, social capital can be transposable with other forms of capital, such as cultural capital. Membership in a social group or the relationships of the members within that group can have cultural value through simple association (Bourdieu, 1977). These relationships are occurring in fields and allow the individual to manipulate their position to establish social and even material gains (Bourdieu, 1989).

2.5.4.4 Symbolic Capital. Bourdieu (1989) stresses another form of capital that perhaps has the strongest effect on the accounts of mental health we see here, symbolic capital. Symbolic capital can be transposed onto the other forms of capital or can exist in their absence

purely in social reality as prestige and recognition. Like other forms of capital, it is only valued by those "endowed with the categories of perception and appreciation permitting them to perceive, know and recognise it" (Bourdieu, 1998, p.102). In this way, symbolic capital is "socially constructed collective expectations" (p.102), such as fame, strength, beauty, respect, dignity, honour, or valour. For those who do not or cannot recognise this form of capital, they experience symbolic violence and are treated as "socially inferior, denied resources, limited in their social mobility and aspiration" (Webb et al., 2002, p. 25). In essence, they are socially punished in the social realm through relationships for not recognising the "natural" order of society, with significant consequences for their mental health, or social suffering (Charlesworth, 2005).

2.5.5 The Analytic Applications of The Theory of Practice

Bourdieu's (1977) theory of practice is useful in this study as it captures social status beyond socioeconomic objective measures, but in the qualitative feature of the accounts explored here. It provides a framework of human activity guided by the symbolic structuring of society. Here, I have used Bourdieu's concept of practice, its elements of the habitus, social fields, doxa, and capital, as the structures which not just shape these accounts of mental health, but the structures in which mental health itself manoeuvres. In Chapter 3, Section 3.6.7, I outline how the features of practice are operationalised and identified in the data.

However, while I found Bourdieu's concept of habitus useful in terms of capturing the class contexts of participant mental health, it does not explain how or what mediates them. In the same vein, while practice is explained as an interaction between social fields (doxa), capital and habitus, it does not explain the mechanism by which practice is carried on. However, Bourdieu (1977, 1987b, 1990, 1991, 2000) does point to language as having a structuring power over practice, yet does not elaborate beyond its role as class distinctions of language use (linguistic habitus) or that language has symbolic power. To understand language's symbolic power to structure social reality and the minds of individuals, particularly in terms of mental health, I turn to the psychoanalytic theories of Jacques Lacan.

2.6 Lacanian Theory

Lacan's (1977) theories are useful here as it enables the deconstruction of what links the psychic and social realms, language. It presents a different conceptualisation of the essence

of what humans are and what accounts for experience. For Lacan (2006), language was not only the basis of all experience, but the unconscious itself was structured like a language, a collection of signs, signifiers, and signifying chains that interpret and intersubjectively ground what is experienced by the senses. This is not unique to Lacan, as it is derived from the work of others who position language as the force that structures consciousness, such as Vygotsky (1980, 2012) and De Saussure (1985). In this study, Lacanian theory provides the link between Bourdieu's class-situated practice and those of mental health through the analysis of the processes that are symbolically mediated by language.

For Lacan (1977), language is the vehicle in which all experience is based, by the contextual signified meaning of signs, which are symbolic of an invisible order that structures reality through rules, norms, values and meaning (culture). These structuring signifiers only exist through our relationship to language and with others that are mediated by discourse (Zizek, 2011). The sense-making by signifiers enables the processing of the external world we encounter through our senses, but also the mental activity that is the basis of mental health, which Lacan (2016) referred to as sinthome or symptoms, the observable manifestations of mental suffering and distress. Importantly, Baily (2009) stresses these symptoms are not limited to psychological manifestation but are a result of the individual's "specific configuration of its signifying chain on the Real" (p.222).

Thus, mental suffering is not confined to the mind but is an interaction between psychological and external planes bound by language (Parker, 2010). Here, Lacan's (2016) concept of sinthome and the centrality of language are useful as it provides a structure to explore accounts of mental health beyond the subjective experience, but in the very structure that is the basis of suffering, language. Lacan (1977) did not view mental health as a biological or psychologically based condition, but mental suffering associated with signifiers and a breakdown in the relationship of the three registers, the Symbolic, the Imaginary and the Real.[1]

2.6.1 The Three Registers

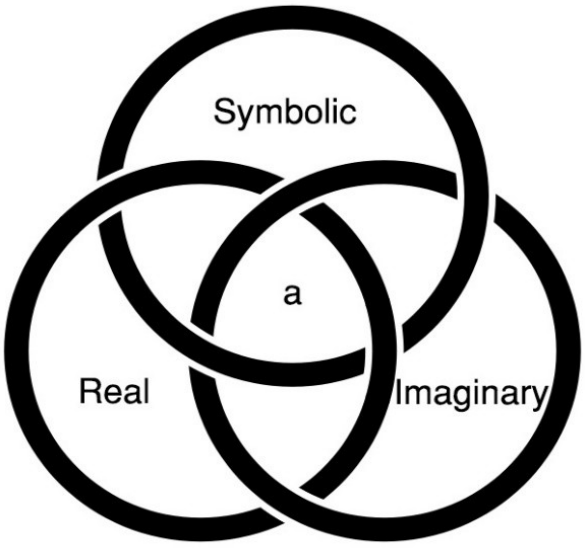
According to Baily (2009), Lacan's three registers act as a theoretical matrix through which the phenomenon of human experience can be understood and examined, and it is applied in this study as such. Through application of this matrix, the Symbolic, Imaginary and the Real "provide a framework for the understanding of the normal functioning of the human mind,

[1] As custom in Lacanian theory, the elements of the three registers, Symbolic, Imaginary and Real are capitalised to distinguish them as distinct theoretical references.

psychopathology, and also all of human institutions and creations" (Baily, 2009, p. 88). Critically, it is the interdependency of the three registers that accounts for the relations between psychological experiences and the social realm. It is that which constitutes the subject, an individual yet social agent. Like Bourdieu's (1977) elements of practice, one element of the matrix cannot be applied without consideration of the other. Each register is bound to the others, and that which is psychodynamic exists within those bonds (Baily, 2009). Lacan (1977) used the image of the Borromean knot to illustrate the binding relationship of the three registers as displayed in Figure 2. When the links between the three registers are weakened or removed, sinthome occurs, such as psychosis, depression or anxiety.

Figure 2

Lacan's (1977) three registers illustrated by the Borromean Knot.



2.6.1.1 The Symbolic. The Symbolic register is that which is internalised as language from the symbolic order "the laws of the unconscious ordering of human society" (Baily, 2009, p.94). This is comparable to what Bourdieu (1989) describes as social reality, existing in the relationships between social actors and the doxas of social fields. However, Lacan's (1977) Symbolic provides greater detail into the mechanism by which social reality manoeuvres, including the vector of language that structures society, and internal schemas of the

unconscious. The Symbolic is that which is universal to the collective and individual human history, as "even the most 'primitive' societies have a symbolic order that regulates kinships, exchange of goods, and marriages." (Baily, 2009, p.94). It is the norms of behaviour, morals, values, religious beliefs, laws, institutions, governments and, significantly to this study, the social structuring and hierarchical stratification of society based on socially constructed signifiers of class. According to Zizek (2014),

> The Symbolic dimension is what Lacan calls the 'big Other', the invisible order that structures our experience of reality, the complex network of rules and meanings which makes us see what we see the way we see it (and what we don't see the way we don't see it (p.176).

We enter the Symbolic when we are exposed to language, and we encounter this Other, the big Other, by this exposure. Lacan (1955) views this symbolic representation of culture as the Other, or the Other, understood as a trans-subjective social network carried by language. It is the voice of the symbolic order, not existing in objective reality, but only by language and the social network of relationships (Hook, 2003). While the Other is formed through the culture of others (groups or powerful individuals), it operates symbolically through relationships between people, in their discourses and the symbolic systems such as law and religion (Lacan, 1955).[2]

The Symbolic contains and regulates, prohibits enjoyment outside acceptable practices and limits subjectivities (Parker, 2010). Subjectivities are never fully defined as language fails to address our subjective truths, thus we remain split or divided subjects (Lacan, 1939). Desiring recognition, we align ourselves to the order of the Symbolic, framing subjectivities for the demands of the Other, always asking, as Lacan (1977) put it, "Che vuoi", what do you want, what does the Other want of me? Similar to Foucault's (1976) biopower, which posits that discourse operates to control minds, Lacan (1955) argued that the Symbolic operates through language on the level of the unconscious through signifiers to structure minds.

The structures that structure society also structure the psyche, forming reality as we know it, not to be confused with the Real, which is unknowable (Zizek, 2011). Our realities are our interpretation of the Real through our senses by language. It is the basis of all apperception and perception, the filter that is subjective experience, rather than the lived experience of an objective reality that can never be known. It is important to note here that this study takes this

[2] As customary in Lacanian theory, the term "the Other" or "the big Other", a reference to the symbolic, is capitalised to distinguish it from "others", which refers to other people.

view as it does not investigate the lived experiences of mental health and social class, as, according to Lacan, these are unknowable. Instead, the data that is analysed are accounts of subjective experiences, constructed within the symbolic and presented to me during interviews as signifiers that construct an account of mental health. The internal psychical structure of signifiers that is the basis of these realities, these subjective accounts, is what Lacan (1939) refers to as the Imaginary.

2.6.1.2 The Imaginary. This study has only analytically engaged with the participants' Imaginary. Life worlds are constructed and carried on the signifiers of the symbolic, accessible only in the language of the interview texts. The imaginary occurs during the mirror stage of development, when a child views its image in a mirror and realises its subjectivity (Lacan, 1936). This does not necessarily occur with a reflection in an actual mirror but in the mirroring that occurs as the infant recognises its difference in being from its mother (or initial caregiver) and signifiers that frame the child as an individual agent (Brennan, 2021). It is not a complete image, but a specular one, a reflection of the self with which the ego is constructed by signifiers. The image of our bodies that we behold in the mirror is a "body mediated culturally by ideological misrepresentation. What we know of ourselves through ideology includes strange alienating ideals about our bodies, our bodies and turned into objects to be bought and sold and consumed by others." (Parker & Cuéllar, 2021, p.83). The connection between the Imaginary and the Symbolic begins in childhood and continues to be pivotal throughout life. Without the imaginary, the subject would have to face the Real, which would be unbearable. A "reality" is constructed, an illusory sense-making of the Real that protects the psyche of the subject.

2.6.1.3 The Real. The Real is that which can exist beyond the realm of human consciousness but can be controlled or influenced as a result of human activity (Pohl & Swyngedouw, 2023). The experience of the Real is that of "extimacy", the interpretation of psychical and psychical experiences of the body through language and thought (Declercq, 2004). The actual features of the Real are beyond the possibility of experience as the subject is bound to the filtering perceptions of the Imaginary and can only experience their own "exstimate" reality. While signifiers shape reality, the Real escapes capture and is unspeakable by language (Baily, 2009). For Lacan (1977), it was in the Real of the body that the psychopathological symptoms from the breakdown of the three registers manifest (Declercq, 2004). In the Real of the physical experience of the hallucination of psychosis, the racing heart of anxiety and the fatigue of depression (Baily, 2009). However, by the analysis of the language of the accounts of mental health as explored here, it is that which is missing, the unsaid, that

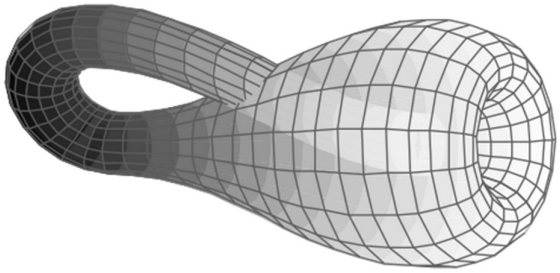
which is concealed by deferring signifiers of the Imaginary that points to the Real for these split subjects.

2.6.2 The Subject

According to Baily (2009), the Lacanian concept of the subject is elusive as it is constituted by signifiers with no objective existence, only symbolic. Like a self-concept or identity, what constitutes the subject is in flux once the individual encounters the Symbolic through language during the mirror stage. The imaginary identity of signifiers that constitutes a self-concept, the ideal ego, is never fully aligned with the subject. They cannot fully capture the self through language and are split subjects, an incomplete collection of signifiers (Baily, 2009). Language, that which is external, becomes internal and then is external again, as signifiers shape the self and are then performed by the subject. Lacan uses the image of a Klein bottle, as depicted in Figure 3, to illustrate the seamless linguistic relationship between the symbolic and the subject in the process of subjectivity, or subjectification (Lacan, 2011a).

Figure 3

Topology of subjectification as illustrated by Lacan (2011a) with the Klein bottle.



Note. Klein Bottle, by Tttrung, 2010, [image]. Wikimedia Commons (https://commons.wikimedia.org/wiki/File:Klein_bottle.svg) CC BY 3.0.

According to Fink (2025), what distinguished Lacan's concept of the subject from other theories of subjectivity is not only that the self is constituted by signifiers, but that these are of the Symbolic, and mediating and constructed on signifiers. With signifiers come multiple and shifting signifying chains that not only structure the subject but also society (Parker & Cuéllar, 2021). Thus, the ideal ego (the imaginary image derived from the mirror stage) and the ego ideal (that which the Other tells us we should be) are carried on signifiers. We are not only a subject made of the symbolic, but a subject of the symbolic, including the power frameworks that structure society, that of gender, class and race, among many other structuring signifiers.

Parker and Cuéllar (2021) show the critical nature of Lacan's concept of the subject in how these power structures of the symbolic shape the self.

> We live in the *exteriority* of the unconscious. Here, in this outer structured field of being, it is as if each individual must occupy his or her place, the one that corresponds to him or her, distinguishes him or her from the others, and then, as they adapt to society, that which makes him or her coincide with them (p. 36).

Here, the subject is constructed by the symbolic, but it also constructs it with its performance of signifiers. In the case of the participants in this study, I take them as subjects, individuals not only shaped by signifiers of the symbolic, but also split by them. The suffering that is described in these accounts of mental health is not purely a psychological manifestation of an individual brain, but the mental suffering of a subject split by the signifiers of the symbolic. The participant's mental health is intersubjective, that of both the individual and the collective symbolic, and I examine these accounts through these processes, discourses and signifiers which split the subject. It is worth noting here that Lacan's (1977) concept of the subject holds resonance with Bourdieu's (1977) habitus in the structuring of the unconscious by the external structures that guide the subject to align with those structures, which is visible in their external practices and internal desires.

2.6.3 Desire

For Lacan (1977), the central facet of his theories was desire. Desire, as opposed to drive (the biological motivation to satisfy bodily needs), fulfils psychological needs. It is central to the structure of the psyche and the essence of many emotions such as love, enjoyment, lust, jealousy, anger and disappointment (Baily, 2009). The very first social psychological need we desire for an infant is the love of the mother (or primary caregiver). It is central to many of our social relationships, to culture, as what is desired (the object of desire) is that which holds symbolic value (the object cause of desire). Lacan (2016) argued that desire was so central to suffering and the emergence of the sinthome, or mental health condition. In the accounts of mental health explored here, participants' desire is central in their negotiations with and of signifiers. Signifiers that give what they desire, and those that structure their desire and thus shape ideal egos and ego ideals. Baily (2009) argues that many symptoms emerge around desires, such as repetitions in destructive behaviours and addictions, compulsions, obsessions, delusions, and phobias. While Lacan (1977) suggested that desire was central to the formation of the subject and our relations with other subjects, he argued that desire is never our own, but always that of the Other.

2.6.3.1 Desire is the Desire of the Other. From the mirror stage, the infant demands its needs, the fulfilment of drives, and the caregiver fulfils these (Lacan, 1936). But as it demands that which it desires, the fulfilment of psychological needs, the expectation that this initial other will provide is generalised to the fulfilment of desire. This need to have desire fulfilled by another, and then by the Other, continues throughout life as the subject engages with language and psychological needs become expressed through signifiers. Once demand for that which is desired is signified by language, desire is the desire of the Other (Lacan, 1936).

2.6.3.1 Lack. It is with this assumption that what we desire is that of the Other, and the illusion that the Other can fulfil these desires that the lack in subjectivity is created and suffering circulates (Lacan 1936). In the mirror stage, the first Other is the mother, who leaves the presence of the child often to be with the father. The second Other, the child questions, "What does the father have that I do not? What do I lack that my father has that my mother wants?" According to Lacan, what the father has is only illusory, as is the lack and what forms the ideal ego. As the subject goes through life, it encounters other embodiments of the Others, in peers and the media (Baily, 2009). That which is desired by those embodiments of the Other is what is part of the trans-subjective symbolic order structured by language. That which is desired to fill this lack is what the Other desires of you, the ego ideal or the "Che vuoi" that the other demands. Once we enter into the world of the Other, that of the symbolic order of language, we are split and lacking, desiring that which will bring the illusion of psychological fulfilment, the Objet Petit a (Lacan, 1977).

2.6.3.2 Objet Petit a. As the split Subject continues in life, lacking illusory fulfilment, mental distress centred around that which the Other says will fill the lack, the Objet Petit a (Lacan, 1977). The Objet Petit a is the object cause of desire and is both at the same time the lack and that which fulfils it, but only temporarily, as the lack can never be fulfilled, as it is based on the Imaginary and conceptions of self. In this study, we will see the participants seek out things that will mask the lack, such as expensive clothing, for example or a high-status job. That which is valued and desired is the object of desire, but the object cause of desire, that which is believed to fill the lack by obtaining the object desired, is the pride, prestige and status that the clothes or job brings, the recognition from the Other for answering the illusion of what the Other wants of us. This is comparable with Bourdieu's (1977) forms of capital. Cultural capital is a valued object, the respect and prestige are the symbolic capital obtained from acquiring these valued objects. However, the valued object is obtained, the lack is momentarily filled, only to return as the demands of the Other are only symbolic and never satisfied. The

Subject is caught in a never-ending pursuit of the illusory Object petite a and is left with a sense of melancholia and depression, as what masks the lack will never fill it (Hook & Neill, 2013).

According to Parker and Cuéllar (2021), the symbolic order of modern neoliberal capitalism profits from the fetishisations of objects of desire, selling products to fill the lack. We are told that if you have this lifestyle and valued objects, you will meet the demands of the Other, filling the lack. We spend our lives chasing the right job, spouse, house, cars, holidays and clothes, all in attempts to construct the ideal ego by meeting the demands of an ego ideal. The symbolic order conceals the illusion that the lack can be filled with consumerism and propels the symbolic order forward with never-ending consumption (Parker & Cuéllar, 2021). The symbolic order of the consumerist norms becomes embedded in the Imaginary by signifiers that are shaped by the ego ideal. As such, the market logic of neoliberal capitalist Symbolic becomes the internal logic of the Imaginary, the evaluative measure of self. The internalisation of capitalist discourses is a never-ending discursive pattern in which the subject never produces self-truths but is caught chasing moments of surplus enjoyment and jouissance (Vanheule, 2016).

2.6.3.3 Jouissance and Surplus Enjoyment. Lacan never provided an exact definition of jouissance, and a direct translation of the French term into English is often problematic (Hook, 2017). A common understanding of jouissance is that of the enjoyment taken from the pursuit of the object petit a. While there are momentary pleasures that arise from the satisfaction of gaining the object of desire, it is replaced by disappointment and melancholia, a suffering of the inability to fulfil the lack. This suffering comes with an enjoyment that, often because it goes against norms or the Other, is prohibited. As such, it is not a private intrapersonal phenomenon but one that is intrinsically connected to the social world through the symbolic logic of signifiers (Pohl & Swyngedouw, 2023). This prohibition is against what would fill the lack and acts as a symbolic castration of enjoyment, linking back to the initial castration in the mirror stage and the formation of the ideal ego. This "enjoyment-in contrast to pleasure-is this insatiable, anxiety-ridden and often painful, but increasingly failing attempt to suture the void opened up by symbolic castration" (Pohl & Swyngedouw, 2023, p.3). Jouissance always leave one wanting more, wanting surplus enjoyment, the desire to desire.

2.6.4 The Mediator of Language

The above discussion on the three registers, desire, lack, object petit a, and jouissance, shares the common element of mediation through language. Lacan's theory developed from

Freudian psychoanalysis and, as such, is centred on language as the formation and structure of the unconscious. (Baily, 2009). It is important to define what is meant by unconscious in Lacanian terms, that it is "comprised of symbolic elements, and because we are speaking beings for whom language is the main vehicle of representation, its building blocks are words, and its structure is grammatical" (Baily, 2009, p.42). Yet, the unconscious is also suppressed by the Subject, and only accessible through the analysis of text (spoken or written). It is this linguistic structuring of the unconscious that makes us uniquely human, separate from other animals, who may have forms of communication, but not language.

Lacan's (1977) theory not only focuses on discourse, but specifically signifiers, and what lies beneath them, the signified, the undisclosed and often paradoxical meaning of the sign operating on the unconscious of the subject. Critically, Lacan (2006) argued that descriptions of lived experiences cannot be taken at face value, as they are always mediated by language. This is both in terms of the experience itself and that of the interpreter of the description. This is why, for Lacanian approaches, language is the focus of analysis in the clinic, and later developed Lacanian analysis of discourse implemented in research (Parker & Cuéllar, 2014).

2.6.5 Lacanian Discourse Analysis

The previous section on Lacan's theory provided one part of the theoretical framework of this study. The application of this theory is made by the use of the analytic method of Lacanian discourse analysis (LDA). The procedural application of LDA applied in this study can be viewed in Chapter 3, Section 3.6.8. In this section, I will only explore the theoretical positioning behind this method. Discourse in Lacanian terms can be understood as the linguistic expression of the three registers (Parker, 2005). The symbolic nature of the signifier and its imaginary signified meaning, shifting chains of signifiers that occupy reality and the way the discourse never can capture all that is true for the agent, that of the Real (Neill, 2013). For Lacan, discourse is how language is organised to structure the symbolic, but organised with purpose, with an intent to signify something more that is held within the individual signifiers. While Lacan was concerned with the speech of the analysand, the analysis of discourse is more concerned with texts. What determines the nature of a text is simply any presentation of significations that is socially structured, and these significations can provide a window into the mind of the speaker (Parker, 2005).

Therefore, the analysis of discourse is essential for a critical investigation of the relationships between psychological and social phenomena (Parker, 2005), such as mental health and social class. Yet, due to the intervention of the Symbolic and the Imaginary, a real discourse analysis is not possible (Neill, 2013). This is because the researcher can only apply their own Imaginary reading to the text, engaging in the symbolic world of signifiers, but with their own chains of signification. What is central to this study is that all activity of mental health is emmeshed in discourse, and as stated by Foucault (1966), language is not neutral, and acts on the subject in powerful ways. However, Lacan (1977) refines this idea down to the power of the signifier and in the signifier.

2.6.5.1 The Master Signifier. Before exploring the four discourses, it is necessary to focus on what discourses circulate in a text, the master signifier. The master signifier is the dominant imaginary meaning attached to a signifier and holds a fetishised and powerful status in the text and in the symbolic order (Hook, 2016). However, the power it holds within a text and for the subject, the speaking agent, is subjective, temporal and socioculturally bound to the intersubjective knowledge of the agent and the Other (Neill, 2013). Yet, for all its power, it fails to capture that which it attempts to signify, as it is an empty signifier that always leads to more and more signifiers. These chains of signification are the basis of the knowledge that supports the master signifier fetishised value, but at the same time are never able to capture the Real (Hooke, 2016). Some examples of master signifiers may be freedom, faith or resilience. When asked to define what these words mean, they only lead to more and more signifiers that never explain the master signifier or justify its explanatory power over the text, and often the speaking agent (Vanheule, 2016).

2.6.5.1 The Four Discourses. The master signifier operates in the different forms of discourse to shape the imaginary meaning or sense-making of the agent. In the case of the discourse of the master, the master signifier operates with chains of signifiers informing the agent with its knowledge, blocking the agent from the truth. These chains of signifiers that hold the knowledge operate as the discourse of the university. It occupies the position of truth-producing ideological forms of knowledge (Hook, 2016). These are often held with significant power in social realms such as institutions, whether ideological or actual. However, when the agent questions these forms of knowledge and the power of the master signifier, they produce the discourse of the hysteric. The truth of the discourse of the university is questioned, and the power of the master signifier is rendered unstable as truth is perceivable as it is no longer masked by the symbolic discourse. The agent no longer accepts the knowledge that supported

the discourse of the university or the authority of the discourse of the master and begins to produce the discourse of the analyst, making new chains of signifiers that represent a more acceptable truth for the agent, yet still chains of signifiers of the Symbolic operating in the Imaginary (Niell, 2013).

Through an application of Lacan's forms of discourse, this analysis "addresses the text as an incomplete subject, seeking to understand without seeking to impose and, in doing so, produces new understandings, new meanings, which are to say, meanings which are not in the text as such." (Neill, 2013, p. 347). By doing so, this analysis deconstructs the text, untethers it from the Symbolic and Imaginary, while at the same time opening the text to new and multiple perspectives. A *Lacanian* discourse analysis explores the interaction between the social realm and the psychological in a deep and robust manner that is capable of generating findings and supporting theories that emerge from the analysis of text, such as the critical findings derived from this study (Neill, 2013).

2.6.6 The Lacanian Approach as a Critical Lens

As discussed earlier, the methodological principles of this study are in line with the critical positionality that is the central underpinning of LDA, that of the interconnectivity of the subject and the social through language (Parker & Cuéllar, 2014). This critical engagement with the language of the individual, with a focus on the unconscious psyche, makes LDA applicable for the analysis of interview texts beyond the capabilities of other forms of critical discourse analysis (Parker, 2010). While other forms of discourse analysis label and describe aspects of discourse, LDA used on interviews applies principles of theory as a tool that does more than colonise the text with theory, but deconstructs the text to engage in a psychosocial reading. This provides significantly more depth of analysis through a critical engagement with the text that is a "politically progressive" method of discourse analysis (Parker, 2010, p.158).

This is particularly relevant for a critical investigation of mental health and social class. In terms of mental health, Lacanian theory provides the structures with which to understand mental suffering while also incorporating the structures that explain the social suffering as described by Charlesworth (2005). Critically, Lacanian theory understands "psychic pain has a material basis which is a strange unconscious combination of personal life history and the history of the society in which people are told they must enjoy and how they may suffer" (Parker & Cuéllar, 2021, p.65). Thus, it provides the theoretical basis of mental health as split subjects divided by the symbolic order that structures society as much as it does the subjects

themselves. In this regard, Lacan's theories provide a framework, in part, that enables an in-depth analysis that accounts for the criticality desired in this study, addressing not only the relationship between the social and the psychological but also how power operates within this relationship through signifiers.

2.7 A Synthesised Theoretical Framework

In this chapter, I presented a methodological framework that is theoretically derived from multiple disciplines and approaches. This was not simply a selection of theories that supported the methods, but a synthesis of theories that, while at times contradictory, together provide a dialectical framework that is effective for analytically challenging phenomena. This synthesis of theory in itself is a methodological contribution, as I used theories that, when woven together, are collectively more useful in synergy than individually. However, I did not simply apply one theory after another, but applied them holistically and collaboratively. Where one theory was limited in its ability to address the analytic aims, I desired, another theory was incorporated to address these aims. This integrated and interdisciplinary theoretical framework holistically positions this study, giving a robust grounding to its insights that the application of the theories individually or successively would not have achieved.

The synthesis is iterative, yet starting with a constructionist and sociocultural perspective, particularly the work of Vygotsky (1980, 2012), language was the locus of this study. However, as we know from Foucault (2013), language is not neutral, but operates with power as discourse. While Foucault would suggest that language is used as a means of power by the powerful to hold their position, how society is divided based on power and how these functions in daily life for the individual, I applied the neo-Marxism of Bourdieu (1977). Bourdieu's work suggests that not only how the capitalist class structure operates and is maintained through practice, but also that the habitus guides the individual to perform class-distinct practices that reproduce and maintain the class structures of society. Bourdieu explains how power operates through the subtleties of practice and links these to the symbolic power of language.

Yet, at this point, the theories of Vygotsky, Foucault and Bourdieu do not explain how language operates with power to shape thoughts, behaviours and practices, only that it has the transindividual ability to do so, leaving an incomplete picture. If language is the mechanism of power, enacted through practice, how does it function on the individual's mind? For this, I used

Lacan's (1977) theory, which incorporates the structuring of society (Symbolic) on the individual's mind (Imaginary), with language shaping the experience of the class-based material conditions of life that escape language but are interpreted and expressed by the Symbolic and the Imaginary (the Real). Not only does Lacan capture the interactive relationship between the social and the psychological through the vector of language, but also how language acts on the individual, splitting them and generating mental distress and suffering, commonly referred to as mental health.

By the analysis of master signifiers, repetition, contradictions, gaps or absences, desire for recognition and identification with the Other. Lacanian discourse analysis, therefore, focuses on dominant signifiers, repetitions, and moments of rupture in the text as indicators of symbolic structuring and the structural positioning of signifiers in chains of signification that are guided by the habitus during the symbolically mediated practices within social fields interacting with various forms of capital and other social actors. This integration of theories enabled me to address the complex relationship between mental health and social class through an in-depth engagement with language. The methodological applications of this are described in detail in the following chapter.

2.8 Summary

This chapter presented the philosophical and theoretical framework that underlies the methodological positioning of this study. It establishes a constructionist, language-mediated ontological position, arguing that while material conditions and mental suffering are real in their effects, they are accessed and understood through a mediation of socioculturally situated language. In this regard, this study's theoretical framework is purposely integrative, where theories not only complement one another but, in their synthesis, provide an in-depth approach. Where one theoretical component ends, another steps in to give further depth or illuminate different analytic facets.

Vygotsky establishes the constitutive role of language and other sign systems in higher mental functioning. Foucault situates discourse within power/knowledge relations, while Bourdieu explains how class structures operate relationally through practice, and Lacan provides a mechanism for linking symbolic structures to subject formation, desire, and distress. However, all these theoretical postulations are integrated under a critical approach. The theoretical basis for the methodology covered in this chapter, therefore, sets out the need for

analysing participants' interview accounts as discursively structured texts and provides the philosophical and theoretical justification for the corresponding analytic methods that were applied in this study and are covered in detail in the following chapter.

3. Methodology

3.1 Introduction

This chapter outlines the research methods used in this study, including a description of the epistemological design, ethical protocol, recruitment strategies, participant profiles, data collection and data analysis procedures, reflexivity, and methods to ensure qualitative rigour. Not only does this chapter outline the systematic research methods conducted during this study, which ensured methodological rigour and valid findings, but it also provides a "road map" to follow, enabling further research that may require similar methodological approaches. This includes the use of RTA on all 14 participants in order to map the data and generate themes. Then, interview transcripts were selected due to the presence of depth as well as incongruities and complexities observed in the RTA. These were analysed using a synthesised textual analysis employing a sociocognitive critical discourse analysis, a Bourdieusian analysis and a Lacanian discourse analysis. As the analytic approach is multileveled yet iterative, theoretically complex and derived from the theoretical framework, I have outlined how each method's theoretical underpinnings have been operationalised and applied as an analytic action in tables and diagrams. This chapter aims to give clarity to the methods used to assure the reader of the quality of research conducted, and the rigour of the methods used that resulted in the findings explored in subsequent chapters.

3.2 Qualitative Methods

The initial research question of this study, "Does social class habitus affect the lived experience of mental health, and if so, in what ways, amongst a sample of participants identifying as lower class, working class and middle class?" focused on the lived experiences. However, as the research developed and the methodology was refined, this study aimed to investigate class-based accounts of mental health as presented in the language by participants during interviews, and as such, an additional research question, "How does language shape the experiences of mental health described in the participants' accounts?" was added. In this regard, a research design that uses qualitative rather than quantitative methods is appropriate and applicable. That is, methods that investigate qualitative features of a phenomenon as opposed to objective, with a focus on meaning rather than measurement (Halloway & Biley, 2011). Qualitative research aims to capture how meaning is generated, reproduced, modified and negotiated to understand the social and psychological processes that underlie them and

their effects (Willig & Borsca, 2021). Importantly, qualitative methods go beyond the inquiry goals of capturing meaning but do so while acknowledging the subjective influence of the researcher, thus providing transparency to the subjectivity within the findings (Ratner, 2002).

In terms of the topics of this study, social class and mental health, quantitative approaches would give a numerical representation of socioeconomic position and diagnosis rates, but would fail to capture the experience of being of a low SES background and having anxiety regarding having the means to support basic needs, for instance. As such, quantitative methods using objective measures such as SES would not have fully explained the impact of social inequalities on psychological outcomes (Tan et al., 2020). This study needed qualitative methods to access the richness of these accounts through interviews and analysis that enabled in-depth insights, beyond numerical representation. Considering the points made above in relation to the research questions and the phenomena under investigation, this study used qualitative methods as they were the most applicable and appropriate for the aims of this study, including that it be conducted ethically.

3.3 Ethics

Due to the sensitive nature of the topics and personal accounts, ethical considerations were prominent throughout this study. For example, informed consent was a key consideration when recruiting participants and conducting interviews, as was the prevention and reduction of harm. The well-being and safety of the participants, as well as my own, were central to the ethical aims of this study. To achieve these ethical aims, an ethical protocol was drafted, approved by the Maynooth University research ethics board and adhered to throughout the entire research process. This ethical protocol is outlined below.

3.3.1 Ethical Approval Process

Ethical approval was granted by the Maynooth University research ethics board on May 24th, 2021 (see Appendix A). Before the application, I investigated the ethical issues typical to research on inequalities and mental health, as well as the intended data collection methods. An application was then made to the ethics committee under the tier three category due to the sensitive nature of the topics and the possibility that participants may have mental health conditions and/or emotional or psychological vulnerabilities or sensitivities. The ethics board raised ethical concerns over several other minor amendments regarding the consent forms, measures, and interview questions, which were addressed and resolved. On resubmission,

ethical clearance was granted under the terms outlined in the consent forms, information sheet and Maynooth University's ethical codes for research.

3.3.2 Informed Consent

Central to the ethical protocol was that participation be voluntary, with participants having complete knowledge of the aims and goals of the research so that participation was with full informed consent. To ensure informed consent, participants were first offered an information sheet (see Appendix B) and the consent form (see Appendix C) for their review before deciding to participate. This included the aims, goals, procedures and methods used, the sensitive nature of the topics under investigation and the inclusion and exclusion criteria. Exceptional care was taken to explain the use of discourse analysis, as Hammersley (2014) argues that the motives of discourse analysis go beyond investigations of accounts, but seek to examine the social world behind the language of the reported accounts, and thus, ethically, the participant must be informed of the use of such methods. At that point, potential participants had the opportunity to ask questions or request further information.

Those who volunteered and were deemed eligible to participate within the inclusion and exclusion criteria then signed consent forms. Participants who required online interviews had consent forms emailed to them before the interview or signed them in person if the interview was not online. Participation was completely voluntary, and no rewards, payments, or reimbursements were promised or paid. Participants had the right to withdraw from the study up until submission of the thesis or publication and were informed of this before signing the consent forms. Access to the data collected was made available on request, and participants were informed that it was likely that their data would be used in academic journal article publications.

3.3.3 Inclusion and Exclusion Criteria

As mentioned above, this study had an inclusion and exclusion criterion. There were no set criteria for inclusion in the study, as anyone, regardless of their social class status or past mental health experiences, could participate. Participants needed to have a general fluency in the English language to enable them to have informed consent and to allow for the continuity of cultural associations with the English language. Participants were not sought from a particular background, although a broad range of people were actively recruited through a broad social media campaign. Participants did not need to have considerable experience with

mental health or a diagnosed mental health condition to participate, as mental health was seen as a universal experience (Scheid & Wright, 2017).

However, due to the sensitive nature of topics, the personal nature of questioning and for the prevention of harm, a strict exclusion criterion was applied to those under the legal age of consent, age 18, anyone with whom I had a close relationship, or where there was the possibility of power imbalances that could have led to a conflict of interest. To prevent harm to those who may have been experiencing vulnerabilities due to mental health conditions or who were currently or had experienced an acute mental health crisis in the past 6 months, or were in a sensitive state, they were asked not to participate. An acute mental health crisis was explained as

> An acute mental health state means you have experienced significant psychological or emotional distress, suicide attempts, self-harm or have been hospitalised for a mental health condition. This may also include experiencing a recent bereavement or trauma that will make you psychologically and emotionally vulnerable (Consent form, p.2).

Finally, those who found the topics of the study sensitive were asked not to participate, and this was maintained throughout the interview process. While participants subjectively evaluated their sensitivity and distress, if I thought that the participant became distressed during the interview, then the exclusion criteria would be enacted, and the interviews would cease. This was outlined clearly in the informed consent process. Particular care was taken to provide support services' details provided in the information sheet to those who were excluded from the study under these terms.

3.3.4 Prevention of Harm

3.3.4.1 Participants. Protection of harm before, during and after interviews was given prominence due to the sensitive topics under discussion and the potential vulnerabilities of the participants. In cases where vulnerabilities were suspected, extra care was taken during the selection process and during interviews. The protection from harm of those who were experiencing vulnerability was a key function of the exclusion policy. During interviews, participants' well-being was checked on regularly and asked if they needed a comfort break. Active listening, nonjudgmental responses, empathetic understanding and verbal paraphrasing were used to minimise harm and establish rapport. While every effort was made to minimise distress throughout this research process, many participants spoke of distressing experiences, and by doing so, felt some emotional distress, which was transient as they recovered quickly. These moments of emotionality did not necessarily cause harm and, in most cases, were

described as beneficial. Jaffe et al. (2015) argue that recollection of trauma in interview settings does not always result in a re-traumatisation, but instead can be therapeutic and a positive experience, which was reported by all participants in this study.

However, when participants did become distressed, the interview would be paused until they were less distressed, with the option that the interview would be abandoned if deemed too distressing, which never occurred. The final decision to continue the interview was with myself, so that even if the participant wanted to continue, I could cease the interview to prevent further distress. After the interview, participants' well-being was again checked, and they were provided with contact details of support services (Ireland and the USA) and suggested they contact them at any stage if they felt distressed directly after or in the future. My own, as well as my supervisor's contact details (university email), were also provided, and I outlined the circumstances in which they may use these.

3.3.4.2 Researcher. While prevention of harm to participants was of utmost importance, prevention of harm and my personal safety were also observed. First, my own mental health was monitored in case I found the topics too distressing or the workload too much, and I was carefully aware of the signs of burnout. I had access to support throughout the project, including my supervisor, student services, counselling services, a private psychotherapist, as well as the support of peers and family. I also kept a reflective journal (see Appendix L) so I could express and document how this project was impacting me and to record any influence this may have on the research.

Another key safety protocol related to my interactions with participants during recruitment and interviews. As some recruitment was with social media, I did not use my personal accounts and created new professional ones and used my university email address for all correspondence. When arrangements were made for online interviews, these were done with Microsoft Teams in my home office while wearing headphones and having the background blurred to ensure privacy. When interviews were conducted in person, I had a strict safety protocol that participants were informed of before they signed the consent forms. Upon meeting the participant, I produced my university ID and offered the ethical approval letter to reassure the participant, but also provide evidence of my identity and role as a researcher. Interviews were only conducted in locations where I felt safe and had a means to leave if necessary. Interviews were never conducted without the presence of another person in the vicinity, as their

presence provided reassurance to the participant, who was often unknown to me, but also to myself if assistance was needed.

3.3.5 Data Protection and Confidentiality

From inquiries made about participation to publications and submission of the thesis, maintaining confidentiality with data protection procedures was strictly followed. All participants were made aware of the data protection and confidentiality procedures through the information sheets and consent forms, and were asked if they understood these prior to participation. The anonymity of participants was always protected, with pseudonyms and any identifiable information being changed or removed in transcripts and excerpts used. Hard copies of participants' questionnaires and consent forms were kept in a locked file cabinet in the Maynooth University Department of Psychology. Digital recordings of interviews were deleted after transcription, and online copies of transcripts, digital consent forms and questionnaires were printed and then deleted. Emails with participants were password-protected with multiple-factor authentication. Participant lists and hard copies of consent forms were number-coded and kept separate from transcripts.

3.4 Participants

3.4.1 Recruitment and Selection Process

Convenience sampling was the main method of data collection used, and in one case, snowball sampling. Recruitment of participants primarily occurred with the distribution of a recruitment flyer (see Appendix D) on social media (Facebook and Twitter). This flyer entailed a brief description of the purpose of the research as well as the inclusion and exclusion criteria. Recruitment continued for a period of six months, during which candidate participants who responded to the flyer, inquired directly or through a gatekeeper, were sent information sheets and sample consent forms for their review. One participant was known to me, but only as a distant acquaintance, and there was no close personal relationship. In another instance, I was known to the gatekeeper to the participants, but completely unknown to the participants themselves. If, on review, they were still interested in participating, they would be added to the participant pool, and interviews would be scheduled.

The recruitment strategy did not specify participant demographics such as gender, race or class, but recruitment ceased when there was a relatively equal balance of (subjectively

identified) genders and social class groups. While attempts were made to access upper-class and elite groups through gatekeepers, no participants from these demographics agreed to participate. Data collection ceased when a period of a month had passed with no inquiries, and data showed replication in terms of the initial observation of content. Additionally, as the method employed discourse analysis, depth as opposed to generalizability was the aim, and each transcript was of substantial length, and with 14 transcripts of significant depth, the recruitment ceased. Further discussion on the limitations of the recruitment process can be viewed in section 8.5 of Chapter 8 regarding the representativeness of the sample.

3.4.2 Participant Demographics

Of the fourteen participants, seven self-identified as male, six as female and one as non-binary. Age ranged between 18 and 58, with a mean age of 37.53 and a median age of thirty-two. Five identified themselves as middle class, six as working class and two as lower class. Of the middle-class participants, two stated they had social mobility from a working-class background, one from a lower-class background, and two of the working-class participants stated they had social mobility from lower-class positions. While the questionnaire did not ask about participant race or ethnicity, observations of race were made, and participants self-identified their ethnicity during the interviews. Participants were all Caucasian, and ethnicities were Irish, Turkish Irish, English and American. Participant demographics are displayed in Table 2.

Table 2

Participant Demographics, MacArthur Scale Results, Subjective Class Identity and Interview Format

Participant Number	Pseudonym	Gender	Age	SSS	House	Food	Money	Things	Class Identity (Social Mobility)	Online/in person
1	Jeffery	Male	19	6	Nicer	Same	Same	More	Middle Class	In Person
2	Sarah	Female	54	3	Nicer	Same	Same	Less	Middle Class (WC)	In Person
3	Ben	Male	18	4	Same	More	More	More	Middle Class	In Person
4	Ari	Non-Binary	32	8	Same	Same	Less	Less	Working Class (LC)	Online
5	Kate	Female	53	6	Same	Same	Less	Less	Working Class	Online
6	James	Male	58	8	Same	Same	Less	Same	Working Class	In Person
7	Cherie	Female	32	8	Same	Same	Less	Less	Lower Class	In Person
8	Susan	Female	53	5	Same	Same	Same	Same	Middle Class	Online
9	Linda	Female	32	9	Nicer	Same	Less	More	Working Class	Online
10	Kevin	Male	31	6	Nicer	More	More	More	Middle Class (WC)	Online
11	Carol	Female	45	3	Nicer	More	More	More	Lower Class (LC)	In Person
12	Alex	Male	27	8	Same	Less	Less	Less	Working Class	Online
13	Patrick	Male	44	7	Same	Same	Same	Same	Working Class	In Person
14	John	Male	52	3	Less	Less	Less	Less	Lower Class	In Person

3.5 Data Collection Procedures

Data collection consisted of a questionnaire and semi-structured interviews. The questionnaire (see Appendix E) recorded participant demographics of age and gender. These questions were self-report, where the participant filled in a blank space for their age and gender, leaving the participants freedom to list any age or gender they identified with. Three measures of subjective social status were used in the questionnaire: the MacArthur scale with a social comparison question and a self-report social class identity. Results are displayed in Table 2, and the questionnaire can be viewed in Appendix E.

3.5.1 Questionnaire and Subjective Social Status Measures

3.5.1.1 MacArthur Scale. Participants first completed the MacArthur Scale, which has a graphic representation of the structure of society as a ladder with ten steps, with numbers one to ten labelled for each step, one being the highest step and ten being the lowest. The MacArthur is used to assess an individual's perceived rank within the context of their community. This gives context and culturally specific evaluation in terms of subjective social status (Adler & Stewart, 2007). The scale is commonly used as a means of measuring subjective social status to capture features of social rank beyond subjective social status measures and has been validated in terms of reliability by Giatti et al. (2012), as well as having high construct validity by Galvan et al. (2023). When the

In this study, Participants were provided the MacArthur scale as a questionnaire that asked them to:

> Imagine that the ladder is a picture of how (your country) is set up, at the top of the ladder are people who have the most money, the highest amount of schooling, the best jobs and the most respect. At the bottom are people who have the least money, little or no education, no jobs or the jobs no one wants, and the least respect. Now think of your family. Tell us where you think your family would be on this ladder? (Questionnaire, p.1)

Participants then mark the number beside that step on the ladder which best represents where their family would be in the society of their country. The MacArthur scale was also used as a prompt during the interview to ask questions such as "What would your position be on the ladder when you were a child?" and "How would people who are higher on the ladder be similar or different from you?"

3.5.1.2 Social Comparison. A subjective social comparison measure was used in conjunction with the MacArthur scale. This asked participants to consider their access to

resources of housing, food, money and things. Participants were asked, “Compared to most families, my family has….” Then they circled their response from the categories of housing, food, money and things based on three choices: more, less or the same.

3.5.1.3 Categorical Class Identity. The categorical social class identity question asked, “Which social class would you consider yourself a member of?” Participants then circled from a choice of seven answers: lower class, working class, middle class, upper middle class, upper class, elite, and I do not know. The purpose of this question was to capture any subjective class identities or social class labels they identified with. This question was also used as an interview prompt during interviews.

3.5.1.4 Analytic Treatment of Social Class Position. While multiple methods were used to capture participants’ social class position, these were used as supplementary to the discursively constructed indicators of habitus (see Table 5 for operationalised indicators of habitus). However, the use of all elements of the participant questionnaire was useful to gain insights into their material conditions of class positionalities and self-declared identity frames. In this regard, the self-identified class category, the MacArthur scale and the resources question were triangulated to produce a reference in terms of the participant’s perceived status in the social class hierarchy. This was also useful when social mobility was a factor, as self-declared identity frames often did not match the associated positions on the MacArthur scale of the resource question, and these incongruences were accounted for in the discursive analysis with indicators of Bourdieu’s (2000) concept of a cloven habitus.

3.5.2 Interview Schedule.

The development of base questions and sub-questions, or interview schedule, for the semi-structured interview was done in relation to the research questions and the aims of the study. It was also informed by literature on mental health and social class, and the theoretical concept of the habitus, so that the questions captured the shared socio-cultural knowledge and practices associated with the participants' social class background and their lived experience with mental health. The questions were divided into three broad categories that aimed to address the lived experience of social class, including class-based identities, class culturally distinct practices and socioeconomic and material conditions. This was followed by questions that aimed to capture the participants' lived experience of mental health and then questions that aimed to address the relationship between the two phenomena. However, it is worth noting that as these were semi-structured interviews, and as such, not all questions were asked to all

participants, and some questions arose based on the participants' responses that are not captured in the interview schedule. All questions were recorded in interview transcripts and, where relevant, presented in the thesis in relation to the text that was analysed.

3.5.3 Semi-structured Interview Procedure

3.5.3.1 Interview Settings. In-person interviews were held in various locations, including the participants' own homes, Maynooth University meeting rooms, or an agreed-upon location. Locations for interviews were agreed upon by the researcher and the participant under the criteria that anonymity and confidentiality could be maintained, it was convenient and comfortable, but also that it was a safe and neutral space for both myself and the participant. This meant that at times it was appropriate for the interview to be conducted in the participant's home. However, as per the safety protocol, this was only agreed upon on two occasions where I felt safe, and another person would be present in the participant's home. This was only done when both the participant and I agreed upon it being an appropriate interview location, and we both felt comfortable. In both cases, the rationale for doing the interview in the participant's home was the limitation in mobility for the participant and limitations in terms of appropriate transport. For other participants, the interview was conducted in a neutral setting such as a meeting room at the local library. Some participants, due to location and COVID-19 pandemic travel restrictions, were interviewed online using Microsoft Teams video calling software. Participants' interview format is displayed in Table 2.

3.5.3.2 Briefing. After initial greetings, I provided participants with my university identification card and engaged in casual conversation to establish rapport. Then, information sheets and consent forms were discussed, and any questions and concerns were addressed. Participants were also offered to review the letter of ethical approval from the university. For online interviews, this part was conducted as a short, separate video call to enable participants to ask questions and email me the signed consent forms. If at this stage participants were happy to proceed, we both signed two copies of the consent forms, one of which they retained along with the information sheet.

3.5.3.3 Interview Process. Participants were first given the questionnaire and the opportunity to ask questions and complete it, which usually took about five minutes. This was emailed to me before the online interviews. Questionnaires were set aside and used as a prompt for further questioning later in the interview. As interviews began, I informed the participants that I would begin recording. Recordings were made using a laptop and stored securely on the

laptop once the interviews ended. Interviews lasted between one and two hours, with a comfort break after each hour. During breaks, I enquired about their well-being, if they found anything discussed distressing and if they felt comfortable continuing. Interview questioning was done systematically with a question bank to draw from (see Appendix F. for sample interview questions). However, to allow for flexibility to gain insights, further questions were asked that were specific to the interview content to gain clarity on topics discussed or to find further insights. Interviews were also in some respects collaborative, as participants were able to bring in topics that they felt were important. At times, this led to tangents where topics unrelated to the interview were discussed. In these cases, I would bring the interview back to the topic questions. This flexibility was essential not only to allow the interview to be more like a guided conversation but to allow for freedom of response.

This openness to let the participant answer as they saw fit was important as it established trust and rapport so that the participants felt safe to share their accounts. At times, these conversations were humorous and light-hearted, with jokes shared. Other times, I used self-disclosure, particularly that I had my own experience of mental health, and if it proved useful, I would disclose my own background, especially if I had shared experiences with the participants. In some instances, particularly with those from working-class or lower-class backgrounds, my disclosure was essential to establish a common ground and trust with the participant. However, when this was necessary, I limited my self-disclosure to general details and used this to turn the interview direction back to a focus on the participants.

If the participants seemed in any way distressed or if traumatic topics were recounted, I paused the interview and asked if they felt that the interview was too emotionally taxing. I reminded them that the interview could be suspended at any stage or that they could skip questions that were too difficult or distressful to answer. Some participants chose to pass on some questions, but all participants chose to continue and said that their well-being was unharmed. None of the participants became so distressed that they wanted to stop the interview, nor did I find it necessary to do so.

3.5.3.4 Debriefing. After the interview concluded, the recording ceased, and I debriefed the participants. This involved checking if any distress was caused by the interview and answering any further questions they had. I drew their attention to the support services in the information pack and reminded them that at any point after the interview, if they felt distressed, even in the future, they should contact the support services or their own chosen support service.

I reminded them that should they have any questions or concerns regarding the interview, they could email me, and if they had any concerns as to how the interview was conducted, they should email my supervisor. Both email addresses were provided in the information pack, and directions were given as to where to locate these. I then concluded the interview session by thanking the participant for their time and participation.

3.5.4 Transcription

To protect the confidentiality of the participants and to abide by ethical protocol regarding informed consent, all transcripts were transcribed only by the PhD researcher (Rachel Brown), without the use of transcription software. Interviews were transcribed verbatim to capture the completeness of the utterances. Accents, slang words, swearing, short (…) and long pauses (pause) as well as laughs and sighs were included in the transcription for completeness and to allow further insight. Transcripts were produced as Microsoft Word documents in digital format but were also printed and bound to enable a "by hand" method of coding and analysis. At all times, identifying information was removed from all copies of transcripts and extracts to protect the anonymity and confidentiality of participants. In some cases, the removed text is replaced by (identifiable data removed).

3.5.5 Storage and Security of Data

Shortly after interviews were conducted, recordings were saved onto Maynooth University's MS Outlook cloud storage, which was encrypted and password protected. After the recordings were transcribed within a few days of the interview, the recordings were deleted from cloud storage. Digital transcripts of interviews were stored on a security-protected university cloud and on a USB device. No participant details were stored on the USB device. All relevant paperwork and hard copies of transcripts were stored in a locked file cabinet in the Maynooth University Department of Psychology office. Interview transcripts were labelled with the interview number and only used pseudonyms with identifiable information removed. Transcripts and consent forms were not stored together to protect confidentiality. At times, the anonymised transcripts were taken out of the office to enable remote working, but only the anonymised transcripts were kept in my possession. All printed and digital information about this study will be securely stored in the Maynooth University Department of Psychology for 10 years, after which it will be deleted and securely destroyed.

3.6 Data Analysis Procedure

The data analysis procedure employed here was systematic as it followed a framework for how data was managed and analysed at different stages from data collection, coding, thematic analysis, Bourdieusian analysis of practice and Lacanian discourse analysis, while making sure to maintain consistency of method for each data source and from collection to writing up the analysis. A summary of this analytic procedure can be viewed in Appendix L. However, while these methods were done systematically, it was an iterative process as opposed to a linear one, where data was returned repeatedly to revise and refine the analysis. This enabled greater insights and richer findings and is a feature typical of qualitative research (Srivastava & Hopwood, 2009).

3.6.1 Initial Notations and Project Diary

During the interview process, notes were taken to record initial insights and, if further questioning was necessary. These were taken as part of a project diary (see Appendix F) in which a reflective entry was made after each interview and notes were reviewed. During transcription, further notations were made regarding sections of text which were initially insightful. Again, throughout this process, regular entries were made to the reflective journal to aid in the process of reflexivity. The journal and notes were returned on several occasions as they were an integrated part of the analysis procedure.

3.6.2 Data Formatting and Use of Software

Interview transcripts were printed and bound to allow maximum accessibility and convenience, but were also accessible in digital format. While initial attempts were made to use the qualitative software MAXQDA, this was abandoned in preference for a more "hands-on" or traditional approach. The rationale for this decision was based on several factors. First, as I am dyslexic, the use of multisensory learning is invaluable to my analytic process. The coloured markers, highlighters, post-it notes, and notes in pencil, including small drawings, are all part of my analytic process, which enabled further insights (see Appendix G). These could not be adapted effectively in the MAXQDA program and were lost in the attempts. Additionally, the richness and depth of my analysis from working with a hard copy were lost in the transition to digital format. After many attempts to use the software effectively and with consultation from my supervisor, the decision was made to continue with the traditional "hands-on" method. As such, all coding, thematic analysis and analysis of discourse were conducted on hard copies of interview transcripts and interview extracts.

3.6.3 Reflexive Thematic analysis

The first phase of analysis was a reflective thematic analysis conducted using Braun and Clark's (2006, 2019, 2023) method. Psychological research often focuses on "description as the foundation of analysis," which underpins theoretical assumptions (Ryan, 2006, p.100). On the one hand, the rationale for the use of RTA on the entirety of the data set was to gain a descriptive account of the data, or to map the content of the data thematically, both on an inductive and deductive level. The initial coding process provided the first phase of analysis, with the codes analysed into themes, providing the basis for the phases of discourse analysis. On the other hand, as a deeper analysis was required to identify the concepts that underpin these assumptions, as well as the psychological phenomenon featured, it is necessary to perform an analysis that goes beyond mere description (Ryan, 2006).

In this regard, a deductive analysis of the data helped to gain deeper insights and identify themes that captured the complexity of the data that would have been lost with a mere inductive or descriptive approach. The use of both inductive and deductive methods in RTA is recommended by Byrne (2022) as it allows for findings that align with the theoretical framework while still having utility in terms of describing the data and mapping thematic patterns. This process involved multiple steps, and although it was methodologically conducted, it had an iterative nature, where previous steps, such as reading transcripts and revising codes, were revisited to refine the themes. Table 3 displays the six stages of reflective thematic analysis from Braun and Clarke's (2006, 2019, 2023) method. The results of this reflexive thematic analysis are presented in Chapter 4, along with coverage of how themes were developed.

Table 3

Six Stages of Reflexive Thematic Analysis (Braun and Clarke, 2006, 2023)

Stage	Analytic Action
1. Familiarisation with Data	Initial analytic and reflective notes taken during interviews, transcription and coding. Multiple readings of texts.
2. Generating Codes	Data was inductively coded line by line, with a focus on latent rather than semantic codes. Codes are listed in a codebook (see Appendix H).
3. Identifying initial Themes	Emerging themes were noted as they appeared in individual transcripts as well as across the data set.
4. Reviewing Themes	Themes were reviewed using multiple hand-drawn theme trees to categorise themes and subthemes and to allow for refinement of themes. This was iterative with the codes, with multiple sessions that included returning to the data for clarification.
5. Defining and naming Themes	Defining themes and sub-themes, and naming themes to capture the experience they represented in the data.
6. Writing of the Report	Presenting the final analysis in a report that includes linking the themes to the aims and research questions, interpreting their significance in relation to the aims and research questions, as well as existing literature, and the inclusion of reflective inferences.

3.6.4 Selection of Extracts

Following the reflexive thematic analysis, which required all 14 participants' interviews to be analysed to map the topics of the data and develop themes, multiple interview extracts were selected for further analysis with the Bourdieusian and Lacanian discourse analysis. Many extracts were explored at this stage for their potential to provide deeper insights, and the selection process was iterative, returning repeatedly to see what preceded or followed an extract that may provide more insights. This was a thorough process of selecting extracts that held contradictions or unexpected framings of the three topics identified in the themes that related to resilience, recovery and subjectification. Extracts were selected based on the observation of key signifiers, the presence of repetition, contradictions and tensions and/or the negotiation of class positioning, moments of affective intensity, discursive instability, as well as evidence of habitus, field/doxa negotiations and capital (financial, social, cultural, symbolic) accumulations. For the data selected that resulted from the RTA focusing on subjectivity, only

three participants' data were selected for further analysis based on how central subjectivity was to their experience of social class and mental health. In these instances, the three participants' data extracts were selected from the transcript because they exemplified the practice of subjectification of the singular subject. However, in terms of a practice of subjectification, this was observed across all participants' accounts and is discussed in detail in Chapter 7.

3.6.5 Socio-cognitive Critical Discourse Analysis

The initial method of discourse analysis was socio-cognitive critical discourse (SCDA). The rationale for selecting SCDA was its critical approach, flexible and interdisciplinary application, and alignment with the philosophical underpinnings of social constructionism. The key value in terms of this study was the inclusion of the cognitive interface as a mediator between social and discursive structures, as visualised in Figure 4 (van Dijk, 2017). Van Dijk stresses the role of these subjective mental models and schematic structures that form the shared sociocultural knowledge that individuals and groups use to mediate experience, which, for this study, enabled the identification of the Habitus in texts. Three areas of a discursive event are focused on during analysis. First, the role of discourses mediating experience, then the role of macrostructures in the discourse, and finally, the interaction of the two via a cognitive interface. These analytic elements and actions are displayed in Table 4.

Figure 4

The Socio-cognitive Discourse Triangle (van Dijk, 2009)

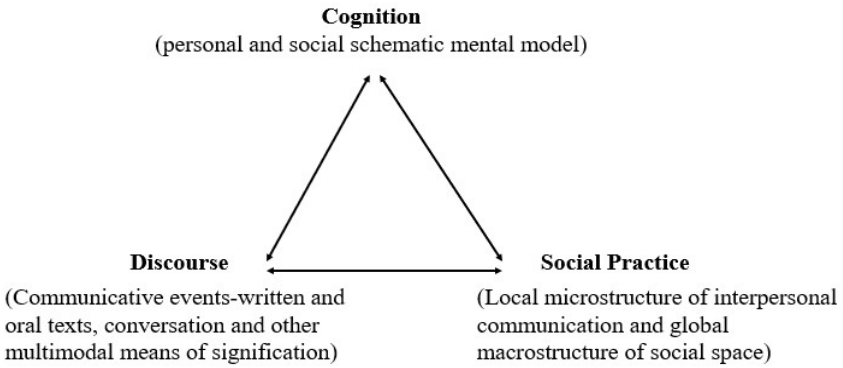


Table 4

Elements of Socio-cognitive Critical Discourse Analysis

Element	Analytic Action
Discourse	Identify the linguistic and discursive features in the text.
Social Practice	Look for discursive representations of power, dominance, inequality and social structures in the text.
Cognitive Interface	Identify language that represents shared sociocultural knowledge, identities, norms, values, and attitudes.

While SCDA was the initial choice for analysis, there were limitations in the depth it facilitated, particularly when other elements of practice were observed in the text or how discourse mediated the macro and micro levels of practice. While considerable time and effort were spent attempting the SCDA approach, it was evaluated as useful but not proficient enough to gain the depth of findings desired. However, SCDA did provide some insights, such as identifying the habitus in the shared socio-cultural norms, values, attitudes and ideologies of language, as well as insights into discursive structures, critically evaluating microstructural factors. As a result, the analysis expanded to include a Bourdieusian and Lacanian-informed discourse analysis.

3.6.6 Bourdieusian Analysis

Like many qualitative approaches, a Bourdieusian analysis of practice has no set procedure and is adaptable to different forms of analysis and data, and is an iterative process of observing practice within the language, most commonly of interview texts (Bourdieu, 1996). According to Pouliot & Mérand (2012), "the combination of methods is firmly rooted in an epistemology that takes the performativity of language and of analytical categories and gives reflexivity pride of place" (p.55). In this regard, a Bourdieusian analysis is compatible with other forms of analysis that focus on language, such as the SCCDA and LDA methods employed here. While the method is adaptive, it is essential for rigour that the method employed is systematic (Mills and Gale, 2007). After careful evaluation of the theoretical contributions and analytical methods of Bourdieu (1996) and literature from those who apply the Bourdieusian method, such as Mills and Gale (2007) and Pouliot and Merand (2012), five key areas of analytic focus, as common to other qualitative methods, were applied iteratively as opposed to linearly and are displayed in Table 5.

Table 5

Elements of Bourdieusian Analysis

Element	Analytic Action
Habitus	How is habitus represented in the text (Shared sociocultural knowledge, identities, norms, values, attitudes, tastes, linguistic habitus)?
Fields	What fields are indicated in the text, both directly and indirectly (society, culture, family, work, MH services, therapeutic settings)?
Doxa	Is there evidence of Doxa or "rules of the game" (social rules and norms associated (or not) with the habitus and specific to a field)?
Capital	What capital is described in the text, directly or indirectly (financial, cultural, social and symbolic)?
Relationality	What is the relationality between habitus, field (doxa) and capital? How do these interact to guide and produce practice?

3.6.7 Lacanian Discourse Analysis

The final level of analysis was Lacanian discourse analysis. Lacan never generated a method for the analysis of texts or specified a method for discourse analysis (Parker, 2005). His theories were derived from his work as a psychiatrist working in clinical settings, and his approach to psychoanalysis was intended for the clinical space of the analyst and analysand (clinician and patient). Consequently, when moving outside the didactic therapeutic relationship, a distortion of Lacan's theories occurs when applied directly as a discourse analysis (Parker, 2005). As such, some adaptation is necessary yet still aligns with Lacan's theoretical underpinnings. This is not unusual for critical discourse analysis approaches as they are adaptable to suit the needs of the research questions, while remaining bound to the theoretical framework (Pavan-Cuéllar, 2018).

However, to ensure consistency and validity of the results across the data, a systematic method of analysis was adapted from Neill (2013) and Parker's (2005). Both Neill and Parker stress that while a systematic approach is necessary, LDA must have flexibility and is compatible with other forms of discourse analysis systems and qualitative approaches that have resonance with Lacanian theory. The nine elements from Parker (2005) and the analytic actions taken are outlined in Table 6, which were applied iteratively and, as applicable to the data.

While these nine elements of LDA from Parker (2013) were useful, LDA is only an emerging approach to critical discourse analysis, and as such is open for further development and interpretation as it is applied to different textual materials and research questions. As such, I also further developed this method of LDA to include a stronger structural approach to language, one that provides a strong linguistic analysis while still having resonance with Lacanian theory and the nine elements described above. Table 7 displays the additional elements that were added to this study's version of LDA that further the development of this analytic approach. Again, these were applied iteratively and as appropriate to the text being analysed.

Table 6

Nine Elements of Lacanian Discourse Analysis (Parker, 2013)

Element	Analytic Action
Imaginary Reading	Multiple readings of texts. Recognise reflexivity and the possibility of multiple interpretations.
Master Signifiers	Identify symbolic anchors (quilting points) in the text. Signifiers that represent underlying self-evident truths or ideologies. These can be present in language by chains of signifiers.
Signifying Chains	Identify chains of signifiers that support the underlying knowledge or "truth" of the master signifiers. They will justify and support the master signifier's power in the discourse.
Subjectivity	Identify how the speaker's position is displayed in the text. How are their identity and subjectivity constructed? Is subjectivity oriented to the master signifier or in opposition to it?
The Three Registers	How is the text connecting to the three registers? How are the symbolic, imaginary and real represented in the text? How is subjective reality positioned in relation to the three registers?
The Other	Locate discourse of the Other (symbolic order) if present. How is subjectivity positioned in the discourse of the Other? Do others in the text represent the Other?
Objet Petit a	How are desires and lack operating in the text? What is the object of desire and the object cause of desire? Is there surplus enjoyment and jouissance? Is there castration of desire in the text?
Tensions in the Text	Identify contradictions, tensions and gaps in the discourse. Is there discourse that contradicts the master signifier? How does the discourse manage these tensions: repressed, ignored, rationalised?
Four Discourses	How do the previous discursive characteristics relate to the discourse of the master, university, hysteric and analyst? Consider the role of capitalist discourse in the text.

Table 7

Additional Linguistic and Structural Element Developments of LDA

Element	Analytic Action
Features of Language	
Relevance	Identify stand-out words, phrases, and expressions.
Repetition	Identify repetition of words or synonyms.
Phononyms	Look for the presence of words that sound the same.
Salience	Note the prominence of a word or words that appear out of place.
Negation	Identify words that indicate opposites.
Absence	Are there missing words that would normally be expected?
Structure of Language	
Signifying Chains	Look for the interrelationality of signifiers.
Subjectivity	Indications of relationality of self in the structure of text.
Intersubjectivity	Indications of others and the big Other in the structure of text.
Intertextuality	Identify words from public discourse and professional discourse.
Spatio-temporality	Look for words that indicate time and space.
Super addressee	Is there discourse of a third person in dialogue?
Subject of the statement/enunciation	Consider what is said or implied vs. what is understood.

3.6.8 Multiple Methods and an Iterative Analytic Procedure

The nature of qualitative analysis requires a deeper understanding of the data beyond mere description. This requires a level of flexibility and a "degree of abstract thinking (theorising) about the concepts underpinning the data," enabling inferences to be made (Ryan, 2006, p. 100F). In this study, it was necessary to use a combination of analytic approaches that, while aiding in exploring different facets of the data, were complementary to one another. Several different qualitative approaches were applied during the data analysis, each with a specific role to achieve distinct levels of enquiry. These approaches included reflexive thematic analysis, socio-cognitive critical discourse analysis and a Bourdieusian and Lacanian informed discourse analysis. The procedures of each of these individual approaches are outlined in the

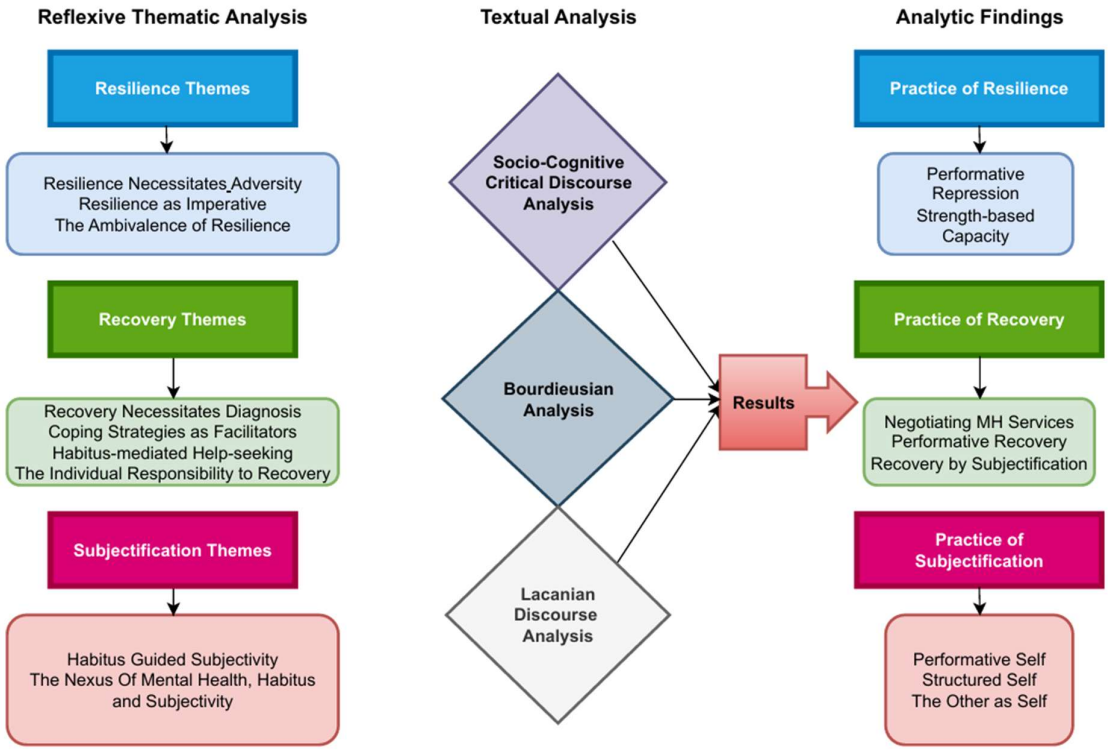
previous sections of the chapter, and Figure 5 provides an illustrative diagram that displays the multiple levels of the analysis and the iterative process.

The rationale for this order was based on the research questions and the analytic process that evolved. While RTA gave one level of insight, the incongruences and contradictions present within and between themes merging from the sample suggested a deeper analysis was needed. The application of SCCDA enabled greater depth in terms of identifying the habitus and structures of discourse as well as macro sociocultural contextual factors, but failed to account for the other elements of practice that were observed in the data. This required the application of the Bourdieusian analysis, but as the research questions relate to accounts of mental health, the incorporation of LDA proved the greatest depth of insights. Even with this combined and critical approach, further developments were made to the LDA method to make it more aligned with traditional discourse analysis approaches by including a stronger structural analysis.

Qualitative inquiry requires this degree of adaptability and flexibility with its procedure, often moving throughout the analytic stages and developing them to acquire greater depth or clarification (Braun & Clarke, 2023). Throughout the analysis process, I moved through the methods and returned to the data to gain a deeper understanding or to address key insights that had become evident with the various methods of analysis. This iterativeness and adaptability were especially important, as they enabled deeper insights, while flexibility allowed for an iterative process to be employed. However, at all stages of the analytic processes, it was conducted systematically and repeatedly to ensure a rigour of method that supported the strength of the findings. Handwritten notes from the process can be seen in Appendix K, and Appendix L shows an audit trail focusing on one participant's transcript, which follows the analytic process from raw data to initial themes and final themes of RTA and then the rationale for the selection of data as well as the analytic process of the textual analysis.

Figure 5

Illustration of Analytic Process



Note. The diagram is for illustrative purposes, as the analytic procedure was integrative and not linear. While the diagram presents the process from left to right, raw data, codes and themes were returned repeatedly to gain a deeper analysis and insight.

3.7 Reflexivity

Reflexivity was a key element to the entirety of this study as my subjective position, habitus, and signifying structure functioned as a guiding principle in the analysis and interpretation of the data, as well as the dynamics of the interviews. In the same vein, other characteristics such as my gender, sexuality, age, race and ethnicity had similar influence, not to mention my own attitudes, ideologies, values and beliefs. In this regard, this study, and indeed any research, should be recognised and historically, culturally, temporally, and phenomenologically situated in the characteristics of those who conduct the research. Bourdieu (2004) states that no science, particularly a social science, can be truly neutral as various habitus' norms of knowledge and logic are influencing and guiding the analysis.

This is why the subjectivity of a reflective process was so important during the entirety of the project, as I was consciously aware of my positionality and made specific efforts at objectivity while still recognising the insights gained. This was documented in a project journal (see Appendix J) and in regular discussions with my supervisors. The reflective journal was also used to document and consistently review the role of my subjectivity in analysis and the limitations of my interpretations, which was essential to establish qualitative rigour as recommended by Mullet (2018).

3.7.1 Subjectivity

This level of reflexivity was necessary as my own subjective positioning influenced the direction of the project, theoretical interpretation, application of theory and the analysis of data. Psychological science has long posed "that objectivity is desirable, even if not completely possible, and that subjectivity is a source of bias that must be minimised or eliminated." (Gough & Madill, 2012, p.3). However, subjectivity is now being seen as an asset to psychological inquiry and beneficial to adopt a "reflective scientific attitude" (Gough & Madill, 2012, p.3). In qualitative research, subjectivity is accepted as an essential attribute to the analytic process once the positionality of the researcher is declared and made transparent to readers (Ranter, 2002). In this way, subjectivity does not take from the rigour of a study, but adds to it as a "hermeneutic procedure for interpreting narratives in a way that comprehends the real psychological meanings that are expressed." (Ranter, 2002, p.2). This understanding of the value of subjectivity in qualitative research guided the selection of methods, specifically that of using reflective thematic analysis rather than interpretive, and the inclusion of Bourdieusian and Lacanian analysis.

My subjective position allowed for key insights as I had an informed background regarding the topics of social class and mental health, as well as broader knowledge of sociological and psychological phenomena and the cultural contexts of Ireland and the United States. Theoretical knowledge was gained academically through degrees in sociology and psychology, as well as a year's study of anthropology. However, what gave me the greatest insight was my own experience of class inequality and of mental health conditions. My own accounts were useful as they allowed for an informed view and insight into the phenomena and helped to establish rapport with the participants. This was enhancing from a critical analysis point of view, but also allowed for a critical assessment of literature that highlights biased studies, constructs, knowledge, and ideologies.

It was also a motivating factor as I was very aware of the implications and personal effects of inequality on a person's mental health. However, there were times when I was aware of an incongruence in intersubjectivity with participants, and I had to put extra effort into establishing rapport during interviews and in the analysis of transcripts and extracts. In these cases, my reflective process was key to giving clarity to the insights present in the data, as opposed to my own subjectivity guiding the analysis, which was recorded in my reflective journal. However, my subjectivity led me to places where my own imaginary readings of the texts were dominant during analysis. While this is inescapable in terms of the subjective nature of qualitative analysis, there were moments where my own understandings based on my chains of signifiers led the analysis off course. While this was initially difficult to overcome, with guidance from my supervisor and multiple readings of the texts, I was able to focus only on what was present in the language of the extract.

In another instance, my subject positioning and guiding principle of my own habitus led me to make interpretations of the texts based on my sociocultural knowledge. This most occurred when my own biases about class distinction led me to interpret participants' experiences that were different from my own through my habitus lens. Again, this was overcome with multiple readings of the text and a critical reading of my analysis, as well as guidance from my supervisor. The point of discussing the above challenges is to provide transparency in terms of subjectivity and the reflective process. These issues are common to qualitative research (Ranter, 2002), and I aimed not to ignore them or make efforts to eliminate them, but to acknowledge their existence and role in the analysis. By applying such reflexivity, my own subjectivity was beneficial to the analysis, even when it was juxtaposed with that of the participant, and as such, the voice of the researcher was useful in this study.

3.7.2 Researcher's Voice and Authenticity

The researcher's voice, one that is endowed with subjectivity, has a vital role in qualitative research. For transparency of subjectivity and as part of the reflective process, an autoethnographic account of the researcher's voice adds to the rigour of a study (Cunningham & Carmichael, 2018). Allowing my researcher voice to be present in a study not only provides academic transparency but also gives this study authenticity. Jackson and Mazzei (2009) stress that the researcher in qualitative inquiry is also the voice for participants, and the voice of those who may be affected by the study's findings. In this way, the researcher's voice is not just their own, but multiple voices that are represented with their own voice. In this regard, a level of

caution must be exercised to separate the influence of the researcher's voice from the voices of those they represent (Jackson & Mazzei, 2009).

To manage this, I adopted a high level of reflexivity throughout the research process so that while my voice was present, the voices of the participants were their own, and my voice was only the analytic voice, but one that was useful. However, I quickly recognised that there is a delicate balance that needs to be maintained between the individual and the professional. Coffey (1999) emphasises the bidirectional relationship of research, particularly fieldwork, and that while the researcher's voices have influence, the research itself is shaped by ethnographic work. She highlights the emotional influences that can come with such in-depth work. This was something I expected due to the sensitive and personal topics covered in this study, but also due to my own experiences, and this came with benefits and drawbacks. To manage this so that it was not the central tenet of the research, and for my own well-being, elements of this were included in the ethical protocol. I also regularly made entries in my reflective journal and had regular in-depth discussions with my supervisor to maintain qualitative and reflective rigour.

3.8 Qualitative and Reflective Rigour

An aim of maintaining qualitative and reflective rigour was central in all elements of this study. As described above, a key benefit of qualitative research is its flexibility and being guided by the researcher's own subjective insights. However, due to this flexibility, it is necessary to maintain a level of subjective scrutiny, reflexivity and systematic methods to establish qualitative rigour. Qualitative rigour, not reproducibility but transparency, reflexive accountability, coherence between theory and method, as well as interpretive depth grounded in text (Mullet, 2018). Method included transparency around approaches and the subjective role of the researcher suggested by Braun and Clark (2019, 2023). Further guidance comes from Mullet (2018), who provides guidelines for establishing qualitative rigour specifically for critical discourse analysis and related critical discourse studies. Table 8 displays a summary of the criteria, objectives and the methods used in this study to establish qualitative rigour as recommended by Mullet (2018).

Table 8

Methods used to establish Qualitative and Reflective Rigour (Mullet, 2018, p. 121).

Criteria for Rigour	Objective	Method Used
Reflexivity	Transparent view of whose reality is represented in the research	Self-reflective journal, peer debriefing and supervision.
Subjectivity	Transparent view of researcher bias	Articulation of own positionality, monitoring of self through rigorous reflexivity, peer reviews and rigorous supervision.
Adequacy of data	Adequate evidence, adequate sampling and a variety of data	A purposeful sampling strategy was used with analysis from multiple data sources. Data was gathered to the point of redundancy and reached thematic saturation.
Adequacy of interpretation	Analytical framework	The analytic framework was broad, clearly articulated and applied.
Authenticity	Educative authenticity, catalytic authenticity and fairness	A critical approach was taken, aiming to redistribute power from the dominant to the disempowered, with different social constructions represented, including participants' understandings of others' constructions.
Consequential validity	Social or political change	Research aimed to increase consciousness regarding the perspectives of those who are silenced or disempowered.
Accessibility	The audience for the research includes the participants	The study was written in an academic yet accessible language, and complex terms and concepts were explained.
Theoretical triangulation	Four levels of context analysed: immediate language, interdiscursive relations, immediate social context and broad social context.	The four levels of context are represented and discussed in the analytical framework and have been focused on during the analysis.

3.9 Chapter Summary

This chapter presented the research methods employed in this study. This included the ethical protocol, including informed consent, and the prevention of harm to both the participants and me as a researcher. Then, there was an in-depth coverage of data collection procedures such as participant recruitment strategies, interview procedures, transcription, data storage and protection. This chapter also outlined the analytic methods and specified any alterations and developments of the methods used. Finally, significant attention was given to reflexivity and researcher voice, which was a key strength of this study, and great lengths were taken to ensure reflective qualitative rigour as described in the preceding section.

The aim of this chapter was not only to assure the reader as to the quality of the research, but to provide a detailed overview of methods, including the combination of preexisting methods and any developments or alterations made to this study's design. As explained above, significant flexibility was adopted, which was a key benefit enabling further and deeper insights to be made by the combined and multilevel analytic methods. The rich data that resulted from long interviews with participants from multiple class backgrounds highlights how subjective accounts of experience are a fruitful site for investigation when given sufficient time and attention as to how to effectively investigate them. Finally, this method section demonstrated that reflexivity is central to research as it can be an analytic tool within itself, yet must be monitored. The methodological features that are explored in this chapter are not only a prominent strength of this study but also offer possibilities for further research pertaining to social, cultural and psychological phenomena. The findings that arose from these methods are discussed in the subsequent chapters, which present the results from the reflexive thematic analysis, followed by three chapters with the results of the multilevel discursive analysis of texts.

4. Reflexive Thematic Analysis

4.1 Introduction

This chapter examines the themes and subthemes derived from the reflexive thematic analysis (RTA) conducted as the initial level of qualitative inquiry in this study. This analysis aimed to address only the initial research question, "How does social class habitus affect the lived experience of mental health?" The RTA method employed here, that of Braun and Clarke (2006, 2021, 2023), was chosen due to its effectiveness at identifying thematic insights across a large qualitative data set, needed to refine the data for further textual analysis. Further rationale for RTA's selection was its focus on reflexivity and the active role of the researcher's subjectivity. RTA aligns with the social constructionists' positionality of this study and is flexible and adaptive to the critical approach as it moves beyond experiential findings but critical interpretations of meaning (Byrne, 2022; Pearson et al., 2025).

While other methods of analysis could have been employed that focused especially on meaning, such as interpretive phenomenological analysis, this would not have been adaptive to the aims of critical discourse analysis in seeking insights from the language itself. In this regard, the meaning derived from the participants' lived experiences was not the focus of this study, but that of the language of the accounts of these lived experiences, which would not make the use of such methods like IPA compatible with critical discourse methods. This is particularly the case with Lacanian discourse analysis due to what Lacan (1977) argues about the semblance of language, where he argues that analysis of lived experience is not possible. Pearson et al (2025) argue that "Reflexive TA is methodologically flexible with researchers making decisions, which support their philosophical positionings" (p. 842). This iterative approach that includes an inductive and deductive approach to RTA strengthens the study's reflexive rigour and provides thematic grounding to the deeper levels of discourse analysis that followed.

The procedural method of RTA, including the six phases of analysis outlined by Braun and Clarke (2006, 2023), is covered in detail in Chapter 3, Section 3.6.3. However, I will briefly summarise the methodological underpinnings and analytical process to provide some foregrounding of how the themes developed. Themes were identified in relation to the initial research question only, and to the goals and aims of exploring accounts of mental health contextualised by social class. Themes were developed reflexively, informed by the study's theoretical framework and analytic aims. As such, an inductive analysis was led to map the

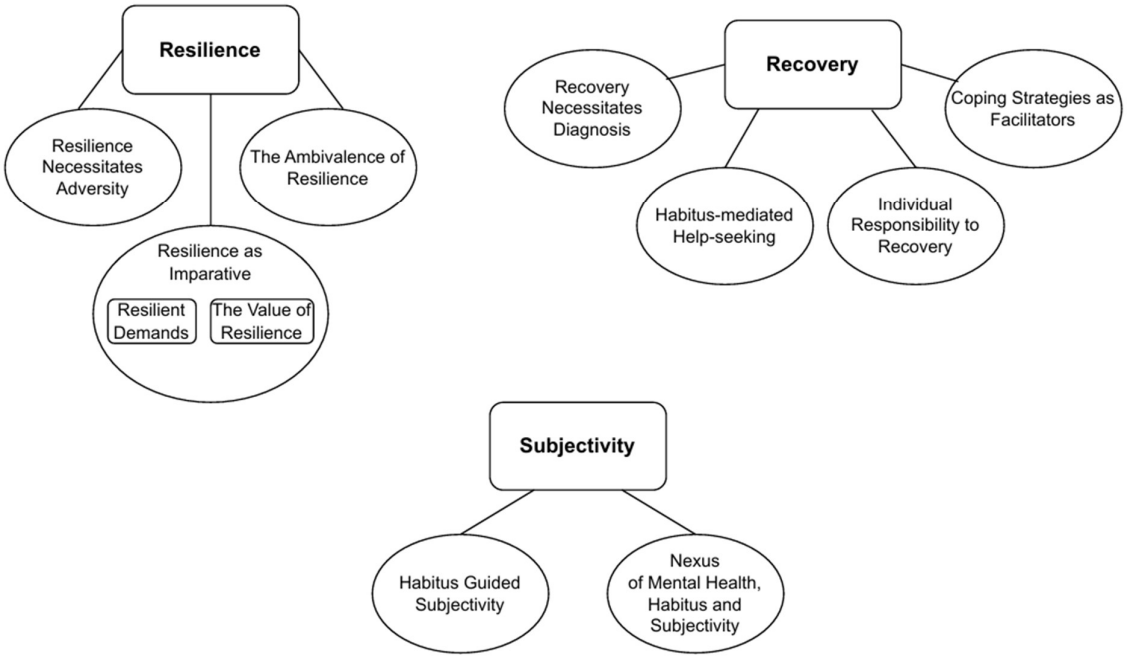
data with the use of open coding (see Appendix I for a table of codes), which was conducted iteratively with the deductive theory-driven analysis and critical orientation. The rationale for including both inductive and deductive coding was to gain insights not only in terms of the topics that were being discussed, in terms of content, but also the meaning that lay in the language itself that was more accessible through a deductive analysis, as recommended by Byrne (2022) and Pearson et al. (2025). Yet, semantic coding and inductive analyses had a secondary role and were employed when appropriate or useful.

The primary use of latent coding was guided by a deductive (theory-driven) analysis that was reflexively attuned to power operating in these descriptive accounts of mental health and social class. While power relations were not asked to the participant specifically, the critical and theoretical positionality central to critical discourse analysis argues that power operates in all discourse and therefore, regardless of whether participants were asked directly about power, power operated in their discourse and thus in their accounts of mental health and social class. (Foucault, 2020). However, questions such as “Who decides what normal is” are related to power and are used to flesh out the role of power within the participants' experience.

With the latent, deductive and critical orientation and aims of addressing the research question, themes were developed from codes that reflected three overarching topics that were consistent across all participant accounts (see Appendix J for theme tables). These were resilience, recovery and subjectivity (see figure 6). As a critical orientation to RTA was taken and themes were reported along inductive lines, they showed not only that resilience, recovery and subjectivity were central to a cycle of mental health, but that there was meaning associated with these accounts, and more insightful and critical themes were then reported.

Figure 6

Themes and Sub-themes identified with Reflexive Thematic Analysis



As this study uses a multilevel qualitative analysis, thematic analysis was only the first phase, and its purpose was an initial exploration of data to provide a thematic structure and grounding for the subsequent phase of discourse analysis. As such, a discussion of findings in relation to the literature is not presented here. Rather, it is presented in Chapter Eight in synthesis with the results from the other levels of analysis. What comprises this chapter are nine themes and two subthemes supported by rich examples from participant accounts. These are not only significant findings in themselves, but show significant complexity around these themes, suggesting a deeper level of analysis is needed, that of the discursive analysis presented in Chapters Five, Six and Seven. What follows in this chapter are the themes and subthemes of the topics resilience, recovery and subjectivity and how these relate to the habitus, but also the broader social realm, often in surprising and complex ways.

4.2 Resilience Themes

4.2.1 Resilience Necessitates Adversity

Across all participant accounts (*N*=14), resilience was framed as something that developed only through exposure to adverse experiences. The multiple participant accounts suggest that this relationship led to the identification of the theme that resilience necessitates adversity. Critically, across all participant accounts, resilience was not only associated with adversity but also with class-specific adversity. Three of the middle-class participants reported that they lacked resilience, as they had not been exposed to the same level of adversity as their working-class counterparts. Even when participants had experienced personal trauma, if they came from a middle-class background, they described themselves as less resilient than those from working-class backgrounds, as we can see from Jeffery, a 19-year-old male who identified as middle-class.

> *I feel like the way I was brought up, like we had our own house and didn't have to worry about the next plate of food or worry about the electricity getting cut off, you know. That kinda set me up and gave me a head start to a certain point. I don't want to say that it made me soft… but it didn't really expose me to what the world could be like until a later point. Like you know, I think the lower you go on the social ladder, the earlier you experience the tough side of life, the earlier you build up a resilience to it. And I think I didn't develop mine until quite late, but I'd say others may have developed it early. Now, I am not saying people from the elite class can't develop a tough skin.*

This account highlights the link between adversity, class-based identities and subjective evaluations of resilience. Here, there is a connection between how resilience is perceived and the subjective class position, as well as the associated social and economic conditions. The presence of attitudes and values influences the subjective evaluation of resilience, which is developed from exposure to adversity. This was a theme observed across the data, regardless of class positionality. In the example, Jeffery describes himself as less resilient due to his status, while those of lower status he assumes have more resilience due to a greater exposure to adversity related to class inequality. From this, we see resilience as the central theme, but in the context of class-related experiences of adversity, both for the working and middle classes.

Another example comes from Linda, a 31-year-old woman who identified as working class and experienced adversity within her household.

> *Umm… I actually don't know. I don't know, I just remember the counsellor telling me I was very resilient, nearly to the point where it was nearly a bad thing for me, you know, I don't know. I suppose, like with family and stuff like alcohol, it was a big part, and*

like there was just… well, see my dad drinking and all… it's… he's always been… (Struggles to get words out) … It's never been acknowledged, you know, it's just, like, just other things in the family as well. I don't know, it's just made me stronger.

From Linda's account, again, resilience is derived from adversity. Interestingly, there is a negative framing of resilience, which will be explored in a later theme, but for now, it's worth noting this ambivalence, hinting that there is a cost to the development of resilience through adversity. In this example, resilience is associated with the adversity that comes with her father's alcoholism, as well as other family dynamics that are not fully elaborated on here. Again, resilience is associated with being derived from adversity, that the adversity "*made me stronger*".

In both participant accounts, the development of resilience is associated with the experience of adversity. Whether this is based on inequality or personal circumstances, resilience appears to be a requirement for coping with adversity, but also a byproduct of it. The primary source of adversity reported by the participants was related to class inequality or personal circumstances, but personal circumstances were often related to class conditions. As some adversity is experienced by everyone, a demand for and the valuing of resilience was consistently observed and forms the next theme, resilience as imperative.

4.2.2 Resilience as an Imperative

The theme of resilience as imperative was derived from the two sub-themes, resilient demands and the valuing of resilience and was observed in participant accounts (N=14). As we saw above, resilience was associated with adversity and framed as a necessity for its development. This suggests that there is a demand placed on individuals to perform resilience as a response to adversity. It was also highly valued, but valued differently depending on individual habitus. Across all participant accounts, there was an imperative to perform resilience necessitated by the presence of adversity, as we saw with the previous theme. However, not only was there an impairment to mitigate the effects of adversity, but also to meet the valued social norm of its performance. Below, the examples from the two sub-themes, resilient demands and the valuing of resilience, together present the theme of resilience as an imperative.

4.2.2.1 Sub-theme: Resilient Demands. As stated above, the adverse conditions that are the normal requirements of daily life, relating to material conditions and structural pressures, place a demand on individuals to demonstrate their resilience. This kind of demand to perform resilience was reported across all participant accounts, regardless of the call-based

adversity they reported. However, there was also a class context associated with the levels of demands required, often based on structural inequality, so much so that the demand to be resilient was internalised as a value, which in itself operates as the demand. This can be seen from Kevin, a 31-year-old man who identified as working class but had social mobility to the middle class.

> *Absolutely one hundred per cent. I always think of things in root cause, and the services are not readily available to these people, and nobody is coming to help you! No one is gonna walk in here and help you, so you need to help yourself. I think that's a lot of where this comes from. Like, if you don't get up and get on with it, the bills aren't gonna get paid, there won't be food on the table, you don't have time to get sick or to be dealing with a mental health crisis. So yeah, I absolutely think it's an attitude of "no one is coming to help you, get up and on with things, do it yourself". And seeking out help gets in the way of providing, and that's part of the mentality of being working class.*

Throughout the extract, the adversity of daily life produces resilient demands. There were no services, and a lack of support. Furthermore, there are resilient demands from the need to provide, which requires resilience. But there is also an expectation to be resilient in the face of daily struggles. So, here we see Kevin describe this resilience as "*part of the mentality of being working class",* where the material and social conditions that demand resilience are internalised into the shared sociocultural schema of the habitus. Instead of resilience being beneficial to mental health, it is part of attitudes that stigmatise those who do not exhibit resilience. The demand to be resilient is not only for the adverse conditions, but the attitude that normalises such resilience and highly values it, even if it is harmful to mental health.

4.2.2.2 Sub-theme: The Value of Resilience. This value placed on the performance of resilience was a clear theme across all participant accounts. However, for those accounts that were reported by participants who identified as working class or lower class (*N*=10), the ability to perform resilience became a valued social norm and a key identity frame. So much so that it functions as cultural and symbolic capital in a class-specific symbolic economy. As we saw with Kevin, to deviate from the performance of resilience was to break with such social norms and that in itself generated a demand. In the next example, we see how resilience is highly valued in working-class contexts. Carol, who was aged 45 and identified as middle class, described having social significant mobility from an underclass background.

> *On a positive note… like my class, there is a bravery in me that wouldn't be there if I wasn't from where I'm from. So, there is this capacity… like I genuinely don't give a fuck, and it's wrong because there is a part of me that really knows what it's like to have nothing, so it makes me brave. Now I don't know if that is common to the people*

of the same class, it's where I come from and whether they say it another way I don't know, but there is something, like a resilience of my thinking, of my class that is often overlooked, and it's seemed to be seen as abrasive or rule-breaking or something that doesn't fit the norm. But for me, I see that as a positive way of thinking, and it's affected my thinking in that way.

Resilience here is framed with positive terms such as "*bravery*", "*capacity*" and a "*positive way of thinking*". Yet, this is contradicted as it is also associated with "*abrasive or rule-breaking"* by those outside her class. Despite this, or perhaps because of it, the resilience associated with her class is something that she appears to be proud of, something positive that can be taken from the challenging circumstances and gives her symbolic capital of respect and prestige within class-specific social fields. Yet as Carol traverses social mobility and encounters new social fields, this class's distinct form of resilience is not as valued, yet still strongly associated with positive and a key beneficial feature derived from class-based adversity.

From the above two sub-themes, there is an imperative to be resilient. On the one hand, the imperative is derived from the conditions of daily life, and resilience is needed to meet these demands. On the other hand, there is an imperative to perform resilience to meet the demands of expectation to perform resilience as aligned with class-specific values and norms. Importantly, while there are social pressures to meet these resilient demands, the demand arises internally, guided by the shared sociocultural norms that are shaped by class conditions, such as adversity from structural inequality experienced on a group level, shaping the values of the group.

In both accounts, there was not only a demand to perform resilience, but it was also highly valued. The valuing in itself places an imperative to perform what becomes a valued social norm, a form of cultural and symbolic capital. Cultural and symbolic capital are only valuable in the contexts that recognise them, both within class contexts and in broader society. While there is an imperative to perform resilience, both from the demand of mitigating adverse conditions to daily survival, and the valued social norm, it was not always reported as beneficial, suggesting an ambivalence around a term that is described almost exclusively as positive in literature and public discourse.

4.2.3 The Ambivalence of Resilience

Most of the participants in this study described themselves as being resilient and that this was a beneficial psychological attribute, both in terms of allowing them to manage the

demands of daily life, gain social mobility and mitigate personal and structural adversity. However, even when participants described their resilience positively, there were often contradictions in some of the participant accounts (*N*=8), suggesting an ambivalence around resilience. The framing of resilience as negative, if not harmful, was described by many of the participants, particularly those from underclass and working-class backgrounds who had experienced adversity in their lives and had significant resilient demands. Resilience was often narrated through coping-as-continuation rather than positive adaptation. This was a surprising insight, as resilience was initially framed as a positive attribute by all participants, even those who showed resilience in terms of also reporting it as a negative experience, as can be seen from Cherie, a 32-year-old woman who identified as lower class.

> *I don't, I shut off. If that doesn't happen, I crack jokes and just get on with it. There's no coping, I don't…. and it's actually something that's really an issue. I don't at all. I just pretend things just don't happen.*
>
> Q: Why do you think that is?
>
> *I don't know… I think it's just from a certain age, like as a teenager, your late teens, your brain just develops a certain way, and if you have a weird situation… like maybe my brain just didn't develop coping skills. I just find it easier to say, "it didn't happen, it didn't happen", and like it's kinda my expression "ah well, ah well".*

While here the term resilience is not used, the underlying theme that is expressed here is that of resilience, which came from the code coping strategies, or in this case, the absence of which functions here as resilience. Importantly, what is framed here as resilience, that of denial and emotional suppression, is framed by Cherie as "*something that's really an issue".* This is interesting, as while this functions as resilience and to continue with the activity of daily life, she views it as negative, framing it as a consequence of her background. Regardless of this strategy's origins, it functions as resilience while it is also framed here negatively, supporting the theme of ambivalence.

In the next two examples, we see elements of the initial theme resilience necessitate adversity. However, there is also the consequence of the formation of resilience, which comes with a cost, yet it is still highly valued, linking to the theme The Value of Resilience. While this points to how these themes are linked, what is more important is the ambivalence around them, as illustrated by Linda.

> *Umm… you could answer that with a positive and a negative. Because obviously, with the negative like maybe it could have, but I wasn't aware of its effects on my mental health. And then the positive is just the resilience.*

In this example, there is an ambivalence between that which generated her resilience, which at the same time has effects on her mental health, and that which resilience should be a protective factor for. This is very similar to how Kevin frames his development of resilience.

> *I think there is both, but I think the positive outweighs the negative. I think some of my experiences when growing up led to me being of the mindset that I am. And it built a lot of resilience, and I don't think that I would be where I am in my professional career if it wasn't for the upbringing that I had.*

Again, there is an ambivalence around the experience of resilience, which, on the one hand, is a positive outcome and has benefited his career trajectory. On the other hand, it was derived from the negative experiences of his upbringing. Key to this is that it has led to a particular "mindset", suggesting that his resilience is a continuous mental state of resilience. This duality in the text, not only of Kevin's account but also of the two preceding examples, suggests that while resilience provides benefits, it again comes with a price, the experience of adversity.

As we saw, this was a constant theme in terms of resilience, that it was derived from adversity, but that it comes at a price. What is interesting is that in all accounts, resilience is framed as a positive and beneficial psychological attribute, while at the same time, negative elements, whether as a cost to the development of resilience or the performance of resilience itself, were described as negative. This suggests a significant ambivalence around what is labelled as resilience, as will be explored in greater detail in Chapter 5 using the Bourdieusian and Lacanian-informed discourse analysis. For now, it is important to report this finding as a key theme that was consistent across all participants' accounts of their mental health. The preceding reporting of the themes and sub-themes suggests that what accounts for resilience is that it necessitates adversity, that there is an imperative to perform resilience due to resilience demands and the value placed on its performance, and that, despite its value, there is ambivalence around its development and performance. The complexity of these themes suggests that further analysis is warranted in terms of how it functions as a key element of mental health and how it relates to other aspects of mental health, such as recovery.

4.3 Recovery Themes

4.3.1 Recovery Necessitates Diagnosis

The theme recovery necessitates diagnosis was identified from the codes hegemony of mental health, mental health services, and therapeutic relationships. Participants' accounts of

recovery (*N*=14) reflected an underlying theme that recovery was derived from the diagnosis of mental conditions or a self-diagnosis with a diagnostic label. This seemed to be related to a hegemonic ideology of the biomedical model that views mental distress and deviations from mental and behavioural norms as mental illness, which is treatable through psychopharmacological and psychotherapeutic interventions. These interventions will bring the patient back to a previous mental state that aligns with mental health norms or recovery. This knowledge was evident across participants' accounts and informed their responses to diagnosis, guiding their recovery strategies as seen with Ben, an 18-year-old male from a middle-class background.

> *And I didn't notice that I ended up developing…. the year I moved to the town school, pretty much 3 years ago now…. I developed, uh, sort of…. well, I was diagnosed with depression. But it was only moderate, so I had to go on medication, and I had to go to counselling.*

This short extract recovery, or that which facilitated it, going to counselling and taking medication, is only a response to the diagnosis. Even his awareness that he had depression is hinged on a diagnosis. Before diagnosis, he describes being unaware of its development. This was common among many participants, particularly those who had the means to access services that provided such mental health diagnostics. Those who did not access services, due to barriers to access or acceptability of service, described their mental distress as stress or in relation to traumatic or adverse circumstances. When diagnoses were received, this seemed to act as a catalyst, if not an imperative, for recovery-based activities, such as coping strategies. When there was no diagnosis present, the intervention related to mitigating stress or distress related to trauma or adversity, but this was observed less often.

4.3.2 Coping Strategies as Facilitators of Recovery

While coping strategies were also observed in the participant accounts (*N*=12) of resilience to protect mental health against the effects of adversity, they were also an aspect of recovery in terms of coping with symptoms of mental health conditions. These coping strategies were a key element that participants used to facilitate recovery, but only a recovery in terms of management or a reduction of symptoms that were indicators for diagnosis. In the following example, Carol. Here she describes the coping strategies that help her manage her anxiety.

> *Eating [laughs], yeah, negative ways. Stress is a real trigger… now I am much better now than I ever was, and I don't know if that is age, therapy or learning. I need to mind myself when I stress, like do I need to take time off, cut back on work. Like I overwork*

> *as a solution to my trauma and history, like escaping into intellectual endeavours. So, like I know that if I'm in that space, I need to cut back and take a holiday, cut back, not answer that email. Also, just to lie down and just ignore everyone and wait for it to go away. That would have previously been the way I cope with things. But I am actively trying to have more balance, so I say no to things.*

Carol describes multiple ways of coping with her anxiety, some that are beneficial and others less so, such as eating and overworking. Her beneficial coping strategies are taking time out and removing herself from that which causes the anxiety. There is also an indication that the coping strategies were derived from experience or a mental health service (therapy). She states her mental health has improved due to these strategies, and that she is "*much better now*" and "*actively trying*", indicating an aim of recovery through these coping strategies. Indicators of class-specific stress that relate to her current socio-economic positioning, that of "*academic endeavours*", and having the means for holidays and therapy highlight the relationship between financial capital and the doxa of new social fields she encounters, as "*holiday*" and "*academic endeavours*" are not an accustomed aspect of her habitus, showing the shift in terms of recovery practices and social mobility.

Another example of how coping strategies are a key theme to recovery is from Alex, a 27-year-old man who identified as working class who had been diagnosed with depression and describes his way of coping with the condition.

> *I do see a counsellor regularly, and that's completely voluntary. Like I, I pay for that myself, probably once or twice a month, I go and have a session with him. And outside of that I speak to my girlfriend, she's definitely big support and for me. In terms of activities… I like to go out for a drive, you know, just sometimes I'll drive around the coast, like, and I do a bit of journaling. I'm still trying to get good at that, but I'm not great at it and yeah. I like to play some video games, watch I like to watch TV series on Netflix and stuff like that, and anything that kind of distracts me from what might be causing me to, you know, feel down or be having a bad mental health day. Distractions help a lot.*

While Alex does attend a counsellor as part of his recovery process, he also describes other activities that he uses as coping strategies, such as going for a drive, journaling and entertainment as a distraction. There are also indications of social support, as he talks to his girlfriend about his mental health. Like the previous extract, attending a mental health service (counsellor) is indicated as part of his coping. The coping strategies represented in these two extracts of distractions, social supports and attending mental health services were the most common coping strategies seen across all participant accounts and functioned not only as a means of dealing with the challenges of having a mental health condition, but also as a key

facilitator of recovery. While these examples show that coping strategies were used at least in part to facilitate recovery, recovery often required help-seeking from mental health services.

4.3.3 Habitus-mediated Help-seeking

Another theme in relation to recovery was help-seeking and could be observed in all participant accounts (*N*=14). Despite the coping strategies that participants employed themselves, they sought help from professional mental health services. While these encounters often resulted in the original diagnosis, which generated the imperative for recovery, the associated recovery activity was to adhere to the therapeutic interventions of the service. In the two accounts above, we see accessing services as part of their recovery strategy. However, the effectiveness of attending mental health services was mediated by the habitus. For example, when the mental health worker was perceived to have a different class background to the participant, as in the example below from Kate, a 53-year-old woman who identified as working class.

> *I think doctors treat people differently. Again, most doctors come from that professional class, wealthy, living in professional areas, and then they have practice in a working-class area. Like we know, antidepressants and all them kinds of medication were more widely prescribed in poorer areas. You know it was just like "take that right, script here, take that". Whereas in other areas, you know, people might have questioned them or they might have treated them differently from the onset. They are more understanding or compassionate, or you know.*

In this example, there is Kate's perception of mental health professionals as other and the stereotype that all mental health workers come from the upper classes. She also perceives that there are different treatments for those from "*poorer areas*", a differential framing that those in affluent areas would receive different treatment. Importantly, this relates to their power to hold the professional to account as the motivation for the more "*understanding or compassionate*" treatment of those from "*other areas".* This suspicion, a perception guided by the habitus, suggests that the perceptions of power and authority are attributed to class positionality, particularly when there is a perceived incongruity of habitus. This was consistent across working-class participants and not seen in middle-class participants. In all middle-class accounts with mental health services, there was a perceived congruity of habitus and class positionality that seemed to facilitate recovery. This was the case with Sarah, a 54-year-old woman who identified as middle-class.

> *I continued working with her on personal things, and I know it's been 5 years, but we have done lots and lots of things in that time. Umm…. I see her once a month, and I am quite happy to say she is my non-managerial supervisor, she is my spiritual advisor,*

she is my life coach, but she is also my counsellor, my psychotherapist, the person who invites me to look at the things that impact negatively on my mental health, those sorts of things. And it's nice because we work for the same organisation, we have a similar lifestyle, and she knows the pressures I would be under, so I think that helps.

Once again, we see a perception, this time of a congruence of habitus in terms of the mental health worker having a "*similar lifestyle*" to the participant, and this benefits the therapeutic relationship and the acceptance of the therapy that aids her recovery. Here, there is a very different report in terms of the perceived power dynamic of the relationship compared to Kate's account. Here, there is an invitation to recovery, where, in Kate's account, the recovery interventions are perceived as forced. By looking at these two accounts together, we see how the habitus guides these perceptions of the therapeutic relationship, impacting the taking up of mental health interventions provided by the services that may have facilitated recovery. In this way, the habitus is the mechanism which facilitates or hinders recovery that would be facilitated by mental health services, a key finding that will be explored further in Chapter 6.

4.3.4 The Individual Responsibility to Recover

In the previous themes, we see an imperative to recovery from a diagnosed mental health condition, with coping strategies and help-seeking centred around the class district activities guided by habitus-generated perceptions. The final theme in terms of recovery was centred around who held the responsibility for recovery and again was observed in many of the participants' accounts (N=12). While the previous themes suggest that coping strategies and help-seeking were the activities performed, the responsibility to perform these lay solely on the individual diagnosed with a mental health condition. This attitude is expressed clearly by Jeffery, who himself experienced depression, yet he projects this attitude onto others, although it can be assumed this attitude is also applied to his own responsibility to recover.

Like, I'm a huge advocate of everyone going through tough things in life. And yes, I'm all for everyone lashing out at sometimes in life, because it happens, it just happens. But if you use it as an excuse constantly and never get help and just kinda let it envelop you, then don't be mad when people tell you to fight your own battle and actually grow up and sort this stuff out, you know. Like, there are medications, there are so many services out there that can help you if you want it, but like some people don't want to get better. And some people open up nowadays, and they do it for pity, and they abuse the system. And it's not fair for those who are actually looking for help, who actually want to get better and recover.

The attitude expressed in the extract above was representative of the theme that recovery from a mental health condition was the responsibility of the individual. The attitude

is guided by his habitus, which holds the assumption that mental health services and supports are equally available for everyone, and it is up to the person with the mental health condition to access them and to recover. The shared socio-cultural knowledge of the habitus guides the assumption based on class distinct experiences of great accessibility to services facilitated by capital, and attitudes of the acceptability of services. As a consequence, we see moral judgment of those who are perceived as not wanting to access services based on the assumption of equality of access and personal responsibility. This links in with the previous theme that there is an imperative for recovery in the responsibility to meet that imperative, and the moral judgment if they do not. In the next example, we see how individual responsibility for recovery has been internalised, and again it is guided by the habitus, but one derived from a different positionality, as Kate's habitus was generated from working-class conditions and social fields.

> *So that was my experience of mental health, and just knowing that I was going to have to make me better, and there wasn't going to be someone who I could rely on to make me better. There wasn't, you know, proper services of professionals or people to listen to that, or even like parents that you could rely on or trust to help you*. It was like you're gonna have to do it yourself.

The preceding extract highlights the attitude of individual responsibility for recovery, but here it is responsibility held for herself. However, the rationale for this personal responsibility to recover is generated by the habitus and the condition of her working-class background, where mental health services and supports that may aid recovery were not available. In this case, personal responsibility comes from the necessity to recover by her own means as opposed to accessing services, as they are perceived as not available to her within her community. This highlights an important variation in the theme. While in both examples, there is an attitude of individual responsibility to recovery, the rationale for the individual responsibility is very different. Jefferey's is focused on moral judgment and presumed service availability, while Kate's is based on personal responsibility and self-reliance based on the presumed absence of services. Key to this distinction is the guiding principle of the habitus and the class-distinct sociocultural knowledge in which these attitudes and perceptions are formed. Importantly, we see these guide the recovery practices of the individual, either help-seeking from mental health services or a do-it-yourself recovery.

4.4 Subjectivity Themes

4.4.1 Habitus Guided Subjectivity

A theme that was consistent across all participant accounts (*N*=14) was that subjectivity was evaluated based on class-specific norms and standards. Subjectivity here was understood as the self-evaluations, including those of subjective mental health, that formed the participant's self-concept and identity. However, self-concepts were not neutral, but as a self-evaluative function based on subjective experiences, particularly those that related to the sociocultural norms from their socioeconomic conditions and generative fields. It is in the following examples that we see the habitus holding these participants to account, impacting their self-esteem. While mental health is not mentioned in these accounts, self-esteem and self-stigma are key elements of it. In the following example from Kevin, there is a link between his background and the presence of his self-concept.

> *In some ways, I would say that I am super self-aware because when you grow up in these sorts of environments, you don't get to have notions and your flaws are always put up for you to see, they are always reflected back on you. I feel there's no beating around the bush in a family of 12, if you're doing something wrong, you're gonna know about it. And so, I think that encourages, in some ways, that encourages some level of self-awareness, umm… but also critical thought, like in terms of that inner voice not being the kindest as well.*

Kevin describes how his background and family dynamics have made him very self-aware, which is associated with evaluations of self and negative self-criticism. Here, the voices of his past remain present, holding him in check to the norms and judgment of his generative social fields despite his social mobility. The norms of his habitus, represented by the judgment of others from his generative social fields, remain present with him as a self-evaluative measure. Yet, there is ambivalence, as on the one hand it is described as generating self-awareness, on the other, it is self-criticism and self-stigma. In the next example from Carol, we again see the habitus guiding self-evaluations, but this time they are in the context of a non-generative social field with which her habitus interacts.

> *And you also feel like there is this charity, a charity attached to you. I remember growing up and feeling like I was a charity case, and I felt like that going to college as well. Like I had to act a certain way to get what I wanted, so it was like always faking and being grateful like "oh please sir, thank you sir, can I have some more sir?*

Carol describes how the conditions of a marginalised background influenced her self-concept in a negative frame of a "*charity case*". Whether this is an actual perception from others or that she perceives them is not important. Rather, this is part of her self-concept, a

label that holds stigma in relation to her class position and that she needs help from others and must be grateful for this help. While Carol had significant social mobility, we can see that even when she is in third-level education, the subjective frame of a "*charity case*" a label from her past still influence her current self-concept, suggesting that while new events, social actors and new social fields can influence the self-concept, the influence of the habitus, her past subjective frames, remains influential in self-evaluations that frame subjectivity. Again, this was consistent across all participant accounts, that the habitus was an evaluative frame with which subjectivity was held.

In our next example, we see this habitus-guided evaluative frame with Susan, a 53-year-old woman who identified as middle-class, highlighting how her middle-class expectations impacted her subjective evaluations and acted as a guide for behavioural norms.

> *Well, the expectations that are set for you by your family, by your community, are based on their experience of their class. And that does influence your sense of self in the world, and uh, and I hadn't really thought of it that way. But it does influence… hugely as to how do you see yourself, how you value yourself. What is mirrored to you by this society that you're surrounded by, cause you will go to what's familiar, because not to is to be alien, and you know.*

Susan describes her self-esteem as being based on the norms of her class, which are transmitted through her family, illustrating the intergenerational aspect of the habitus. Importantly, while this is also a description of the formation of a self-concept, it is also an example of self-esteem, as she indicated that part of the influence is "*how you value yourself".* Here, self-esteem is bound to the socially constructed self-concept, where the self is only valued when it is in line with the social expectations of her class, but also society. This example not only highlights the relationship between self-concept and self-esteem but also the influence of sociocultural as well as societal norms that guide and evaluate behaviours.

4.4.2 The Nexus of Mental Health, Habitus and Subjectivity

While the habitus guided self-evaluations, which had an impact on mental health in terms of self-stigma, this was particularly relevant when participants experienced challenges with their mental health. When subjectivity is related to mental health norms, this is where the habitus has particularly strong effects, and this was observed in all of the participants' accounts (N=14). In the following example from Linda, we see how intergenerational attitudes carried on the habitus guide subjective mental health evaluations.

> *Like, because when I was in college, I actually went to the counsellor just to see because I thought it was something wrong with me, like I had social anxiety or something wrong*

with me, but it turns out I'm normal (laughs). But yeah, I just thought I had a lot of stuff that was wrong with me, but I ended up being OK. But I know a lot of it would have come from maybe my parents and maybe their ignorance, or you know that sort of way.

From Linda's account, her subjective mental health is guided by the norms and values of previous generations. While those who held those norms and values are not present, they have been internalised and guide the interpretation of her mental states. As they deviated from what was normal within her social fields, they were perceived as a mental illness. However, as the counsellor informs her that what was perceived as "*something wrong*" was normal human behaviour, this impacts her sense of self and self-acceptance. This was common among many participants, a relationship where habitus and mental health intersect in producing subjective outcomes. Another example of this theme is from Patrick, a 44-year-old man who identified as working class.

Like I'd even get anxious about being anxious and about having to hide it. Just all day long trying to figure… I was just fixated on trying to fix things. Like I would go all day long trying to figure out how to make things better or fix problems. And what those thoughts started, they wouldn't stop. Like I could spend hours thinking about what I would do if this happened or what I would say if my boss said that. And I was so ashamed of the way I was. Like other lads wouldn't even show their emotions, not where I'm from anyway, you can't show you're afraid, and I was afraid of everything and nothing! And I would look at myself, and be afraid of myself, of what I was doing, like my anxiety was who I was, it was me, it was my mind! And I was so ashamed of that….and then…I would worry about that too!

Patrick's anxiety is all-consuming and limits his life, and is central to shame and self-stigma, generated by a comparison to other males from his background. While these males are not present to judge his anxiety as he stays home during these anxiety attacks, their judgment is based on his habitus and the shared sociocultural working-class norms of male stoicism. Critically, his anxiety is due to his self-awareness that the anxiety is central to his identity, which then, in a recurring pattern, produces more anxiety. This example suggests that subjectivity is held by the habitus, particularly in terms of self-evaluations based on mental health and how this happens in a cyclical manner where distress is evaluated by the habitus, which, in most cases, results in shame and a compromised subjectivity generates more distress.

4.5 Chapter Summary

This chapter presented the results of an RTA that was carried out as the first phase of a multilevel qualitative analysis. The RTA aimed to identify overarching themes in the data that

were representative of the participants' accounts of mental health and also addressed the research question. Three overarching categories of themes were reported: resilience, recovery and subjectivity, each of which captures a different aspect of a mental health cycle that was observed in participants' accounts. However, within each of these overarching themes, distinct themes and sub-themes showed that these accounts of mental health were complex, class-situated and habitus-guided. In terms of resilience, key themes were resilience necessitates adversity, resilience as imperative, made up by the sub-themes resilient demands and the valuing of Resilience. Yet there were complexities and contradictions in these accounts of resilience, which were captured by the theme, the ambivalence of resilience.

The next overarching theme was recovery, which was thematically reported as recovery necessitates diagnosis, coping strategies as facilitators of recovery, followed by habitus-mediated help seeking, and the individual responsibility of recovery. Each of those themes showed how recovery was central to these accounts of mental health, but also how the habitus played a central role in mediating the activities and evaluations that were performed with the aims of recovery from a mental health condition. The overarching theme was subjectivity and was reported by the themes, habitus-guided subjectivity and the nexus of mental health and subjectivity. Again, each of these themes highlights the mediating role of the habitus in terms of mental health, but also suggests how these mediations produced self-concepts and, at times, in ways that were further damaging to mental health, such as self-stigma and shame.

While this RTA chapter gives results that are valuable insights in itself, there was an observed mental health cycle of resilience, recovery and subjectivity, but in all aspects of this, the habitus mediated these experiences. However, as we can see from these themes, there was often ambivalence and contradictions between and within these accounts, which suggests that further analysis is warranted to investigate why there is such complexity. While it is clear that the habitus mediated these experiences of mental health, this RTA does not show how the habitus is operating. However, it does allow for a mapping of data around these key themes, the complexities, contradictions and tensions within themes and between themes enable refinement of the data for extract selections for the discursive analysis. The following chapter presents this next phase of analysis, a combination of socio-cognitive critical discourse analysis and a Bourdieusian and Lacanian-informed discourse analysis. This further analysis addresses the complexity, ambiguity and tensions that were seen in the resilience, recovery and subjectivity themes and further investigation of that which the habitus is a key feature of practice.

5. The Practice of Resilience

5.1 Introduction

This chapter explores practices of resilience and their associated implications for mental health. Resilience is commonly framed as a positive psychological characteristic and a protective factor for mental health. Discourses of resilience present processes drawn from "multiple biological, psychological, social and ecological systems interacting in ways that help individuals to regain, sustain or improve their mental wellbeing when challenged by one or more risk factors" (Ungar & Theron, 2020, p.2). We can draw from this that resilience is rather an arbitrary yet powerful signifier. Discourses frame resilience as essential to mental normality and a highly valued psychological characteristic. Yet, as Stepleman et al. (2008) argue, there are variations as to what is being signified as resilience, as it is only ever explained by relating it to more signifiers that explain nothing but more signifiers and then refer back to the original signifier of resilience (Neill, 2013). Resilience, then, is symbolically constructed by language and is dialogically dynamic, never meaning anything while at the same time meaning everything to the person who is perceived as, or perceives themselves as, resilient. Thus, resilience functions as a master signifier, holding a fetishised value as both cultural and symbolic capital across multiple social fields and has a powerful effect on the individual.

The following is an exploration of participants' experiences of resilience, illustrating not only the spectrality of how resilience is signified, but also how it is practised. It does so by critically deconstructing the language which participants used to describe their accounts of mental health, which resilience was part of, either when directly indicated, or by associated experiences such as coping and adversity. Presented here are practices of performative resilience, suppression as resilience, and strength-based resilience. An additional section addresses the capacity for resilience, which was strongly associated with the aforementioned practices of resilience. As we will see from this exploration of extracts, the master signifier of resilience is acting on these participants, producing interesting outcomes, not always in line with what would be expected from the practice of resilience.

5.2 Performative Resilience

In this first section, the language of participant accounts suggests that the practice of resilience can be performative. As Butler (2002) describes, performativity is the acting out of

symbolic scripts within a socially regulatory frame. Agency, or choice in performativity, is limited, as the habitus and the doxa of social fields guide it (Bourdieu, 1998). Here, I treat performativity not as conscious acting, but as the reiteration of socially regulated scripts within particular fields. A practice is considered performative when it aligns with valued classed distinctions, is orienting the subject towards recognition by an imagined or actual Other, and in its repetition points to tension between habitus and field. The analysis, therefore, attends to imperatives, normative language, and self-evaluative statements that indicate regulatory demands. As such, practice in itself is performative, and when aligned with the habitus, it occurs unconsciously. However, a practice can also be done intentionally to meet with new or greater valued class distinctions or forms of capital, making it a performative activity. In the following extracts, the valued commodity that is required to gain distinction is resilience. Yet, as we shall see, when a performative practice of resilience is incongruent to the habitus, tensions arise with interesting consequences for mental health.

The first account comes from Ben, an 18-year-old male who self-identified as middle-class. Ben grew up in a rural village where most of his friends came from working-class backgrounds, but later moved to a large town where he attended a private school, where he struggled to fit in. Despite his affluence, Ben is not removed from adversity, and after the loss of his older brother to suicide and, subsequently, his parents' divorce, Ben struggled with grief and distress. Here, I asked him how he coped with these challenging circumstances.

> *When I was in the [rural village] with the lads, I had taken part of their attitude of you have to just get on with things, you can't let them hold you back.*

In this short extract, Ben reflects on a past point in time when interpersonal activities influenced his attitudes toward coping. While the extract does not explicitly use the term resilience, what is described as coping with adversity, in this case, grief, is closely representative of how resilience is described in the literature (Smyth & Sweetman, 2015; Stepleman et al., 2008; Ungar & Theron, 2020), but also how it is reported in the RTA theme resilience necessitates adversity. First to note is Ben's reference to his friends as *"the lads,"* which indicates a familiarity and positionality as a member of the group. "*The lads*" on its own is not significant, but as we read on, Ben states, *"I had taken part of their attitudes,"* and the use of "*their*" is juxtaposed with his perceived inclusion as one of "*the lads*." While "*taken*" suggests an otherness, as the attitudes were not inherent to Ben, but those of the habitus of his friends. This places Ben's subjectivity in contention with his friends, as he identifies with them,

yet the language differentiates him, with "*part of"*, suggesting only adoption of attitudes that were acceptable to his habitus.

The term "*attitude*" frames his friend's distress and coping as a matter of choice and excludes the contextual nature of the "*attitude*". The phrase "*you have to just get on with things"* is structurally significant to the following *"you can't let them hold you back",* as the imperative "*you have to*" suggests a responsibility to answer a demand. Given the dialogical nature of language and its equivalence to the Other, the imperative rises from the Other. The use of "*just*" before "*get on with things*" is important, but only in its relation to the full statement, as the nature of the "*things*" is not stated. The relationship of "*jus*t" to "*things*" acts as a modifier that negates the "*things*." This can be illustrated if "*just*" is replaced with the synonym "*only*," and with this simple linguistic substitution, the modifying action of "*just*" is clear. It implies other "*things*" that could, or should, be attended to, likely the activities of tasks of life, such as work, while the negation of "*things*" is likely the rumination of internal emotional states. Here, the language itself sets the demand for what is valued and attended to, affirmed by "*you can't let them hold you back*", indicating an outcome that should be strived for. Yet, we don't know the nature of the "*things*" that, for his friends, can "*hold you back"*, but only what the language indicates about the perceptions of his habitus and the discursive context for Ben.

Earlier in the interview, Ben described how he evaluated his class position based on the differences between him and his working-class friends (*the lads*). This seemed significant in terms of his subjectivity, so I asked him directly, "*Were they working class?*"

> *Exactly! … but it's something I learned from this sort of, well, I don't know what you would really say about the lads, they had this attitude, they had to work, work, work, work. And they were working class, and the only thing they could have on their mind was work. And they would be like "I can't deal with that", because they were doing the job. And obviously, I wasn't doing the sort of work they were doing, but I applied that to my workouts.*

His response to my question, "*Exactly!"* is a strong statement of agreement that "*the lads*" were working class. However, the subsequent use of "*but*" is a negation of his inclusion as one of the "*lads*", holding his subjectivity in contention again. While he identifies with them vicariously, his subjectivity is set apart with the repeated use of "*they*" (seven times), and not we. This is further expressed by his difficulty in finding signifiers to describe his friends (*this sort of, well, I don't know what you would really say about the lads).* Here, two habitus are indicated, that of Ben's middle-class habitus and the indication by Ben's othering and labelling

his friends (*they were working class*). This indicates his subjectivity is not abstractly formed but linked to class labels and distinctions of class. This is important as the language that frames this practice is dependent on Ben's habitus and the "*attitudes*" of the other habitus he adopts.

For example, the signifier "*work*" is paired with the signifier "*working class,*" showing a linguistic relationship between objective identification, but also the *perceived* "*attitudes*". The statement "*they had this attitude*" is followed by the imperative "*they had to,*" holding the term "*attitude*" in contention as "*they had to*" implies an imperative to *"work*", not because of a motivating attitude as opposed to financial need. What is meant by "*work*" is not indicated, but due to the context, we can make a reasonable assumption that the "*work*" that his friends perform is likely paid labour. The phrase "*the only thing they could have on their mind was work*" can be linked to the previous framing of the "*attitude*" of the "*working class*." Yet, "*I can't deal with that*" suggests an internally derived imperative, with "*deal*", in the discursive context (a discussion about mental health), likely related to the mental management of the effects of adversity referred to as "*that*" in the phrase. From these signifiers, there is an assumed practice of an "*attitude*" where paid labour mitigates psychological distress by preventing rumination (*because they were doing a job),* which can be adopted as a practice to mitigate distress.

Consequently, Ben adopts the coping strategy of sublimating physical work for psychical work (*something I learned)* based on the perceived "*attitude*". Critically, while "*learned"* implies an exchange of knowledge or skills, what we see here is the adoption only of signifiers, that of *"work"* as coping. The signifier "*work*" functions differently for Ben compared to his friends due to the contrasting subjectivities, illustrated by the statement "*I wasn't doing the sort of work they were doing.*" Here, there is a structural equivalence with the signifier "*work*" and the isomorphic presentations of physical exertion (*work*) as a coping strategy. From this, a second practice is indicated by *"I applied that to my workouts*", sublimating psychical work for physical work. However, the nature of the two practices is critically different when the phrases "*they had to work*" and "*I applied that to my workouts*" are compared. The first signifies an imperative to meet daily needs, while the latter signifies leisure performed by choice. As such, the second practice (*workouts*) is only an isomorphic performance of the first practice.

It is with this performative practice of resilience that we return to Ben's subjectivity and question why there is a preference for a practice aligned to another habitus. Ben's ideal

ego, derived from the mirror stage and his engagement with the symbolic order, frames a fantasy version of self, yet this is not clearly illustrated in this extract. What we do see is a desire to end his suffering from his encounter with the death of his brother and his parents' divorce. By seeking another's practice, it is a fair assumption that his own practices of coping do not bring him relief. His ego ideal then is informed by the perception of his friends as being more resilient due to first, them being working class, and second, their "*attitude*" towards "*work*" which he misconstrues due to his habitus and lack of intersubjectivity. Importantly, Ben misinterprets that his friends are practising resilience, and the performance of their practice does not serve as resilience for him due to the misinterpretation of signifiers. Consequently, Ben's mental health deteriorates, and he attends mental health services where he is diagnosed with depression. Details of his experience with services will be explored in the following chapter on the practice of recovery.

Another example of a performative practice comes from Kevin, a 31-year-old male who self-identified as working-class with social mobility to the middle-class. Kevin recounts substantial and enduring adversity related to poverty, marginalisation, violence, and drug and alcohol use. This adversity affected his expectations for the future, and he didn't perceive a trajectory that might have led to social mobility. However, this changed when he joined a targeted government program for marginalised youth, and he received a skills-based education that enabled him to get employment in the IT sector. This job provided him with financial, social, and symbolic capital and social mobility to what he described as a "*middle-class*". Yet, despite his social mobility, he still experiences adversity, although different from that of his past, the past adversity and associated resilience still influence his present. First, I ask him, "*How did those attitudes* (about mental health from his working-class community) *affect how you dealt with things, like stress or if you were upset about something, how did you deal with it?"*

> *Like growing up, it was like, don't sit there and wallow in it. You need to fix it! And I think that in some ways, that builds resilience. So, my emotional reaction to things is ok, this is not the end of the world, and you kick into problem solving, you kick into ok, how do I fix it?*

He begins with "*like growing up,*" locating the text to a past time point and the conditions of his generative social fields. As he recounts these formative experiences, there is a dialogical presence in the attitudes likely related to the coping strategies of others that were in his life "*growing up*." While Kevin uses the term "*resilience*," it is not defined or elaborated on, but what is described can be associated with attitudes about adversity and coping. The

phrase "*don't sit there*" stresses the importance of not being passive in the face of challenges, with the term "*wallow"* suggesting an indulgence in emotional states (e.g., to wallow in depression, self-pity, despair). Structurally, this signifies a negative attitude towards passivity, but also the enjoyment in its performance (jouissance), yet judgments for the enjoyment. The preferred is an action-oriented response *(to fix it)*, with the "*it*" indicating something elsewhere, an external problem that needs to be solved through action. To be clear, it is not suggested that this reflects Kevin's actual personal attitudes. Rather, in the context of the temporal and discursive frame associated with *"growing up"*, it is an attitude about personal difficulties associated linguistically and structurally with such judgmental terms from his sociolinguistic ecology internalised in the habitus to return through his coping strategies.

Importantly, we are not told what kind of difficulties this discursive frame relates to. Mental health, whether situational or endogenous, or other kinds of setbacks or traumas, is not indicated in the text at this point, nor what qualifies as wallowing. For example, in one context, an unwillingness to seek help from others could be met with such judgment, and actions to "*fix it*" might include seeking counselling or confiding in a friend. In another context, these might also be seen as indulgent actions in place of getting on with life in more practical respects. To "*fix it*" functions here as a floating signifier, potentially signifying very distinct orientations on the signifying chain, with accompanying axiological implications depending on the discursive context of social fields and the habitus of those who speak it.

Returning to the word "*resilience*," we can see that there are positive values associated with it (*And I think that in some ways that builds resilience)* linked to a stoic disposition *(ok, this is not the end of the world),* and an orientation towards *"problem solving."* We can observe that "*resilience*" is both literally at the centre of the extract and is also a pivotal signifier that separates the language of reactions to adversity, such as "*wallowing,"* on the one hand, and the stoic and practical language of "*how do I fix it"* on the other. In this extract, we can see how language frames a practice of resilience that is associated with an action-oriented response to externally associated adversity or the "*it"* that needs to be "*fixed"* through "*problem solving*" and a valuing of a practice from the sociocultural context during his "*growing up*."

However, after Kevin gained social mobility, he continued to struggle with stress, and as it increasingly impacted his mental health and relationships, he sought the mental health services of a psychotherapist. Now we see different signifiers of resilience when I ask him, "*How do you cope with stress now*?"

I think I lean on things more, like I do a bit of meditation. I try to tackle the root cause of why I'm feeling a certain way, as opposed to the action or the immediate thought in my head. Umm… I'm getting better at going back and saying, "Oh, this is what's wrong with me, this is why I'm having a bad day." And I am taking ownership over my mental state, and that's a lot better because before, I was "I feel this way because you made me feel this way," whereas now, I feel this way because I haven't dealt with something I need to.

The extract begins with the phrase "*lean on things more,"* like "*meditation"*, a learned skill and a new practice. This suggests a new trust-orientation, a willingness to rely on something new, or that is new to him, a learned practice that encapsulates both a philosophy and technique prioritising reflection and an inward orientation of consciousness. This is contrasted with the more reactive characterisation of "*action"* and "*immediate thought"* that suggests a lack of reflection of his previous orientation, as if acting without consciousness or reflection. He also, through the words "*try"* and "*tackle,"* indicates that the "*root cause"* is something that is a struggle to either identify or manage, with no promise of success. But he is "*trying"* to be more reflective and less reactive, something that was previously judged when we consider the language of the previous extract.

The second observation that follows is linked to the phrase "*getting better at going back and saying, 'oh this is what's wrong with me, this is why I'm having a bad day'."* This is noteworthy in that it links the reason for negative thoughts or feelings with this "*root cause* ", the unknown internal source of struggle that is expressed with certainty with the "*this*" in the phrase *"this is what's wrong with me, this is why I'm having a bad day."* In this regard, the cause associated with the thoughts and feelings is not the situational factors, including others, but indicates a more psychodynamic process linked to the "*root cause*". "*Going back*" indicates a secondary reflective step following the initial feelings or thought, a step that consciously distances the cause from the situation at hand and locates it within himself. This he elaborates clearly by separating the cause from the present other and attributing it to the split self (*before I was 'I feel this way because you made me feel this way,' whereas now, I feel this way because I haven't dealt with something I need to).*

Crucially, this utterance centres around the word "*ownership,"* indicating an acceptance of responsibility over his "*mental state."* This suggests that for Kevin, the internalisation of responsibility is linked with healing, or the internalisation of responsibility as a condition of healing. Key phrases that link this together are "*getting better at"* and "*getting better,*" signifiers linked with both the concept of healing itself (e.g., getting well) but also the practice of "*getting better at …*," the honing of the skill through the practice of internalisation of

responsibility. In other words, he is first, "*getting better"*, as in he is healing, and second, "*getting better at …"* the skill of healing, and a third, he is getting better at internalising responsibility for his actions, thoughts, and feelings.

Returning to Lacan's (1936) characterisation of the subject as split, alienated by language (mirror-imaginary), and the symbolic from their real self and structured around a primordial lack, his ideal ego. This would suggest that Kevin seems to be accepting responsibility for thoughts and feelings that he cannot ultimately account for (note his "*trying to tackle"* the root cause). Ironically, the immediacy of his thought and action that he ascribed to the previous practice, one that emerges in reaction to a present situation (present both in terms of time, and 'objects' physically or mentally manifested), arguably reflects the Real or that which eludes symbolisation or cannot be articulated (the felt characteristic of emotional experience), and also potentially repressed object-relations or desires, linguistically structured in the unconscious, but potentially transferred to present objects. On the other hand, his position of accepting responsibility for his mental state is framed as a virtuous stance, as if to say shifting the spotlight of responsibility from the external Other to the internal locus of control is framed with developmental terms (*getting better*), where a move in that direction is a move towards healing, towards being better at meeting the demands of the ego ideal.

If it is the case that the shift from attributing causality for his feelings, from external objects to internal processes, represents a positive development and change in the right direction, what is this contingent on? Looking back on his statement, "*I lean on things more"*, and the new therapeutic techniques like meditation, it is reasonable to say that the value of such an intervention (meditation or psychotherapy) is based on its ability to affect such a shift. *"This is what is wrong with me…"* is more than a nuanced re-diagnosis. Rather, it is a discovery of a truth behind his tendencies towards negative or destructive thoughts and feelings as being other than circumstantial or situational. Note that when he states "… *and that's a lot better, because before I was 'I feel this way because you made me feel this way', whereas now I feel this way because I haven't dealt with something I need to."*, what makes it "*better*" is only the direction of the attribution. From this shift, we see the second practice, which is acquired through mental health discourses, and as it is not in line with the practices of his habitus, is performative. Here, tensions are produced between this first practice (that of the first extract) and this new second practice that he performs.

By looking analytically at this account, his entry into both acknowledging mental health difficulties and the adoption of treatment approaches (entry into mental health discourse), we can identify not only a before-and-after account of treatment, but more importantly, a reorientation of responsibility for adversity and coping. This change in responsibility orientation is linked with getting better (healing), which, in this extract, would seem to suggest that healing means precisely that reorientation, the adoption of a new discursive frame and the performativity of the second practice. What is lacking here is any sense of improvement in terms of symptoms. Considering the before-and-after practices associated with resilience, it is plausible that the two sets of discourses provide Kevin with different ways to practice resilience, each signified and valued differently in different social fields.

It is also worth considering an element of time to these accounts, with both Kevin and Ben recollecting past and present circumstances where resilience was required and performed. We also see different habitus operating, Ben and Kevin's, as well as the habitus of those they interacted with, often adopting signifiers from others' linguistic habitus. These signifiers operated on participants' understandings of adversity, coping and subjectivity, which guided their practices of resilience. When initial practices were in line with their habitus, yet failed in some way to mitigate adversity, there was a demand from the Other to be more resilient or perform resilience more acceptably. When new practices were performed, and if incongruent to the habitus, a splitting of the subject occurred with these tensions. Regardless of the type of practice performed, those attuned to the habitus, or the performative practices, neither resulted in a lessening of distress, because, as we saw, it was only a shifting of signifiers that produced the performative practice and not an actual new or better way of being resilient, only one that was more valued in the relevant social fields. With a critical deconstruction of the language of these two accounts of resilience, several important insights have come to light that suggest practices of resilience can be performative, but also that a performative practice can, in itself, cause mental distress.

5.3 Repression as Resilience

Repression of emotions was common among many participants as a practice of resilience. While resilience is commonly understood as psychological processes that mitigate emotional distress from adversity (Ungar, 2020), what was observed from accounts was very different. In the examples explored below, two participants, Kevin and Sarah, both had upward

social mobility and came from working-class backgrounds. Both described how their backgrounds affected them emotionally, and at first glance, these appear to be accounts of working-class emotional stoicism that provided resilience. However, as we look closely at the language, instead of resilience, there is a repression of emotions, which has consequences for their mental health.

In the first extract, we again hear from Kevin. At this point in the interview, Kevin was speaking about his observations of a working-class mentality related to coping. Here, I ask him, "*Has this mentality, that you say is part of being working-class, does that affect how you emotionally react to things and how you cope with your emotions?"*

> *Yeah, absolutely, it still does. And I would say that I am quite the empathetic person, but definitely, there are bouts of impatience, and I think to myself, why is that a problem for you? Why make a big thing of it? And I detach the emotions from it and do what I have to do. And I find I do that with my kids, my wife, and at work. I do it less so than before, but I still do it. I'm still a product of that upbringing or that mentality. And as I said, sometimes it is a positive thing, it's resilience in some ways, but at some point, there is a negative aspect to it, there is a point where it isn't a positive, and you're just not dealing with it. Like I don't blow up small problems, and if I'm stressing about something, it's usually a big deal. But I would say absolutely, I am still of that mentality. The natural instinct is to go to that, I almost have to fight against it and to try and deal with it in a more productive way.*

The first observation is a temporality within the text referencing two time points. The present tense is indicated by the description of the current practice (*I detach the emotions from it*), and the past is indicated by his direct answer to my question (*Yeah, absolutely, it still does",* as well as "*I do it less so than before, but I still do it).* The use of "*before*" indicates the previous time point, and "*it*" the practice he both previously and currently performs, yet currently he tries to resist. From this temporality, the two practices emerge. The first practice, indicated by "*I detach the emotions from it*", suggests an intentional detachment or repression of emotions (*impatience*, *stressing)* caused by some unstated form of adversity (*it*). It is a repression of emotions as the language indicates emotions have occurred, that they are first felt and attached to adversity, but then actively repressed (*I detach the emotions from it*). The second part of the phrase, "*and I do what I have to do",* suggests an imperative to achieve some necessary activity, where a lack of emotions is required. Considering his working-class background and the sociocultural norms of working-class stoicism (Charlesworth, 2000), the practice aligns his subjectivity with these norms. His positionality in that statement, which is signified by the first-person pronoun "*I*", implies this is a self-directed imperative, perhaps derived from external or internalised demands.

However, the nature of the demand is not indicated in the text but only implied with the floating signifier "*it*". The "*it*" in this instance is the object or cause of emotionality and is only linguistically associated with "*I find I do that with my kids, my wife, at work".* The presence of "*I find*" structurally suggests a lack of intent of what the practice is applied to, indicating a generalisation of the detachment of emotions from the external adversity of "*it*" to that which is not intended, his family and his job. Importantly, this repression is labelled as "*resilience in some ways*", associating the practice with the master signifier resilience. However, "*in some ways"* suggests an incompleteness in terms of its functioning as resilience that would meet his expectations of the signifier.

With further exploration, multiple contradictions are present in the text, suggesting this practice is not satisfactory as a resilience that beneficially mitigates his emotions. The statement "*I would say that I am quite the empathetic person*" is followed by a tentativeness towards a complete identification as "*empathetic*", diluted by "*I would say*" and "*quite"* and the oppositional "*bouts of impatience".* The "*bouts"* imply this "*impatience*" is inconsistent and a temporary loss of control from being the "*empathetic person*", the preferred disposition. The practice is to "*detach the emotions*" to regain control and return to the "*empathetic*" state, a contradiction in itself, yet it enables him to meet the demands of life (*do what I have to do).* Again, the framing of "*resilience in some ways*" suggests it is incomplete as resilience, but more so, it has the damaging side to it, that to practice it comes with costs (*has a negative aspect to it).* The "*it*" now signifies the practice that is not resilience but avoidance by "*not dealing with it",* and now the "*it*" here refers back to the object of the emotionality. This negative framing highlights a devaluing and an opposition to the practice, which he tries to avoid ("*I do it less so than before, but I still do it").* Yet, the practice, again signified as "*it*", is one he struggles to refrain from (*I almost have to fight against it).*

The second practice is not clearly defined, but indicated by "*deal with it in a more productive way."* To "*deal*" suggests management, and we can link the use of "*it*" here to his emotionality, the same "*it*" that his initial practice aimed to control. On its own, this practice is neutral in its efficacy to produce effective resilience, but in its opposition to the first practice, framed negatively and devalued, the "*more productive*" practice is linguistically framed as more effective and therefore holds greater value. Looking structurally at the text, we see a tension between the two competing practices due to this oppositional framing of the signifier,

and it is necessary to consider his value orientation and look at what else is indicated in the text by the two practices, habitus.

First, there is the presence of Kevin's initial habitus in the shared sociocultural norms expressed in his internal dialogue (*Why is that a problem for you? Why make a big thing of it?)*. This linguistic devaluing frames his emotions as a "*problem*" and a disproportionate response (*big thing*). The presence of the habitus is also indicated by the floating signifier "*it*" with signification as the practice he must fight against. In his response, "*Yeah, absolutely, it still does".* The "*it*" here is the "*mentality*" that is a "*product of that upbringing"*. Critically, despite his social mobility, this "*mentality*", the "*it*", "*still"* guides his practice. Finally, we can confirm that it is the primary habitus that guides the first practice with reference to "*natural instinct"*, that it is inherent and outside his control. The second habitus is indicated in the same manner, with the presence of practice. While not explicitly indicated in the text, the "*more productive*" practice indicates the second habitus, likely exposed to Keven with discourses and doxa of new social fields he encounters since he gained social mobility. Using this same correlation, the devaluing language of the first practice indicates a devaluing of the first or primary habitus, and the second "*more productive*" practice implies a second or newer habitus, which, like the practice, holds higher value, showing a duality in his habitus.

Two internal ideals derived from this duality generate tensions for his subjectivity, that of the ideal ego and the ego ideal. The ideal ego is derived from the mirroring of the generative social fields, forming an imaginary, idealised self that guides the performance of the first practice, aligning it to the primary habitus and his ideal ego. We only need to look at Kevin's critical internal dialogue *'Why is that a problem for you? Why make a big thing of it?"* to see the ideal ego holding him to account for his emotions. The other internal ideal, the ego ideal, is derived from the demands of the Other, that of the symbolic order and the internalised societal expectations. The ego ideal is indicated by the framing of the second practice as "*more productive*" and, consequently, the valuing of the second habitus over the first. The ego ideal is what Kevin desires to be, generating tensions with his ideal ego, further dividing the subject. Thus, he is a split subject, split by language and the duality of habitus and practices of resilience. Bourdieu (2004) referred to this duality as a cloven habitus (habitus clivé) where different habitus are held in contention, producing internal tensions in subjectivity and, as Friedman (2016) argues, emotionality. This division is structurally present in the statement "*I almost have to fight against it and to try and deal with it in a more productive way."*

Despite the tension, the object of desire is the performance of the second "*more productive*" practice, and his Objet petit a, the object cause of desire, the associated second habitus, that which will meet the expectations of his ego ideal and satisfy the desire of the Other. However, the performance of the second practice will never gain him the second habitus or fill the lack, as his ideal ego holds primacy with the guiding principle of the inherent habitus, the "*it*" that he tries to "*fight against*". Importantly, the relationship between the practices, habitus, and subjectivity is not linear but dialogical, and as he attempts to apply these practices, it is the signifiers of resilience that are doing the splitting of Kevin. While we see a repression of emotions that may act as resilience in the short term, this only maintains the demands of his ideal ego, that of stoicism held by the signifiers of his internal dialogue (*Why is that a problem for you? Why make a big thing of it?).* Finally, signifiers of resilience from his ego ideal demand him to be a more "*empathetic person"* who performs resilience in "*a more productive way*". From looking closely at the language of Kevin's account, a practice of resilience where emotions are repressed functions, in part as resilience, yet produces tensions for his subjectivity.

To explore this practice in greater depth, we can consider Sarah, a 54-year-old woman who subjectively identified as middle class and, like Kevin, had social mobility from a working-class background. While she describes her position currently as financially secure, she recalled the precarity of her working-class upbringing. Despite this precarity, Sarah stressed the solidarity in the working-class community she grew up in and the strong working-class norms that her family lived by. Here I asked her, "*Has your working-class background affected you emotionally*?"

> *When you go and look at my social class, my family, my upbringing, we buried things. We buried things, you did not look at them, you did not talk about them, we did not share them. Mum and Dad lost a child and don't know where it's buried, burying their negativity, hiding from it, not embracing it. And I think my social class has affected me because… I try to embrace it, but I still hold back from it, from embracing what would be seen as poor mental health. And I suppose that was a survival technique, you didn't have time to carry all your wounds. It's like what I call poor pride, like when you are proud of the very little you have, and one of the things they do have is, you know, I suppose what they were protecting was good mental health. I mean, you don't get upset and go crying in the street.*

Again, there is temporality, or a sense of then and now, as with previous accounts, which she moves between throughout the extract. Sarah starts the utterance with "*When you go and look",* suggesting a reflection not only of the past, but an autobiographical reflection (*my social class, my family, my upbringing*). Within the language of this reflection, subjectivity is

linked to that of the generative social class group, stating "*we buried things"* and "*we did not share them*", the "*we*" indicating a subjective alignment. There are also the shared sociocultural norms of her habitus (*We buried things, you did not look at them, you did not talk about them, we did not share them).* That which is "*buried"* (covered or hidden) is referred to as "*things*", the emotions which must not be acknowledged or displayed to others. Again, like in previous accounts, this can be associated with a working-class stoicism, later referred to as "*poor pride*". However, like the temporality, Sarah's language switches between aligning with those of her background with "*we*", and her current positionality with "*they*" in the phrase "*one of the things they do have",* points to the tension in her subjectivity.

Returning to a temporal language of the past, Sarah states, "*Mum and Dad lost a child and don't know where it's buried",* followed by the reflective language of *"burying their negativity, hiding from it, not embracing it".* This is interesting as it points to the events of the past that are still present unconsciously, but also her judgment of her parents' response to the death of their child through the repression of signifiers. The signifier "*buried*" is used again, as well as the related "*burying*", yet used in different, but connected ways. First, it is the literal reference to burying a body, covering it, making it unseen and as she explains, her parents lack even the knowledge of where the body of their dead child is buried. The event and the associated emotions are repressed, out of sight, out of mind. This is followed by the symbolic reference to "*burying*", again to hide or repress, but this is a statement of judgment of her parents' coping, their grief framed as "*negativity".* Yet again, there is a duality with the judgment that it should not have been repressed, indicated by the negation "*not embracing it*".

While the term resilience is not used, the management of emotions relating to adversity, in this case, grief (signified as negativity), equates to a resilient response. In this statement of judgment over the past practices and attitudes, the second practice is indicated by "*I try to embrace it, but I still hold back from it, from embracing what would be seen as poor mental health".* Here, the practice is to "*embrace it",* the "*it"* references the "*negativity*" that was her parents' emotional response. The second part of the statement (*embracing what would be seen as poor mental health)* is critical as it points to the symbolic nature of this second practice, with the word *"seen*". This suggests only an "*embracing*" of the visual displays of emotionality (*poor mental health*) and not an actual resilient process. This is similar to the first practice, a reframing of signifiers, but these are more similar to hegemonic discourses of resilience. Considering the judgment towards her parents' practice, the framing of the second practice indicates its higher value and desirability.

While the second practice is framed as more desirable, there is tension with her attempt to adopt these new signifiers. The statement "*I still hold back from it"* points to the primacy of the initial habitus that guides the "*holding back*". A practice that is inauthentic to the primary habitus suggests a second habitus exists, though only hinted at by the practice. In the text, we see a desire to align herself with a second habitus through the devaluing of the practice aligned to her primary habitus (the repression performed by her parents) and a desire to perform the second practice (*I try to embrace it)*. This second practice would not provide her with resilience through embracing emotionality, but only a new signification for emotions. Yet, it is desired as the second practice provides distinction in terms of acquiring the second habitus, one more valued and more in line with her current middle-class subjective status and desired identity. However, the demand for a practice drives her desire for something more effective than repression, as with repression, that which is repressed (the emotions associated with death, and that escape articulation, or the Real), will always return (*I still hold back*).

It is here in the tension between the past and present, old and new practices, primary and secondary habitus, that Sarah's subjectivity is held. As before, tension between the ideal ego and the ego ideal is present in the language. Returning to the term "*poor pride*", we see the working-class stoicism performed through the suppression of emotions to hide emotionality from others (*don't get upset and go crying in the street)*. The "*pride*" suggests a certain enjoyment (*jouissance*) in suffering from adversity and emotional stoicism. While this was indicated as a practice of previous generations, the final sentence (*I mean, you don't get upset and go crying in the street)* is expressed as a current attitude that is her own practice. Sarah is still held to account by her ideal ego and the sociocultural norms of her habitus, the practice of suppressing emotions (*you don't get upset*) from the view of others, in this case, those "*in the street*" or her community.

She is also held by the ego ideal, indicated by her negation of the perceived better practice (*I try to embrace it, but I still hold back*), one where emotions are embraced, yet as she states, it is an embracing that which is "*seen as poor mental health"* a statement that contradicts the shame in public displays of emotions indicated by *"you don't get upset and go crying in the street".* Again, we see a polarity in terms of resilient practices requiring the resilience to be performed in opposing ways, dividing and splitting the subject.

From both Kevin's and Sarah's accounts, we can see how repression of emotions functions as a practice of resilience, one that is habitus specific. This can be read in the texts

as two possibilities for resilience, each tied to different time points, habitus, practices and subjectivities. It is here that the subject, already split by language, is also caught by tension between two competing significations of resilience. First, observed in the data, a stoicism associated with working-class contexts and a practice of resilience through repressing emotions. Then, the Other, the symbolic structures of society (including that of class), fetishises certain significations of resilience. Practices that display emotionality are valued, as are those who do not perform the stoic symbolic practices. However, it does not matter which practice Kevin or Sarah performs. Either way, they are caught, split between two subjectivities, distinguished by differentializing signifiers of resilience that only function symbolically. These symbolic practices are ineffective at providing them with relief from their experience of emotions that are associated with adversity, as the practice of the generative habitus represses rather than resolves, and what is repressed returns, as we have seen in these two participant accounts.

5.4 Strength-Based Resilience

In the previous section, the repression of emotions was used as a resilient practice, enabling participants to withstand the emotional strain related to adversity. Closely linked to repression was another practice in which participants simply withstood the effects of adversity regardless of the negative effects on their mental health. While strength-based practices were observed to some degree in all participants, they were more prevalent among those who self-identified as lower and working-class. Crucially, strength-based resilient practices did not result in positive mental health outcomes, but the opposite seemed to be the case. In the following exploration of extracts, participants' language gives insight into this strength-based practice and the associated conditions that required it, as well as the sociocultural norms that make this practice highly valued, despite its clear costs.

We begin with Ari, who was 32 and identified as non-binary and working-class. Ari had experienced poverty, abuse, and insecurity after the death of their mother at an early age. Throughout their childhood, Ari faced significant adversity not only related to socioeconomic conditions but also physical and emotional abuse from their stepmother, which significantly impacted their mental health throughout their life. Now, gaining social mobility was the focus of all activities, including leisure, education, employment and relationships. Yet, the pursuit of social mobility produced more adversity, with stress and pressure to achieve an acceptable level

of status associated with an aspired middle-class trajectory. When I asked Ari, "*Can you tell me about your experience of mental health?"* their answer illustrates the complexity and contradiction of the strength-based practice of resilience.

> *Like from where I am on the ladder, a good measurement of mental health is your ability to deal with stress. I'm like, you cannot break under pressure, you don't have time. And I think that I've been forced to be resilient in ways that are unhealthy. Umm…like am I resilient? Yes. Is it good for me? Absolutely not. And so…like my mental health is already sort of precarious, like teeter totter of constantly trying to balance everything in my life. And then you add sort of money problems into the mix, it does not help you add class issues into the mix. And it is sort of a whole new element, like I'm playing 4D chess with my mental health all the time.*

Again, as with previous examples, there is evidence of two points in time. The first indicates by the past tense reference "*I've been forced to be resilient,*" suggesting past resilient demands with the imperative "*forced*", yet the adversity is not indicated in the text. This past time point is also indicated by "*already*", implying a previous precarity of mental health and the addition of "*a whole new element*", suggesting current temporal states. The phrase "*like from where I am on the ladder*" indicates the present, as does "*playing*". Not only are there two points in time, but two socioeconomic conditions are indicated by the use of "*ladder*", referring to the MacArthur scale used directly before the interview. It is an interesting term to have used and may relate to a desire for social mobility or an indication of positionality in the hierarchical order of social classes. Associated socioeconomic conditions are also indicated by "*money problems,*" suggesting an adversity of trying to meet financial needs with their current position on the "*ladder*".

It is also from the signifier "*ladder*" that the habitus is indicated, as the ladder of the MacArthur scale is a symbolic representation of the hierarchical class structure and not a SES measure. This is further signalled by reference to "*class issues,*" the symbolic class conflicts that are distinguished from "*money issues*" in the text. This is important as it indicates the habitus through Ari's linguistic positioning in the text, as well as the temporality of past and present tense terms. It is with the indication on the second habitus, that which is desired and their activities centre on (*under pressure, constantly trying to balance everything in my life, into the mix),* the primary habitus is indicated as the starting point, and that which anchors the experiences to the initial time point. Additionally, the presence of an initial practice of simple bearing the adversity points to the guiding principle of the primary habitus, which naturally performs this strength-based practice. Despite this pulling back of the primary habitus, the

second habitus is the object of desire, that which would bring distinctions of social mobility, but also the conditions where resilience is no longer required, their Objet petit a.

The practice associated with their primary habitus is focused on "*constantly trying to balance"* and their management of "*the mix*". Here again, we see the relevance of "*time"* first used in the internal dialogue of "*you don't have time"* and that their mental health cannot "*break under pressure*", a framing linking their practice as strength-based and of balancing multiple resilient demands. The description of resilience suggests an equality of demands due to resilience being signified as "*balance*", yet this is not what the language suggests. It is contradicted by the second use of time at the end of the extract, where they state, "*I'm playing 4D chess with my mental health all the time,"* indicating that Ari does spend time, and intense mental effort (*4D chess*), attending to their mental health. This suggests the first practice of managing multiple demands and simply bearing the stress and pressure is not beneficial, as indicated by "*Umm…like am I resilient? Yes. Is it good for me? Absolutely not".* However, this practice has another purpose, indicating the quality of their mental health *(good measurement of mental health is your ability to deal with stress).* Here, with the signifier "*resilient*", there is an imperative to perform the practice regardless of the costs and their awareness of them.

It is useful to consider if Ari didn't frame their strength to bear the mental weight of adversity as resilience, but simply stated, "*Is it good for me? Absolutely not*." By removing the signifier "*resilient*," the costs of this practice to their mental health are clear. Here, Ari's pursuit of the master signifier resilience (*resilient*) is shown as harmful to their mental health, yet it legitimises, if not valorises, their ability to withstand the damage. Critically, the framing of the practice as "*resilient*" absolves what generates the resilient demands, the Other. The Other is present in the extract in two ways. First, in the conditions of Ari's position in the social structure (*money problems; class issues)* and their positionality within social fields, perhaps hinted at with the use of "*forced", "pressure*" and "*you don't have time".* The second indication of the Other in the text is the expressed values, aspirations and desires (desires of the Other) that the Other asks for by the ego ideal held in contention by the ideal ego of their habitus.

On the one hand, there is Ari's ideal ego, the fantasy of self that is strong and resilient. Yet, this fantasy is indicated by the desire to escape from being *"forced to be resilient in ways that are unhealthy."* It is these conditions that are indicated by their opposite in the text that we can see Ari's ego ideal, someone who does not have to perform resilience, as they do not have the "*money problems",* the "*class issues"* and no longer has to "*balance*" and their mental

health is no longer "*precarious*", relieved of the "*pressure*" by gaining the Objet petit a. Yet, to get to this positionality, and maintain it they will have to perform resilience. Thus, Ari is caught between the desire not to be resilient and the need to perform resilience to move beyond resilient demands. However, as their practice is that of simply bearing the adversity and accepting the damage to their mental health, linguistically framed as being "*resilient*" aligns the practice to the master signifier, justifying the costs to their mental health. Despite their knowledge of these costs, and perhaps because of it, they push on practising resilience. Here we are left questioning whether Ari will have the strength to get what they desire, and if they do, will it fill their lack? We will return to Ari in Chapter 7 regarding their practice of subjectification with a more in-depth analysis of their subjectivity.

Another example of a strength-based practice comes from Alex, a 27-year-old man who identified as working class. After his father left the household when he was young, and once old enough to work, Alex contributed to the financial responsibilities, but they often struggled financially. While he initially attended college, he dropped out to get a job and support his family. He expressed strong aspirations for social mobility with a plan to rise through the ranks of his job in the leisure industry. Alex claimed he did not subscribe to a working-class identity or the sociocultural distinctions of his community and spoke of emulating middle-class distinctions with clothing and language. Most of his time is spent working, and he spoke of his struggles with stress and burnout. This impacted both his physical and mental health as he suffered from anxiety and IBS (irritable bowel syndrome). After he states that he has anxiety, I ask him, "*Okay, and how would that kind of present itself? Like you said, you knew you had started to experience anxiety. What was that like*?"

> *I think sometimes I feel a lot like… I can get this feeling of the world is against me, like I have no luck. Everyone else is getting the look in, and I don't get any. I just have to, you know, fight me way through every situation. And I also suffer physically from IBS, which is, and you know, a knock-on effect of my anxiety. That's why I still kind of go to counselling because I work through that a lot, and yeah, like I just…I can get angry. I can get kind of … some kinds of…. Not angry towards anyone, just angry in general. I'm not looking to have a fight with anyone, I just become kind of like a grumpy old man, for the better phrase, you know, and I just don't really want to talk to anyone. I just probably, you know, lock myself away in my room for a long period of time, and then you know, it just kind of just goes in waves. Sometimes I'll just come out of it myself. Sometimes it might take a little help from someone else or from the activity I do to distract me. Yeah, like just dark heavy, like you feel really heavy. You feel really fatigued and tired. Just like oh what, will I even bother getting out of bed today kind of thing, you know. That's the characteristics of my anxiety that I've, you know, experienced.*

As before, there is temporality, while previous extracts displayed a then and now, here (despite my question being a reference to the past), the language situates the text in the present, indicated by multiple present tense terms (*feel, I just have to, suffer, take, sometimes*). Yet, there is an indication of anxiety preexisting with the last word, "*experienced*". This suggests the anxiety is also a current resilient demand. The adversity is not of external material conditions, but emotionality about a perception, not necessarily of the Real, but of a perceived *reality* indicated by "*I feel a lot like… I can get this feeling",* that is only sensed or felt, and the struggle to articulate or express it with language. The adversity appears as a linguistic distortion or exaggeration, indicated by "*the world is against me".* It is interesting that, instead of describing external conditions of adversity (previously indicated in the interview), there are only feelings and an exaggerated or symbolic adversity. Perhaps this language is a feature of the catastrophizing common to anxiety, but it justifies the negative and judgmental framing of his emotional response, including his anxiety.

Moving through the extract, the framing of the source of his anxiety as "*I have no luck*" is that of chance, indicating a perceived lack of control and diffusion of responsibility. The "*luck*" is derived from a comparison to others (*Everyone else is getting the look in, and I don't get any).* This language indicates being a victim of chance, and that "*luck*" favours others, framing his adversity as unfair and outside his control. The following statement, *"I just have to, you know, fight me way through every situation",* indicates a perceived resilience. The use of "*just have to*" implies either an imperative to "*fight*" or a lack of agency. Interesting is what is fought against, "*every situation*", again a generalisation and exaggeration previously alluded to by "*the world is against me".* This framing is interesting as it is likely his primary habitus guiding these perceptions by the shared socio-cultural attitudes of his generative social fields and socioeconomic conditions.

However, what is important here is that there is no indication of adverse conditions outside of his narrative or worldview. Instead, it is the attitude itself that is generating the anxiety, with significant effects, as he suffers from IBS. Despite the acknowledgement of "*a knock-on effect of my anxiety",* his language perpetuates the internal conditions of distress. This is important as it sets the demand for the resilient response that is explored in the next extract.

Again, as in previous accounts, there is the presence of multiple practices, or ways of coping, but at this point, they are not framed as resilience, but as a response that aims to mitigate

the effects of adversity, which aligns with discourses of resilience explored so far. The first practice is interpersonal, the attending of counselling, devalued by "*it might take a little help from someone".* Yet it is not the primary practice, but the subsequent practice only in response to the aforementioned IBS signified by the "*why*" in "*That's why I still kind of go to counselling".* This suggests that the primary practice, indicated by "*fight*", is now contradicted by "*I'm not looking to have a fight with anyone",* suggesting that this practice is not desirable but repeatedly performed (*fight my way through every situation).* The practice depletes his strength, as indicated at the end of the extract with "*you feel really heavy. You feel really fatigued and tired".* From this failure of the first practice (linked to the primary habitus), he then turns to the interpersonal practice, which also fails him, as there is an indication of a third practice (*will I even bother getting out of bed today*). This is one of social isolation (*I just don't really want to talk to anyone; lock myself away in my room)* and to wait out the anxiety (*it just kind of just goes in waves)*, which is indicated as effective in part by *"I may come out of it myself."* Even this is an ineffective practice, as he resorts to the simple strategy of distraction. (*I do it to distract me).*

As Alex continues with the interview, there is a greater duality and complexity, but now linked to the master signifier resilience. Here I ask him, "*Has your class background made you resilient?*"

> *Both resilient and fragile. I'd say… umm… It's kinda a thin line between the two, from what my experience is. Because in one sense, trivial things like someone, I don't know someone of money or who has an affluent life, might get upset because they don't have the newest iPhone, where I'm happy to have a phone, you know, that way? That's a very basic example, but it's the way it is. But then again… I am mentally fragile because of the struggles I've been through. And you know I've had…. I've lived through poverty, I suppose. But it's sometimes like... it benefits me and at the same time doesn't… like a double-edged sword, like I'm tough but vulnerable, if that makes sense?*

Beginning with the duality of being "*Both resilient and fragile,"* contradicting common discourses of resilience as purely positive. The inclusion of "*fragile"* suggests resilience is framed as a strength-based strategy by the presence of the opposing "*fragile*". This is followed by "*It's kinda a thin line between the two from what my experience is"*, an example of the discourse of the hysteric that questions the master signifier. Resilience is challenged further by "*trivial things"* that those *"of money or who has an affluent life"* would need resilience for. On the other hand, the use of "*struggles"* and "*poverty"* as opposed to "*the newest iPhone*" is framed as a legitimate adversity, thus making Alex's resilience more valid and valued by the comparison to those of a higher status. This framing indicates the presence of the habitus, his

own as well as his perception of others' habitus, yet their voices are not present, only his perceptions. Unlike the previous participants, we do not see Alex desiring the others' resilience or the associated habitus. Instead, it is devalued in the language through the comparison of material goods that act as cultural capital (*get upset because they don't have the newest iPhone, where I'm happy to have a phone).* Here, the devaluing of others' resilience and capital gives value to his own, one that is strong and resilient, having "*lived through poverty"* and legitimised as the authentic and better practice of resilience, providing the logic for his subjectivity (*but it's the way it is).*

The signifier resilience frames his subjectivity, as the ideal ego is bound to the habitus originating from discourses of resilience from the generative social fields, that of accepting what one has (*I'm happy to have a phone)* and being exposed to "*struggles*" such as "*poverty"* without resistance, instead bearing the psychological strains as shown by the previous extract. These signifiers frame resilient demands, but also what resilience is appropriate for, and Alex's subjectivity, as someone tough and resilient. However, this framing is held in contention by signifiers that contradict those of his ideal ego (*fragile, mentally fragile, vulnerable*). These polarising signifiers further split the subject, emphasised with the reference to a "*double-edged sword",* a tool that protects while at the same time harming that which it aims to protect. What forms his strength-based resilience comes at a price, that of fragility and vulnerability. This vulnerability explains the differential valuing of others' resilience as it lessens the demands of the Other and that of his ego ideal, bolstering his practice as more legitimate than those whom he frames as having less resilient demands. The extract ends as it begins, with duality, highlighting the ambivalence of the signifier of resilience (*tough but vulnerable).*

The language of Ari's and Alex's accounts points to a practice of resilience where adversity is simply suffered and tolerated. However, key signifiers showed the psychological costs of this practice, yet Ari and Alex accepted, if not enjoyed, as if proud of their mental battle scars acquired through the strength-based practice of resilience. It was observed in the data that this practice was more common among working-class participants and was a valued sociocultural class norm. This is not to say that those from middle or upper-class backgrounds do not perform strength-based practices, but it was not observed in this study. This suggests a link between conditions of adversity associated with class-based conditions, sociocultural norms of resilience, the habitus and practices of resilience. This relationship also explains the acceptance of the mental costs of strength-based resilience, since the value placed on the

practice includes any injuries incurred. Here, two participants, both struggling to manage their mental health, perform practices of resilience that further place it under strain. Yet, they seem to be unable to practice less costly practices, highlighting the guiding principle of the habitus and the sociocultural value of strength-based practices. Finally, this example the empty, yet powerful master signifier of resilience acting on participants, producing costly mental health outcomes.

5.5 The Capacity for Resilience

In this section, resilience is explored further by focusing on the capacity for resilience. All the previous accounts of resilience suggested that their practices came with costs, leaving the questions of how long resilience can be practised and to what level. Now I consider two accounts of resilience, one where resilience is preserved due to the perceived mental costs associated with it, while the other suggests a point where resilience is no longer possible, as the capacity is depleted. This is contrary to how resilience is commonly portrayed in the discourses of mental health, that of an infinite capacity to be drawn from to overcome any magnitude or duration of adversity with repeated recovery and adaptation that generates positive outcomes (Newman, 2005). Yet, as will be revealed in the following analysis, resilience holds significant value and can act as a commodity to obtain that which is desired, the performance of which is feared due to the psychological expense of its practice.

The first example comes from Patrick, a 44-year-old male who identified as working-class. Patrick experienced significant anxiety throughout his life, which, at an earlier point in the interview, he explained as related to the precarity of his background, especially the limited financial means of his family, and his ability to meet the norms of his working-class peers. He recounts that in his early twenties, that anxiety became overwhelming, and he began to restrict his life experiences to avoid anxiety that would require resilience to overcome. I asked him, "*Did your class affect your resilience?*"

> *You made your life smaller, so you had less to be resilient for. So, like I had no girlfriends, I wasn't keeping up. Like friends were going on holidays and buying houses, and I wasn't keeping up. I could see that, and I wanted to keep up, and that was hard. I did fuck all, like I went to work but only because if I stopped going to work, then what would I do sit in my bedroom all day. Just living life small, like I didn't have many friends, I wouldn't sleep right.*

What is interesting about this extract is that resilience is not clearly defined, nor are there details of a practice, despite the indication of resilient demands (*to be resilient for).* For example, resilience is necessary to achieve certain activities that act as valued capital, suggesting resilience itself is a valued commodity. The capital described here is what Patrick desires, that of the indicators of class status, the "*buying houses"* and "*holidays",* while the "*girlfriend*" and "*friends*" suggest social capital and "*sleeping right*", an indicator of good, or normal, mental health, or an alignment with the language of mental health hegemonic norms. From this valuing of capital, his habitus is indicated, but more so an ideal ego, that which is mirrored in his peers, a fantasy of self who can be resilient to acquire the status indicators within his social fields. There are also signifiers of his desire with "*I wasn't keeping up*" and "*I wanted to keep up*". Here the objects of desire are the "*girlfriend", "holidays", "buying houses" ", friends",* and *"sleep right".* While his Objet petit a, the "*keeping up*", in meeting the status distinction of his peers. The Objet petit a highlights the fantasy of his ideal ego, a resilient person with status, which he lacks and points to the physical effects of the anxiety (*and that was hard; I wouldn't sleep right).*

However, to obtain what Patrick desires, resilience is required, and for him, the perceived capacity to be resilient is limited, indicated by "*so you had less to be resilient for"*. While there is no clear practice in terms of psychological activity that would mediate the effects of adversity, instead, Patrick's practice is to reduce the demand for resilience to preserve his capacity. In this case, the demand is what is required for the "*keeping up*" with his peers and the anxiety that the "*keeping up*" produces. As such, the costs of resilience are too high, and Patrick's awareness of his resilient capacity motivates him to deny himself that which he desires, but would bring relief, if temporary, to his anxieties. In the language, there is evidence of this contradiction, of the castration of his jouissance. On the one hand, there is that which he desires, but is fearful of the resilience required to obtain (*girlfriend, holidays, buying houses, friends, sleep right),* and on the other, his avoidance of resilient demands by "*living life small*" and "*doing fuck all*" which perpetuates and maintains his anxiety. Here he is caught between the demand to be resilient and the costs that come with it.

The only thing indicated as something Patrick uses his resilience for is "*going to work*", as the alternative (*sit in my bedroom all day*) suggests he would ruminate on his anxieties, something that would require greater resilience, again denying himself the jouissance of rumination. Here, the Other is present in the social prohibitions that not working would incur by his indulgence in rumination. The only enjoyment he has resiliency for is work, yet work

falls short of providing him with jouissance or bringing him the status indicators which he desires. Thus, we see a cycle of repetition of desire, the denial of the Objet petit a, and the self-castration of jouissance, all of which maintain the anxiety. From Patrick's account, not only was there an awareness of the costs of being resilient, but also a limited capacity that was preserved for what was necessary and valued (*going to work*). The language showed how interpersonal activity (his peers) impacted subjectivity, but that this was tied to the Symbolic (capital, status and social fields), which in turn impacts the Imaginary realm of self (habitus and subjectivity), bringing experiences the physical effects of and implications of the anxiety. It also suggests that one's ability to perform resilience is limited by a capacity, perceived and symbolic, and an imperative to utilise this capacity to achieve that which is socially valued.

Later in the interview, Patrick explains how shortly after this point in time, he accessed support from a psychotherapist and began to gain confidence and make life changes, including attending university, getting a better job, making friends and having a relationship, all requiring resilience he did not believe he had the capacity for. Yet, as he acquired the objects of his desire, his anxiety shifted to new social comparisons within the new social fields brought about by social mobility and the social connections through his girlfriend (who was of a higher class). This suggests that his capacity for resilience has not changed, only the focus of anxiety and the Objet petit a, highlighting that resilience is not an unlimited capacity, but one that is limited, and for some, must be used sparingly.

The second example that points to a capacity for resilience comes from Carol, a 45-year-old female who identified as upper-middle class yet had considerable social mobility from a lower-class background. Her upbringing was marked by significant adversity associated with poverty, abuse, and marginalisation. Carol returned to education in her twenties through a targeted program that aided minority groups to access third-level education. She now has a highly paid professional position, which has brought substantial improvements to her material conditions and gains to her financial, social, cultural and symbolic capital from her social mobility. Yet, she continues to struggle with her mental health as her social mobility has brought with it new forms of adversity, such as the challenges of new social fields, the demands of a high-status job and the pressure to maintain her current level of capital. She also describes struggles with her identity as she lacks the knowledge (doxa) required for the social negotiations her new status brings. Here we see in the language of her habitus in the perceptions of adversity, that of her past and her present, and the influence of these signifiers on her current

practice of resilience, including her resilient capacity. Here I asked her, "*What was that like, where others in your community were experiencing the same thing?"*

> *Everyone was just trudging, dragging themselves through life every day… fighting, emotionally overloaded or underloaded. I just thought everybody felt like that. I just accepted that's what I felt like, and this is what my life will always be like, because this is what life is like. I didn't have really any insight into how anyone else's life was. I was just busy trying to survive my own life… literally survive it rather than live in it necessarily.*

The language of Carol's recollection of her childhood highlights the generative social fields that formed her habitus (*I just thought everybody felt like that)* and her alignment with those in her community (*I just accepted that's what I felt like).* This shared sociocultural knowledge is present in the language that frames the perception of a future with enduring adversity, evident when she states, "*This is what my life will always be like, because this is what life is like".* Importantly, resilience is not mentioned here, nor coping or other terms that would signify resilience. Instead, terms like "*trudging, dragging themselves through life, fighting",* and "*survive"* suggest only bearing the suffering to progress or move through it, to simply "*survive it rather than live*." This indicates only a drive for life and not a resilient response to adversity. If we compare this to Ben's extract earlier, the assumption of the resilience of the lower and working classes does not fit Carol's account. Furthermore, the common understanding that exposure to adversity builds resilience is not present in the language. Instead, we only see a drive to survive a life where the very activity of living is the adversity.

As the interview progressed, I asked Carol to describe her experience of mental health. She spoke about how, after she had gained social mobility, she continued to struggle and experienced debilitating anxiety and panic attacks, and eventually became suicidal. Here, the language provides a link between the two points in time, but also can be read as the differences in her experience of adversity and resilience between her childhood and the challenging period described below.

> *I just snapped, and I think the capacity to continue forward or the resilience to keep going in life… I just couldn't do it anymore. I didn't have anything left in me to push through. I had suicidal thoughts at other points in my life, but it wasn't depression or anything… I just had enough. See, it wasn't like that, it was more…. I just couldn't see any way out of the way I was. I knew this was gonna return, that I was never going to get any long-term freedom from myself and the stress of my life. So, at that particular period, it wasn't that I wanted the anxiety to end, because I knew it would always come back, and my life had always been this cycle of these stressful situations always coming back*

and me having to find the strength to get forward and get through it. And this was something… I was like, I just don't want to live anymore, and not only was this hard, but that my life was always gonna be like this.

There are some interesting comparisons in the language of these two extracts. First, there is a continuation of signifiers indicating movement and progression (*continue forward; to keep going; push through; find the strength; get forward and get through it).* This language of movement is structurally linked to the first extract, with the "*trudging, dragging, and fighting",* showing a consistency of the habitus guiding language and thus perceptions between these two time points. While there's a change in the conditions of adversity, there is still the language of struggle and movement with "*push", "continue forward",* and "*keep going*", although indicating less exertion than the "*trudging, dragging, and fighting".* This may point to the different levels of exertion needed to address different forms of adversity associated with the two points in time and conditions. The first conditions are socioeconomic and very challenging, the second psychological, perhaps less challenging in terms of externally derived demands, but more enduring, highlighted by the repeated use of "*always*" when referencing past and future, resilient demands.

Unlike the first extract, here she spends her resilient capacity not on external conditions, but on her psychological distress. For example, she states, "*I just couldn't see any way out of the way I was. I knew this was gonna return, that I was never going to get any long-term freedom from myself and the stress of my life".* Here, the adversity is indicated by what she desires to escape, to get "*long-term freedom from*" that of the self, indicated with "*the way I was*" and "*myself"*. This is further illustrated by the statement "*the stress of my life",* which indicates ownership of the "*stress,*" a subjective psychological state. Again, in Carol's language, there are signifiers of the split subject as she refers to herself as the object that suffers (*I*), who is the self that experiences the anxiety. While her subjectivity is also the adversity that requires the resilient demands (*myself*), the symbolic self, that of the ego ideal, the demands of the Other, which expect consistent resilience. While there is a desire to fill the lack of the split subject, there is no clear Objet petit a. Instead, there is only the desire for repetition of a practice of resilience that generates more adversity, a jouissance in her suffering.

Critically, while the term resilience is used (*the resilience to keep going in life),* this is prefaced by "*the capacity to continue forward",* and again, we see the language only of survival. Not the signifiers which are common to the discourses of resilience, that often frame resilience in its performance as beneficial. Here, the signifiers of Carol's understanding of

resilience are of drive and survival with a limited capacity, not of an infinite supply of resilience with enduring beneficial outcomes. While the drive enables Carol to survive the conditions indicated in the first extract, with the current conditions, the practice perpetuates the anxiety and prevents any response that benefits her mental health. It is clear from the language of this extract that a practice based on drive alone is so costly that Carol lacks "*the capacity to continue forward"*. Carol's capacity for resilience (signified as survival and movement) is fully depleted after a life spent primarily trying to survive.

However, another drive is present in the language, the drive to stop, bring an end to the resilience with the ultimate cessation, death (*I had suicidal thoughts, I just don't want to live anymore).* Here, it is useful to consider the Freudian drives, as we can observe two drives present in the discourse (Freud, 2017). Here, the life drive (Eros) and the death drive (Thanatos) compete for dominance, further splitting the subject, generating tension and distress. On the one hand, there is the desire to end the practice of resilience that is so costly, while on the other, the ideal ego, that of the generative habitus that frames subjectivity as a survivor, and her ego ideal, formed through the doxa of new social fields, requires her to meet the demands of the Other, and be endlessly resilient. The demands of both the ideal ego and ego ideal cause repetition of the practice, which is psychologically expensive and of a finite capacity. This depletion in drive (which for her functions as resilience) brings Carol's experiences of the anxiety and panic attacks, where the only alternative to escape its effects is suicide. Yet, despite this potential endpoint, there is repetition of the drive-based resiliency, and the language suggests a certain level of jouissance, or enjoyment in the drive (*not only was this hard, but that my life was always gonna be like this),* which sustains the repetition of this practice, which in itself is a form of adversity.

As such, Carol is caught, split between the paradox of the drive for resilience and the desire for death, that which will end her repetition and suffering. After this utterance, I then ask Carol if she got professional help from mental health services, and she explains that, thankfully, due to the interventions of her husband, she did not attempt suicide, and instead, with her husband's support, she seeks help. As a result of this interpersonal intervention, Carol contacts her GP and engages with multiple professional mental health services. Her account of mental health services brings further insights regarding her practice of mental health, which are explored in the following chapter on practices of recovery.

This section explores extracts that present an account of resilience that is contrary to the literature and general understanding in the public discourses of resilience. Instead of an infinite ability to practice resilience, the language suggests that resilience does have a limited capacity. This capacity is dependent on several features, such as the perceived severity, duration and type of adversity experienced. More importantly, it is how resilience as a master signifier held these participants to account, requiring endless resilience from them, regardless of how it was practised, or the damaging effect it had on their mental health and quality of life. The capacity to continually be resilient is challenged by the associated costs. When resilience is performed over a lifetime, the capacity, or ability to perform resilience to mediate the effects of adversity, or to meet the demands of the Other, is depleted. In the case of these two participants, the cost of resilience was too high, and the mental reserve was spent in full or rationed. As the reserve emptied, resilience can be practised no more, leaving either a retreat from the adverse conditions or, when left with no other perceived alternative, an end to life.

5.6 Chapter Summary

The preceding chapter explored participants' accounts of resilience. Through a careful yet critical analysis of language, the signifier resilience was found to function as a master signifier shaping multiple practices of resilience. These practices were a highly valued commodity across all participant accounts, regardless of their class status. While there were variations in terms of practices, these were related to mental health norms of different habitus and social fields. First discussed was performative resilience, where participants' practices were performed to align them with valued signifiers of resilience. Then, repression of emotions was found to be a practice of resilience that was strongly linked to working-class habitus. This was closely related to the strength-based practices, where adversity and its associated effects were simply borne despite the costs. Finally, participants' capacity for resilience was explored and showed that, contrary to the framing of resilience as infinite, there are limits in its capacity, and a point where the costs are too high, and resilience can no longer be performed.

While there was an identification of different practices of resilience, careful analysis of the language of these accounts provided insights into how these practices shaped participants' mental health. In the language, we saw evidence of two time points, two habitus, and two practices shaping subjectivity around the master signifier resilience. Importantly, this duality generated tensions between signifiers of resilience aligned to generative social fields, habitus

and signifiers of resilience from social mobility and the demands of the Other. While these practices highlighted the variations in significations of resilience, they also showed the contextual nature of experiences of adversity, coping and resilience that related to different class positionalities.

These findings suggest that not only does resilience come with significant costs, regardless of how it is practised, but that there is an inequality of resilient demands where those who are exposed to greater levels of adversity, through class inequality, tend to perform and value resilience more than those who have less resilient demands. However, it is worth noting here that this framing was derived from the accounts of lower class, working class and middle-class participants who reported class-based experiences of adversity, and no upper-class or elite perspective was captured. Yet, it can be argued that regardless of what class-based adversity would be experienced, as resilience comes with mental effort, it may have come with a cost to these higher status groups, but be practised in different ways as attuned to their habitus and class-based adversity. Importantly, the differential valuing of resilience was found to be most significant with those who had social mobility. Taken together, the practices of resilience explored in this chapter suggest that resilience operates as a master signifier, and the application of the signifier resilience comes with costs in terms of symbolically shaping subjectivity in ways that produce more suffering and are damaging to mental health as opposed to being a protective factor. In the next chapter, we see the results of the failure and costs of resilience that result in suffering, which are addressed through practices of recovery.

6. The Practice of Recovery

6.1 Introduction

In this chapter, the practices of recovery observed in the participants' accounts of mental health are explored. Activities performed with the aim of recovery often occurred after the participant's resilience failed to meet the expectations of a protective factor, and mental distress and suffering occurred, which, in many cases, was diagnosed as a mental health condition. As such, recovery is the second phase of the mental health cycle, which emerged as a central theme from the RTA. Yet, as highlighted in Chapter Four, complexities and contradictions were consistent in the recovery themes, not only between participants, but in individual accounts. This warranted a deeper and critical analysis of these recovery practices, specifically the language that framed them, and their structural situatedness in terms of capital, social fields and habitus. As with the previous chapter on resilience, I have problematised the concept of recovery, and through a critical examination of language, highlight how practices of recovery often do not lead to the cessation of symptoms or mental distress, but are a performative display of signifiers guided by the habitus and the perceived demands of the Other that often result in further suffering.

Before delving into extracts, it is necessary to explore the dominant recovery frames to situate the extracts within mental health discourse. While recovery was initially associated with physical illness, disability and addiction, the concept is now applied to mental health (Ralph, 2000). Recovery in mental health terms is conceptually linked to mental illness, in that by the diagnosis of illness, there is the possibility, if not imperative, for recovery (Cam & Yalçıner, 2018). This framing is associated with the biomedical approach to mental health, where maladaptive behaviours and deviations from mental norms have neurochemical and psychological correlates and can be treated, or at least managed, through psychiatric and psychotherapeutic treatments (Cohen, 2017). However, Ralph (2000) argues that recovery is far more complex than neurochemical, psychological and behavioural adjustments, but involves the engagement of social and community supports as well as improvements in material, socioeconomic and sometimes personal conditions. Recovery is also viewed as more than returning to previous states, but a process of creating circumstances that are more favourable than those before the onset of a mental health condition (Ralph, 2000).

Ralph's (2000) views align with another common framing, that of the recovery model of mental health. The recovery model has increasingly become an alternative to biomedical approaches as it recognises the dynamic and contextual nature of mental health experiences and is viewed as more ethical than the biomedical model (Thornton & Lucas, 2011). Adapted from the recovery approach to physical disability, the recovery model views recovery not as an absence of symptoms and a return to previous states, but a continuation with life, managing the symptoms of a mental health condition through acceptance, resilience, coping strategies and social supports (Anthony, 1993). While Anthony describes recovery as a "way of living a satisfying, hopeful, and contributing life even with limitations caused by illness" (p. 527), this approach has been criticised for its idealistic expectations and for placing the responsibility of recovery with the individual (Stylianidis et al., 2016). Yet, this model's framing of recovery suggests recovery incorporates multiple domains of activity and experience, critically social and structural facets.

However, the concept and signifier "recovery" can be viewed critically as conceptualisation and discourses of recovery are socioculturally embedded, operating within the contextual power frameworks (Cohen, 2017; Cohen, 2025; Stylianidis et al., 2016). For example, Cohen (2025) highlights the role of neoliberal norms, coining the term "neo-recovery" as the influence of neoliberal ideology of economics impacting what accounts for normality and what is valued and should be strived for in terms of recovery. This includes participation in production and consumption, but also the absolving of structural influences as the source of mental distress, replacing these with personal responsibility, commodification through privatised care and limitation of socially provided recovery supports. Cohen (2025) argues that "neo-recovery" ideology guides recovery norms, including those of the biomedical and recovery model referred to above. Recovery, in the neoliberal context, is more about engaging in labour, consumerism, socialising, social reproduction and participating in activities that align with behaviours normalised by society than a reduction in distress (Parker & Cuéllar, 2021).

Finally, the Lacanian concept of subjective destitution is useful as it suggests that distress cannot be fully resolved, but at least reduced or mitigated, through the recognition and then abandonment of symbolic frames rooted in the demands of the Other (Black, 2022). By producing the discourse of the hysteric, questioning the discourse of the university (norms on which mental health and recovery are framed), the master signifier of "recovery" loses power

to dictate what recovery means for the individual subject. Aided by the discourse of the analyst, the analysand can recognise the lack generated by their imaginary subjectivity, adopting new signifiers of recovery that bring less distress. In line with Cohen's (2025) "neorecovery", Cruz (2024) posits that subjective destitution in neoliberal contexts is a psychic emancipation from capitalist ideology embedded in conceptions of madness. Recovery in this context is the recognition and rejection of the discourses that bind us to repeat that which brings distress, the hegemonic recovery discourses that reproduce capitalism by rehabilitating us as workers and consumers.

Considering the preceding coverage of dominant and alternative recovery frames, this study views recovery as a lessening of mental suffering that is associated with the initial distress or diagnosis that they describe. However, what facilitates this recovery are the practices employed to alleviate the mental distress, but also how "recovery" functions as a master signifier on the subject, as observed in the texts. As these practices were bound to subjective positioning, personal mental health histories are guided by their Imaginary attuned to the habitus. In this regard, it was necessary to include text that provided the context of what is recovered from to situate recovery practices in relation to the distress that they attempted to alleviate. Three key aspects of recovery are presented that are representative of practices observed in all participants' accounts of mental health. First, is negotiating mental health services, then performative recovery, and finally recovery through subjectification. These accounts provide an in-depth example of how recovery is practised on intrapersonal, interpersonal and structural levels, resulting in various recovery outcomes associated with signifiers of recovery derived from contextual positionalities and experiences.

6.2 Negotiating Mental Health Services

All participants had some experience with mental health services such as counsellors, group therapy, psychotherapists, psychologists, psychiatrists and inpatient mental health facilities as part of their practice of recovery. These services were accessed as one method of help-seeking described in the data, although often after initial resilience and coping strategies were attempted first. Critically, these interactions with services were not a one-way receipt of therapeutic interventions that resulted in recovery, but rather a negotiation of structural, interpersonal, and intrapersonal elements of practice mediated by discourse, which resulted in various recovery outcomes. In some cases, these negotiations benefited participants' mental

health, with a reduction of symptoms and suffering, or enabling independent coping. Other negotiations failed to facilitate recovery and, in some cases, created further distress. In the following, two participants' negotiations of mental health services are explored, each coming from different class positionalities and contextual circumstances. Yet they present with similar negotiations of services, but with very different outcomes in terms of recovery.

The first example comes from Ben, who was encountered in the chapter on resilience. As previously discussed, Ben struggled with his mental health after his brother's suicide and parents' divorce. After initial attempts at resilience, his mental health continued to deteriorate as he described the depression surrounding his grief as he withdrew from friends and school, struggling with low mood and sleep. Ben attends his GP, who refers him to a publicly funded youth psychiatric service, where he is diagnosed with depression and prescribed antidepressants. He recalls this as an effective service that facilitated some level of recovery, specifically helping him to manage his grief. Yet, once 18, he was transferred to adult mental health services, where he was diagnosed with depression and prescribed antidepressant medication. He describes how he was dissatisfied with this service when I asked him, "*Can you tell me a bit more about what that service was like and why you stopped attending it?"*

> *I had a phone call with Adult Mental Health, and they were meant to check up on me and get me an appointment. This was when I was coming to the end of being on the tablets. And they said, "How are you?" and I started to talk, and she just interrupted me and asked how much sleep I was getting and was just asking me this list of questions, ticking boxes. And I was like, this is ridiculous. They think that they are able to judge how a person is feeling just by ticking a box, from the most generic questions. So, when they asked if I had no sleep, I told them I only had 2 hours every night, but I was happy with that. And they just went on to the next question. They didn't even notice that I hadn't had any sleep, they were just too busy ticking boxes to get onto the next question. And like they said, "Have you had suicidal thoughts?" and I said, "No, but I have been very depressed." And once I said no, they just moved on to the next question, they had their boxes ticked, and they just went on. Then the phone call just ends, and if you don't… It's just a yes or no to them, and they don't need any other answers. It was ridiculous to me that that's what they thought mental health was, that was their definition of mental health. It was really poor to see, and luckily, I was at a stable stage, but I was thinking that if they called people who weren't stable, how would they react? Umm... and it's uh… It's difficult to see that's how Ireland deals with people who are in very difficult scenarios.*

From Ben's account, we can see that he, as a split subject, is appealing to the Other for recognition not only of his symptoms, but also of his subjectivity (*they were meant to check up on me; and I started to talk; they didn't even notice*). Instead, he encounters a resistance from the discourse of the university to his discourse of the hysteric, as underlined by the invitation

to express how he is (a shallow polite formality), but then abruptly interrupted by the demands of the symbolic order represented in the structure of the questionnaire (*ticking boxes*) and the time limits of the conversation. The mental health professional in this case, rather than acting in the role of analyst, inviting the emergence of the unconscious through Ben's free speech, imposes a university-style discourse through formal codes and knowledge categories. A clear example of this is Ben's statement, "*So, when they asked if I had no sleep, I told them I only had 2 hours every night, but I was happy with that",* which potentially highlights a contradiction or an unconscious untruth, inviting both a recognition and an enquiry from the professional that is not answered. Similarly, when he declares that, although not suicidal, he has been very depressed, there is no follow-up. The desire of the hysteric, in this case, is not satisfied by the university discourse, a desire not simply for assessment, but for recognition of his subjectivity and suffering.

Ben's desire seems to be for the knowledge of the analyst, that of the "one-supposed-to-know", but who, in effect, would provide the space for articulation rather than knowledge. However, by being presented with a narrow symbolic framing of the university discourse, it is not beyond possibility to assume, as Ben alludes, "*I was at a stable stage, but I was thinking that if they called people who weren't stable*", suggesting a comparative frame. Here, to enter into a recovery requires manipulating the language of the university, for example, by responding affirmatively to the question of suicidality. The desire of the hysteric in this case is not satisfied by the university discourse. Here, the "*ticking a box*" symbolic frame provides the valued signifiers worthy of recognition from the Other, and those who embody the discourse of the Other, the mental health worker. The implication of this for recovery seems to suggest that Ben, in this case, should seek to achieve recognition of the Other by enrobing his subjectivity in those valued signifiers at the expense of his own signifying chain. This is indicated by "*it's just yes or no to them, and they don't need any other answers",* hinting that there were other experiences, "*other answers*" that were important to his distress. Essentially, the cost of institutional recognition is symbolic conformity, which is a paradox of recovery and indicates that, through the process of a negotiation of signifiers, the hysteric is in the weaker position.

As Ben continues, there are further indications of his desires for recognition, but here, promoted by my question, "*Do you think they were the same or a different social class from you?",* recognition is linked to his class positionality.

I'd say different, even though I feel like they should be the same. It's just the fact that…. It's just the attitude they have. Because they probably have perfect mental health, or whatever they think of as perfect, and they look at me and see me as a patient. (pause) They see me as a patient, someone with poor mental health, and they see me as a unit in a system. Umm… they don't actually notice anything about me, but they do have these preconceptions like we were talking about. And uhhh...how they just completely base it on "ok, you have depression, here's a tablet for that." They just don't see me as my class, they see what I have and send me on. And I don't even know how to explain their class, it's almost like a medical class, if that's even a thing.

Initially, intersubjectivity is assumed (*they should be the same),* suggesting a socio-cultural knowledge of the symbolic order and class-associated professions, but also the desire for intersubjectivity. However, the evaluative status of the service is not associated with class, but with mental health. "*They",* the service, have a complete subjectivity, are the infallible Other, the symbolic structure that is not split but has *"perfect mental health".* While Ben is split framed as "*someone with poor mental health",* and as the "*patient*", language that depersonalises and alienates him through symbolic mortification as the discourse of the university silences his immediacy of experience by the services discourse (*you have depression, here's a tablet for that)*. Language makes Ben an object, a "*unit in a system*". The "*system*" recognises the symbolic structure that objectifies with the medical gaze (*they look; they see me)* that overlooks the subject (*they don't actually notice anything about me).*

The mental health workers are framed as a *"medical class"* and other and unrelatable as they operate within different discursive frames of a doxa as opposed to an identifiable habitus. "*They*" are other to Ben, even beyond the symbolic structure of class, which supports the fantasy of Ben's subjectivity. This complexifies any notion that habitus is merely a social or socioeconomic class experience and reflects the role of professional and technical discourse mediating intersubject relations indicated by the sentence "*They just don't see me as my class, they see what I have and send me on. And I don't even know how to explain their class, it's almost like a medical class, if that's even a thing".* Clinical decisions seem to pivot on the evocation of a particular signifier, that of *"depression",* as a formulaic and depersonalised mode of relating to the doxa of the social field of mental health services. Ben expects to have his class recognised, and thus his subjectivity recognised. Instead, only symptoms that align with the symbolic structure of the doxa are the qualifying capital, which brings recognition (*They just don't see me as my class, they see what I have and send me on).*

As the interview continues, Ben describes how his depression became worse despite availing of mental health services and being on antidepressants. Dissatisfied with the public

mental health services, he attempts to access the services of a private clinical psychologist. Initially, the psychologist refuses him service as his mother is unable to pay the fees in full, but is later accepted as a private patient once he is placed on his father's health insurance. The difference in accessibility of the service based on his ability to pay distressed Ben, so I asked him, "*Do you feel you are the same class as the psychologist?"* he replied, "*Yes".* I then asked if this affected the therapeutic relationship, and his reply provides more critical insights in terms of his practice of recovery.

> *Yes, 100 per cent! Because he knows exactly where I'm coming from. Like when I am talking about wanting to do a psychology degree, and he is saying, "You have the money to back you, just go for it!" He is coming from the way I have been taught, and is anything, he is the person shaping my attitudes most at the moment and the reason why I am staying on the ball. So yeah, 100 per cent it helps and like we often go back and forth, and because we are on the same page, he is able to challenge things I say, and we are able to communicate. And it 100 per cent helps that he is on the same page as me, and he can communicate, because it's just like him lecturing, because it's just so easy for him to get his points across, because I just take it 100 per cent on board.*

If we compare this to the previous service, there is a perceived intersubjectivity, a congruency of habitus between Ben and the Psychologist (*he knows exactly where I'm coming from*; *he is coming from the way I have been taught*; *we are on the same page*). The term "*coming from*" suggests a shared background, while "*same page"* suggests the same class positionality, considering the question asked and his repetition of the expression "*100 per cent",* an affirmation of the effects of these shared habitus frames. This intersubjectivity, a shared sociocultural knowledge that has been "*taught*", acts as a perceived congruency of habitus, allowing for an open dialogical exchange (*often go back and forth)* where the psychologist can "*communicate*" with Ben, due to a shared linguistic habitus. This communicative rapport and assumed habitus congruence have a mirroring effect, shaping the ideal ego. Language positions the psychologist as equal, supporting an aspired career trajectory through the mirroring of potential that is perceived as achievable due to the perceived congruency of habitus (*Like when I am talking about wanting to do a psychology degree, and he is saying, "You have the money to back you, just go for it!").* It is useful to consider how the language of this extract would differ if Ben were from a working-class background. Would the psychologist be framed as an equal, have the same impact on aspired trajectories and sense of self?

Not only does this highlight the role of intersubjectivity of habitus in language, but also how language performs power, but only to those who recognise it. On the one hand, there is

the perceived equality of power that allows the "*back and forth"* between Ben and the psychologist. On the other hand, there is the expert power of the psychologist through discourses of the analyst as he questions Ben's discourse of the hysteric *(challenge the things I say)*. The influence of the psychologist is clear as Ben states, "*he is the person shaping my attitudes most at the moment and the reason why I am staying on the ball."* What "*staying on the ball"* means is not described here, but due to the discursive context is likely referring to recovery norms aligned with either Ben's habitus or those of the university discourse that is produced by the psychologist, which here is the aspired trajectory indicated by "*wanting to do a psychology degree"* and the response from the psychologist "*You have the money to back you, just go for it!"* This is not to say that this influence of the psychologist was used maliciously; instead, it appears to have beneficial effects on Ben's mental health as he gains what was desired, the recognition of his subjectivity and potential. While the previous service framed Ben and his suffering with objective diagnostic signifiers, here the language suggests a recognition of subjectivity and class positionality in the symbolic.

There is an interesting difference in Ben's description of this mental health service when compared to the previous extract. In the previous, clinical discourses remove subjectivity, objectifying suffering by reducing it to measurable symptoms. These discourses of the university silence his immediacy of experience, as indicated by "*and I started to talk, and she just interrupted me and asked how much sleep I was getting and was just asking me this list of questions, ticking boxes,"* and his subjectivity with "*they don't actually notice anything about me."* In Ben's description of the therapeutic relationship with the psychologist, his subjectivity is recognised. A recognition facilitated by a perceived congruency of status in the symbolic order (*he knows exactly where I'm coming from).* This perceived intersubjectivity not only establishes rapport, but is perceived as subjectivity recognition, not only as an individual, but one of status, value and potential. This differential framing has implications for Ben's negotiations of these services as he rejects the discursive structure of the Adult Mental Health services (discourse of the university) and accepts those of the psychologist (discourse of the analyst). In either case, Ben is presented with signifiers that shift his understanding of suffering and grief to new signifying frames, which, when adopted, provide him with what he desires, recognition from the Other.

Another example of negotiating mental health services, but within a very different positionality and context, comes from John. Like Ben, John encountered two distinct types of mental health services, and in some ways, their experiences are similar, but the outcome in

terms of recovery is quite different. John is a 52-year-old male who came from a working-class background and had downward social mobility to a self-declared lower-class positionality with significant experiences of adversity related to poverty, marginalisation and inequality. John engaged in petty criminality from an early age, a common activity of the youth in his community, and consequently spent time in prison in his early twenties. He described his struggles with drug and alcohol addiction and the effect this had on relationships with family and work. At the time of the interview, John was unemployed and supporting himself, his partner and two children with unemployment benefits. His socioeconomic conditions brought him great distress and were central in the dialogue during his interview. In the following exchange, I ask John, "*Can you tell me a bit about that, like your own mental health?*"

> *I'd say I was depressed about myself, but like I didn't even know what that meant at the time, like I was pissed off and frustrated, at meself at me Da. I don't know. Like, I was so angry all the time about everything, and I'd lash out, and now I know kids lash out, but like, I'd go on these mad benders. Like I wouldn't even know what I was mad about, mad about the whole fucking world. You know I would just scream, like roaring into the air, like ahhhhhhh! (pause) I was angry all the time. I had to get out of me head to take the edge off. Like, even now, how am I supposed to deal with this shit? I have nothing and I'm going nowhere. Like it ain't gonna get any better unless I win the lotto. Like I drink, I'm an alcho, like I know that.*

The locus of John's distress frames his practice of recovery and negotiations with mental health services, so it is important to explore this first. The statement "*I was depressed about meself*" is central, as the language indicates the focus of distress, that of the split subject, further emphasised with "*I was pissed off and frustrated, at meself."* Next, the reference to his father points to this parental influence in relation to the mirror stage and formation of the ideal ego, but also that of the initial representation of the Other. The ideal ego guides the evaluations of self (*I have nothing and I'm going nowhere)* and an expected trajectory. As John fails to meet the ideal ego, his suffering is expressed with the terms "*pissed off," "frustrated",* and "*angry all the time,"* while the initial framing of distress is from clinical terminology (*depressed).* This clinical framing gained by exposure to clinical discourse sits in contradiction to his own signifying chain of distress, indicated by "*I was pissed off and frustrated"*, "*I was so angry all the time about everything",* and "*mad about the whole fucking world."* His chain of signifiers that express his distress are not associated with the medicalised signifier "*depression,"* but frustrations around his failure to meet the ideal ego and the associated conditions of his class position. This is an interesting distinction in signifying frames, as signifiers from his linguistic habitus are reframed by those of clinical discourse.

Moving through the extract, there is further division as his distress is centred around split subjectivity, there is distress at the symbolic order that generates the conditions of distress (*mad at the whole fucking world),* a key recognition of external circumstances, beyond his control. To mitigate this distress, his practices are coping mechanisms focusing on jouissance (*lashing out; mad benders),* which enables a disassociation from self *(get out of me head),* again pointing to a split subjectivity which recovery practices centre on resolving. However, the consequence of this practice only generates more distress (*made it worse; trouble)*, by furthering the tension between this practice of recovery and the ideal ego.

As the interview continues, I ask John, *"Did you ever think of talking to someone, like someone professional, like services?"* He describes that after a period of heavy drinking, he was banned from the family home at Christmas and broke down the door trying to get into his parent house while the rest of the family were having Christmas dinner. After this incident, his father brings him to what John describes as a "*mental hospital or some rehab,"* but leaves after one day. Below he describes his account of this service.

> *I thought it was bullshit, like I wasn't mad. Like there were proper nutters in there, like drooling all over themselves and rocking back and forth. Like it gave me a fright, I tell you that like, but it didn't stop me from acting the bollox.*
>
> R: Did you talk to any mental health professionals while you were there or when you left?
>
> *Yeah, like there was this doctor who came to me room and asked me all these questions, like did I want to kill myself or hearing people talking to me… in my head like, stuff like that. Like proper looney shit. But like he never asked me anything about what was goin' on or what was goin' on in me head like, why I was depressed…. why I was so fucking angry all the time. Notin' about my life notin' like that. He just asked these questions he had on a this uhhh… sheet of paper like and wrote shit down. I don't think he even looked at me, like looked me in the eyes. Like he was this posh fucker like you know. You know the type all beardy with glasses and shit (laughs). It was a joke, like how was he going to help me? Like I would have given him a fair go if he looked at me and talked to me like he gave two fucks. No, those types don't give a shit, it's just a job to them and we are like…. I don't know, like we don't matter to them types.*

First to note is the framing of subjectivity as other to the patients in the service. Those described as "*proper nutters"* with visible symptoms (*drooling all over themselves and rocking back and forth).* The rejection of this other through linguistic frames (*I wasn't mad)* distinguishes him from those categorised as mentally ill, but also a rejection of the symbolism of psychiatric distress, highlighting the stigma associated with the identity of the psychiatric labels. However, this momentary association with the others in the hospital has a mirroring effect for John, a distressing encounter (*gave me a fright*) at the categorisation of his distress

that symbolically categorises him as mentally ill. His differentiation of being a "*proper nutter*" versus "*acting the bollox"* is interesting as both labels point to behaviours that deviate from mental health norms yet have different framing effects on subjectivity. "*Acting the bollox"* is an acceptable identity frame to John's ideal ego and habitus, while "*proper nutter*" is rejected as associated with psychiatric labels, which are unacceptable to his ideal ego. This key negotiation of signifiers frames the subject to acceptable versions of self.

The second element of negotiation with this service is the interaction with the mental health worker. In this case, the "*doctor"* represents the Other, not in an individual sense, but by the language of psychiatric discourse, he is the embodied clinical Other. Symbolically embodied in the doctor is the authority, knowledge and power structures of the symbolic as he enacts the discourse of the university. The doctor asks John a series of questions, psychiatric diagnostic discourses that label and categorise John's distress (*did I want to kill myself or hearing people talking to me… in my head).* Like Ben's experience, these questions silence the subject with a standardised evaluation (*a sheet of paper)* operating as a mechanism of the discourse of the university.

Here it is essential to note that this discourse, those of the "*sheet of paper*" or diagnostic categorisation, facilitates access to these mental health supports though recognition from the structures of the institutions of mental health systems. This separates John from his experiential signifying chain by the objectifying signifiers that categorise suffering in line with the clinical discourse. This silencing is clear in the statement "*But like he never asked me anything about what was goin' on or what was goin' on in me head like, why I was depressed…. why I was so fucking angry all the time."* This is ignored and he is presented with the diagnostic signifiers of suicidality and auditory hallucinations. Here, the language performs symbolic violence, excluding John from his own experience by a symbolic mortification of his habitus guided signifying chain, but also the care and support the service may have provided.

Despite this symbolic violence, there is still the desire to be recognised by this other who is the symbolic embodiment of the Other in the doctor. A desire to be seen (*looked me in the eyes),* to be heard (*he never asked me anything)*, and to have the contextual and structural factors underlying his distress recognised (*what was going on).* At first, there is a framing of the doctor by stereotyped class distinctions (*posh fucker; the type; all beardy with glasses)* and the perceived lack of shared sociocultural knowledge (*how was he gonna help me).* Not only does this other John from the doctor in terms of intersubjectivity, but does so with discontent

over the perceived class distinction. There is a further othering with language that indicates an us and them attitude with the use of "*those types*" and "*them types*" and the collective "*we*" who "*don't matter*" to the other "*type"*. Yet, this appears only as a secondary barrier, as the primary desire is for his suffering to be recognised by the doctor *(I would have given him a fair go if he looked at me and talked to me like he gave two fucks).* His suffering and subjectivity unrecognised, he leaves this mental health facility after one day and returns to his previous coping strategies of drug and alcohol use, criminality, and a rejection of the symbolic order.

After John recounted his experience in the psychiatric facility, I then asked him, "*Do you think if you stayed there longer, they could have helped?"* He goes on to describe his encounters with social workers he met in prison after being arrested for petty crime to support his drug and alcohol use.

> *No, I'd say I'd just be doped out of it, like the rest of em. Like I was alright, I sorted myself out. After I was in The Joy (Mount Joy Prison), they like set you up with like social worker types, and like they were good like, talk to you about your life and you get sorted with accommodation and help you get work. See I think the going to prison, like it wasn't for long, but them people help you out, like help you get sorted. Like I just look at all that as like a bad patch, I was grand after that.*
>
> R: What was the difference between those who were helping you in prison and the doctor and the mental hospital?
>
> *Right ummm (Pause). Your ones in the Joy, they are like people who help you afterwards, they know the craic. They know what you're facing when you get out and what was the craic that got you in there. They know it's not all what you say…. all black and white. Like that shit is grey! (laughs) The doctor hadn't a clue, hadn't a fucking clue! They don't know! All those people, the doctors, the judges the politicians…. not a clue. How can they, growin up with what you call it… a silver spoon in their mouth. They just don't get it, what it's like to live here, to have nothing and have people look down on you. Like people are scared of me if I go some places, scared because I wear these trainers or some shit, I don't know. I like it like that sometimes, like it gives me confidence. Like don't fuck with me, you feel safe, uhhh my kids are safe. But I don't want to be like that, I get tired from being like that you know, I'm tired.*

In his response to my question, his otherness from the patients in the psychiatric hospital is further declared with "*I was alright, I sorted myself out",* indicating those in the hospital needed help and support, and he did not. The acceptance of help is paired with being "*doped out of it, like the rest of em",* an interesting distinction as John's method of coping is self-medicating with street drugs and alcohol. This not only indicates the unacceptable identity frame of being a patient (one in need of care), but also a stoicism and independence related to working-class and underclass habitus norms that we previously saw with participants with similar habitus. However, this is contradicted by his account of another service, the prison

social workers who "*help you out, like help you get sorted",* a clear indication that John desires help from others. Yet again, there is a framing of otherness with "*social worker types"* and "*them people",* linguistically separating him from these professionals. The support this service provides, accommodation and employment, focuses on the conditions that underlie his distress, as opposed to the symptoms of distress and provide recognition as they "*talk to you about your life".* While "*they*" are still othered, there is a perceived intersubjective understanding indicated by "*they know the craic. They know what you're facing when you get out and what was the craic that got you in there,"* a recognition of the circumstances and complexity of John's situation (*They know it's not all what you say…. all black and white. Like that shit is grey!*).

Critically, class is not removed from these negotiations as the mental health worker is associated with others who represent the symbolic order (*all those people, the doctors, the judges, the politician)* and those who have the privilege of capital (*silver spoon in their mouth*). They are framed as lacking in the intersubjectivity (*they hadn't a clue; they just don't get it),* while the prison social workers are framed as having intersubjective understanding while still being other (*they know the craic).* Structurally, this is important as what follows is a description of how his habitus functions as both symbolic capital (*Like don't fuck with me. You feel safe, my kids are safe),* but also symbolic violence as this habitus is judged by others and indicates his marginalised position in the symbolic order (*They just don't get it, what it's like to live here, to have nothing and have people look down on you).* Again, the recognition of the Other, that of the symbolic violence of *being* lower class and displaying this habitus to the gaze of others, is central to John's distress. This connection between mental health services, his suffering and class-based contexts can be viewed as a dialogical relationship between symbolic structures, services and subjectivity.

In terms of recovery, John does not describe a reduction in his suffering from psychiatric mental health services, and only hints at a temporary recovery from the prison social services. Instead, this extract ends with "*I'm tired"*. Language that suggests the exhaustion of his negotiations with services that provided little, if any, recovery. The acceptance of one service over the other, and the provision of interventions that provide recovery, hinges on the discursive framing of distress and what they signify for subjectivity. The psychiatric hospital operates on foreign and unknown discourses of the university with the knowledge of the biomedical model that objectively scrutinises under the medical gaze of the embodied Other (doctor). The prison's social services provide recognition of the symbolic violence associated

with the social and material conditions of John's lower-class position. Yet, this only provides temporary recognition while he is assisted by the service. Once they are withdrawn and the conditions return, so does the suffering.

What is consistent across these two accounts is that both John and Ben are presented with signifiers that either framed them as objects or as subjects situated within the symbolic order. Both participants rejected the objective frame that is a measurement of recovery through observable or reportable criteria and accepted the service that frames them and their suffering as attuned to their subjective needs, critically their class positionality and conditions as well as associated habitus. While both participants favoured the subjectively orientated service, the effectiveness of these services and the outcomes in terms of a recovery were vastly different. For Ben, there were indications of some level of recovery, while for John, there is a temporary recovery when the conditions that generate his suffering are addressed, but then it is lost once they are removed and he returns to his coping strategies.

These participant accounts suggest a practice of recovery of a negotiation of signifiers derived from interactions with mental health services and institutions. The practice of recovery in itself was a nuanced interaction of habitus, status and structures on the intrapersonal, interpersonal and structural planes of practice, mediated by the negotiation *of and with* signifiers presented by mental health services and those of the participant's habitus. As such, this practice, while a discursive negotiation between institutions and individuals, is the negotiation of signifiers of distress and subjectivity that enabled or hindered recovery in terms of a reduction of suffering. Signifiers were negotiated in terms of acceptance and rejection, but then negotiated on an intrapersonal level in terms of how the signifier structured their subjectivity. Here, recovery hinged on these negotiations and was observed within all participant accounts of interactions with mental health services. In the next section, again, it is the signifier that shapes recovery practices, recovery practices that are centred on performativity.

6.3 Performative Recovery

This section explores how practices of recovery are presented in these accounts of mental health as performative. All participants' practices had elements of performativity that aligned with specified signifiers of recovery. In many cases, this was done to meet valued and

symbolic forms of capital, such as access to choice and normalised and class distinct behaviours, maintaining a household, socialising, consumption and engaging in labour. These practices operated as highly valued symbolic commodities signifying mental normality and recovery as aligned with mental health discourses. In what follows, I explore one participant's account as an example of this performativity that was a common feature in all participants' practices of recovery. As in the previous section, indicators of distress that recovery was desired from provide important context to practices and, as such, are presented first.

The example of performative recovery comes from Susan, a 53-year-old woman from a middle-class background who expressed a strong middle-class identity and described her activities as distinctly and intentionally middle-class. Susan explained the class divide in her neighbourhood growing up, and the expectations for her in terms of an acceptable lifestyle and career that would bring her class distinction. She also spoke of the pressure to maintain the appearance of mental normality within her family and community, due to the attitude that mental health issues were shameful, a private matter and not part of middle-class norms. This becomes relevant when Susan loses her job, which provided her with access to financial, cultural, and symbolic capital that provided middle-class distinction. Subsequently, she describes experiencing significant anxiety and depression and eventually a suicide attempt. Below, she responds to my question, "*Can you tell me more about that (depression), what it was like?"* which provides insights into the suffering, which the practice of recovery attempts to address.

> *Uhm… I was just miserable. I was doing a job I hated… I was a square peg in a round hole, and I had no choices because I had been expelled from school, and it wasn't well well-thought-out career path. And I felt I had no options, and this was going to be my miserable existence forever. And so, I just felt very unhappy. Umm… and I suppose that that would manifest in just feeling no joy, no happiness. Umm… A lot of numbing would go on. Umm… didn't see the point in anything umm… so some risky behaviours, I suppose, because umm… well, you know, so what. Uh, and then… I will get anxious then about umm… the lack of choices, and it would swing between feeling miserable, feeling trapped, and that could make me feel very anxious and no, no…. how would I define that umm…I suppose the world, my friends and people I worked with their life was moving in a way that I felt mine would never. They were happy, and I wasn't, and they were making life choices that were furthering their happiness. But umm... so, I just felt I was observing the world rather than participating in it, watching other people making choices and living their life…. and I was stuck.*

In the text, subjectivity is constructed in comparison to others, but specifically to her middle-class peers, indicated by "*my friends and people I worked".* Considering a discussion

at a previous point in the interview about her aims of class distinction, this suggests that the habitus and social fields are important contextual factors linked to Susan's distress. On the one hand, this evidence of the habitus in the alignment to peers indicates the ideal ego, but also a lack originating from the ego ideal with comparison to contemporary peers, showing a dialogical link between the ideal ego and ego ideal, in the social comparison. With this social comparison, the ego ideal holds subjectivity to the demands of the Other projected through the "*observing"* and "*watching"* of others. While the others are "*making life choices"* and "*furthering their happiness",* a framing of agency and progression, Susan's circumstances are framed as "*I had no choices", "I felt I had no options," "lack of choices",* and *"I was stuck",* reflecting the perceived lack. Importantly, the phrases "*they were happy, and I wasn't", "they were making life choices and furthering their happiness",* and "*watching other people making choices and living their life"* structurally link the performance of choice with emotive mental health states, but also the social comparison that is the locus of subjectivity, and thus her lack and suffering.

Failing to meet these framings of success and mental health, subjectivity is constrained by the desire to align with a lacking habitus and meet the demands of the Other, as mirrored in others. Signifiers of distress (*miserable, miserable existence forever, very unhappy, feeling no joy, numbing, risky behaviours, didn't see the point, anxious, feeling trapped*) are themselves held by the ego ideal and the demand of the Other, as even this distress is a social comparison. The others, "*they were happy*", "*furthering their happiness*", and Susan's "*happiness",* of lack of, is centred on signifiers that shape the expectation of what it means to be "*happy*". In this case, the signifiers and experience of "*happiness"* are structurally linked to the signifier "*choice/choices*". Thus, Susan is caught between the demand to meet performative norms, performing choice to bring happiness, while at the same time, she is held by restrictions in her response due to the failure to be "*happy*". Critically, the relationship between "*happy/happiness*" and "*choice/choices*" suggests that "*choice*" is significant to mental health norms.

"*Choice/choices*" operates as a master signifier as it functions with dominance and repetition in the text (*I had no choices, lack of choices, making choices, people making choices)*. Some phrases also allude to choice, or lack of, such as "*I had no options", "miserable existence forever", "feeling trapped"* and "*I was stuck"*. "*Choice*" can represent several things, such as autonomy, agency and power over one's life, not by the availability of "*choice*" but by

its performance. For Susan, the performance of "*choice*" is highly valued, acting as cultural capital meeting the norms of the habitus as a status indicator of symbolic capital, but also meeting the demands of the ego ideal and the Other. "*Choice*" as a master signifier is representative of the symbolic order where the performance of choice has an almost fetishised status in contemporary neoliberal society (Veresiu & Giesler, 2018). Moving through this participant's account, "*choice"* consistently appears to hold a powerful, elusively positioned role in the text, strongly shaping subjectivity and desire. As desire is always the desire of the Other, we see the master signifier of "*choice*" act as the object of desire, with the "*happiness*" that is derived from "*making choices"* suggesting the Objet petit a. Yet, this happiness that is observed in others is only a fantasy, as "*choice*" is performed for the Other and the displayed "*happiness*" a performative mental health norm.

As the interview continues, there is further repetition of the master signifier "*choice"*, but now it is structurally paired with signifiers of distress and, critically, production and consumption. During the interview, I noticed how Susan spoke about having a job a lot in a conversation that was about mental health, so I asked her, "*Was it the status that came with the job, or with having a job that had a substantial wage, the only important thing? Or were there other aspects of having a job and working that affected you?"* Her answer gives further insights into the link between the Symbolic and Imaginary and the associated effects on her mental health.

> *Well, work takes up so much headspace, so when that's removed, umm, there's a lot more craft that can rattle around, and so that's not good. And so, there's… There wasn't the distraction of things to get involved in or consumed by…. so, they're removed. The social interactions that go with the job… I used to travel quite a bit, which was all very nice, and you get to stay in really nice hotels. So that was all removed. There was just the hum-drum of everyday living, and then trying to live on social welfare benefits after having a really good salary was a huge adjustment. I had to really watch what I'd spend money on, even down to the groceries I'd buy. Whereas before I used to always love Super Quinn before it became Supervalu, when it was Super Quinn, that's where I would have chosen to do my shopping. And now I was going to Lidl and ALDI, and that was a huge crush. Now we love Lidl and Aldi, and you never know where to get in the middle aisle! (laughs) At the time, that was a huge adjustment.*
>
> R: That's really interesting, you say shopping in Supervalu, which is kind of seen as the posh supermarket, and then you would have shopped in Lidl or Aldi, which is the less posh supermarket. But did that psychologically put a toll on you that you were not in the posh supermarket?
>
> *Yeah, because it wasn't a choice, I felt I had to. Umm... like now, when I go out for the shop to do the groceries, I'll decide where I'll go. Maybe I'll go to Dunnes, maybe I'll*

go to Tesco, maybe I'll never go to Supervalu now, but maybe I'll go to Lidl or Aldi's. I don't have to go to Lidl now. This is the choice that was removed, and so that felt very… umm… unfair. And that compounded how I felt, you know, and it just made me feel more similar to how I used to feel when I had no choice. It's the lack of choices, and they've been forced on me, and the lack of control I have over my own outcome, or my destiny or my stupid shopping (laughs)!

The linking of the "*job*" to mental health is not only by preventing rumination (*work takes up so much headspace; craft that can rattle around; the things to get involved in and consumed by),* but is framed as benefiting mental health by the indicators of class that meet the ideal ego, but also the ego ideal, with the socially comparative norms. This is also indicated by the presence of the master signifier of choice with the use of "*removed"*, "*They're removed"* and "*So that was all removed"* suggest a lack of choice by the removal, the negation pointing to the master signifier. With the loss of the job, the ability to perform specified choices, those indicated earlier in the text are "*removed"*, and the object of desire and Objet petit a is no longer a fantasy, and instead is faced with the "*hum drum of everyday life", "trying to live on social welfare benefits",* and *"really watch what I spend money on"* a change reflecting the day to day effects and class distinctions mirrored by the difference practices that seem as foreign to her habitus. This breakdown between the Symbolic and Imaginary brings great distress to Susan, as she cannot perform what, which is the Other asks of her, to work (production), and gain access to the symbolic capital of choice.

Not only is production central, but so is its counterpart, consumption, as an indicator of normality and class distinction. Without income (financial capital), there is a "*huge adjustment"* to her practice, one that is in contention with the habitus. "*Adjustment"* suggests the previously held positionality that was symbolically indicated by the choice to shop in a high-end supermarket (*Super Quinn)*, but now it is held in contention by only being able to afford to shop in the discount supermarkets (*Lidl; Aldi).* Again, there is an emphasis on the lack of choice with the phrase "*because it wasn't a choice, I felt I had to,*" which is interesting with the use of "*felt"* as opposed to just "*had to,"* pointing to the perceived lack of choice rather than an actual one. This lack is attributed to external entities (*the choice was removed; It's the lack of choices and they've been forced on me),* which is then contradicted by "*I had no choices"* and "*the lack of control I have over my own choices",* a desire for agency in the performance of choice. Crucially, it is the performance of choice that is a measure of a trajectory (*my own outcome, or my destiny),* and in consumption (*my stupid shopping),* the

symbolic capital holds subjectivity, identity, and class distinction by meeting the demands of both the ideal ego aligned to the habitus and ego ideal aligned to the demands of the Other.

From a simple conversation about grocery shopping, the language points to a practice of consumption that is symbolic of status, impacting subjectivity, self-worth and mental health. The previous exploration of extracts was necessary to understand what Susan's distress was centred around, which recovery is desired to alleviate, as presented in the following extract, as Susan continues.

> *So, I used to just sit, miserable, and it was a horrible time. And that was all wrapped up in how I was feeling, but compounded by losing my job and the… the lack of options then of getting another one. And then, when I started to feel even slightly better, I just frantically applied for anything and everything. I was at it constantly, and I would become nearly obsessed about it…. I need a job! I don't care what it is! I just need a job! I need a job, and I need a job! I'd throw out my CV, applying online to any I'm going, "I don't want this… this is a terrible job", and I'd feel like I can't leave a job when I've been trying to get a job. And so, it was all becoming very frantic for a while.*

Again, signifiers of distress (*miserable; horrible time)* are linked with the signifier "*job".* The value associated with the job is significant as it is the focus of the practice of recovery, by facilitating the performance of choice, the master signifier of mental normality and object of desire. In the text, the job is framed as a need (*I need a job! I don't care what it is! I just need a job! I need a job, and I need a job!)* to fulfil the "*lack of options",* a phrase pointing to the master signifier choice. While the job does not resolve suffering, it brings access to the performance of choice (object of desire), the happiness (Objet petit a) associated with the master signifier "*choice*", which is a fantasy, as the subject will never fill the lack by the desire of the Other. As such, this practice of recovery is only performative, and no long-term recovery, in terms of lessening distress, was achieved by gaining a job or performing a choice. This is further illustrated when Susan answers my question, "*So what resolved it then? What brought you out of that time?"*

> *It was all of their combination of things that did it, like when I did make the suicide attempt, my partner then just said, "That's it, we're over, we're done". And the fact that I had done that, it was done. Umm… so everything changed. Umm… and I ended up moving back in with my father and my brother, [he]had a fit, and there was all sorts of murder about the fact that, at that stage I was 50, so it was only three years ago and happened to move back in when I like, you know, I shouldn't have been in that position. And I was like, "yeah, yeah, I know I should have... I didn't... and I don't… and this is where I am right now." And I got the job. I mean, now my dad lets me stay with him for a few months. I was able to save some money, moved in with my current partner, well, I met her and then moved in with her, and I started a new relationship. So, everything*

in my life changed because of where it ended up and everything falling apart, so I had to rebuild, and so that's what resolved it. I literally rebuilt from the… from the ground up after that.

In the final extract of this exchange, we continue to see the presence of "*choice*" in the described lack of it, returning to the family home and the evaluative "*I shouldn't have been in that position".* We see the ideal ego in the voice of her brother, who reflects the norms, attitudes and expectations of their shared habitus, with judgment in not meeting these norms shown by the phrases "*there was murder"* and "*[he] had a fit*" that she "*happened to move back in",* a framing that suggests a perception of choice and personal responsibility for the circumstances. Then there is the reference to the previous practice of recovery, "*I got the job",* followed by what actually brings some recovery. While the job facilitates income (*I was able to save money),* there are indicators of reframing subjectivity and abandoning the demands of the ideal ego and ego ideal (everything in my life changed). Susan starts a new relationship that is authentic to her sexuality, accepts the lack of agency and the illusion of choice (*where it ended up; everything falling apart).*

While this appears to be the start of recovery in terms of symbolic mortification, with the rejection of symbolic frames, the master signifier of "*choice*" remains central with the use of "*I"* in "*I had to rebuild",* a choice made for the construction of this new life. Yet, this is perhaps not so new, but a repetition of the same performative self-alignment to the symbolic, indicated by "*rebuild"* and *"rebuilt",* suggesting this new subjectivity is built around the same symbolic frames. Here, recovery is signified by regaining the positionality that enables the ability to perform choice. Even in the rebuilding that Susan describes, it is still a repetitive performativity of that which the Other frames as acceptable signifying norms, to work, consume and perform choice.

In this section, a performative practice of recovery was explored. While this was a singular participant account, there are elements of performativity in all other participants' accounts, as they, too, performed recovery in alignment with mental health and recovery discourses that were characteristic of the symbolic realm. As we saw with Susan, her distress was centred on a lacking ideal ego and the strong influence of social comparisons guided by the ego ideal. Recovery frames were attuned to the context of the symbolic and recovery signifiers, with the performance of these frames mediating activities of the recovery practice. This framing of recovery maintained the illusion of alignment with the Other, of being less split and recovered.

However, as we saw from the language in the text, this was a fantasy of the Imaginary that drove the performance of the socially valued activities that are both symbolic and cultural capital, production and consumption. These maintain the symbolic order and provide access to an arbitrary but highly valued form of symbolic capital, choice. In this regard, the performance of choice was symbolic of recovery, so much so that it operated as a master signifier in the text, specifically in consumeristic terms. Here, recovery was validated by production and consumption that provided access to the object of desire, choice, and the fantasy of the Objet petit a, happiness. Critically, the performance of symbolically aligned mental health norms as a means of recovery was central to subjectivity, the formation of the ideal ego and the ego ideal. In the next chapter, we will explore practices of recovery in relation to the processes of the formation of the subject, subjectification.

6.4 Recovery through Subjectification

Subjectification, generally described as the process of forming a self-concept through internalisation of the symbolic (Lacan, 2011a), was a practice of recovery observed in several participants. While subjectivity was part of all accounts of mental health, subjectification that brought about a reduction or end to distress functioned as a means of recovery. While Chapter 7 explores the practice of subjectification in itself and as a fundamental aspect of mental health, this section examines it only when it is central to recovery practices. Here, participant accounts of mental health conditions are explored with a focus on their practices of recovery, illustrating how signifiers, those of mental health discourses as well as class-specific ones, shape subjectivities to generate new versions of self that were perceived as recovery, reducing suffering. For others, subjectification recovery practices sustained split and fragmented subjectivity, maintaining suffering. As with the other features of the mental health cycle, contextual factors of class positionalities and related habitus frames are inseparable from these accounts and as before, we first explore the participants' description of their suffering that recovery practices aimed to resolve.

The first example comes from Kate, a 53-year-old woman from a working-class background who has some social mobility, but still strongly identifies as working class. When I asked Kate, "*Can you tell me more about your experience of mental health?"* she recalled the typical teenage struggles with identity that brought distress and challenges to her mental health.

Yeah, I remember when I was 15, all them years ago, it wasn't really talked about, but depression is how I felt it was. Umm… there was no going to the doctor, you know, to say I'm depressed or feeling down. It was kind of like "sure, what's wrong with you, you're grand, get up, go to school, do what you have to do. There were people I knew, girls, who basically suffered from depression and were put into local unit 9, which was like the mental health ward. And you'd be put in, it didn't matter what age you were, everyone would be lumped into the same place, and they were just pumped full of drugs. So, I knew the solution for me wasn't going to be going to the doctor anyway and getting pills or being treated by the medical system. So that was my experience of mental health, and just knowing that I was going to have to make me better, and there wasn't going to be someone who I could rely on to make me better. There wasn't, you know, proper services of professionals or people to listen to that, or even like parents that you could rely on or trust to help you. It was like you're gonna have to do it yourself.

First to note is how distress is signified, not only with the psychiatric label of "*depression*", but of a felt emotional account (*depression is how I felt).* However, the term "*depression*" is held with some ambivalence as the symbolic frame does not seem to capture the distress fully and is of clinical discourses that come from outside her sociocultural fields. This is evident from the attitudes and sociocultural mental health norms in the language linked by the two statements "*there was no going to the doctor"* referencing the norms of the field, and "*the solution for me wasn't going to be going to the doctor"* indicating the first practice of framed as a working-class stoicism and emotional suppression that was previously observed with other working-class participants' resilience. The language of others reflects these habitus norms and criticises the use of this signifier and the associated displays of distress with "*sure, what's wrong with you, you're grand, get up, go to school, do what you have to do."* An indication of the first possible practice of recovery from common to her generative social fields, that of repressing the signifiers of distress and "*depression*".

This practice is further indicated as the signifier "*depression*" itself is repressed from the language of her community (*it wasn't really talked about),* as well as the associated help-seeking *(there was no going to the doctor, you know, to say I'm depressed or feeling down*). Further sociocultural norms relating to stigma and fear of help-seeking are evident in the description of the psychiatric services, the second practice of recovery in the text, not experienced by Kate, but by her peers (*There were people I knew, girls, who basically suffered from depression and were put into local unit 9).* The signifier "*depression*" is not only associated with the practice of help-seeking from psychiatric services, but also with the negative consequences of this practice. The language suggests disempowerment, exclusion and institutionalisation as a consequence of help-seeking associated with the signifier "*depression*" (*And you'd be put in, it didn't matter what age you were, everyone would be lumped into the*

same place, and they were just pumped full of drugs.) This linguistic framing justifies the rejection of help-seeking by accessing psychiatric services, but also the working-class stoicism, as neither practice is framed as having the potential for recovery for Kate.

Importantly, it is this framing that provides the rationale for rejecting these practices, which is the first indication of subjectification as an alternative practice of recovery. Here, others that should provide interventions or supports (*doctors, medical system*, *proper services of professionals or people to listen to that, or even like parents that you could rely on or trust)* are not available or are rejected as they do not meet an expectation of "*trust*". Subjectification is indicated as a practice in the text by "*I was going to have to make me better"* and *"you're gonna have to do it yourself".* Not only does this indicate an agentive practice of self-directed subjectification, but also the presence of the split subject with these self-references. The self is addressing subjectivity with the "*do it yourself"* practice that will "*make me better".* In the absence of others who could facilitate recovery (*someone who I could rely on to make me better),* there is an auto-subjectification, as the emerging practice.

Yet, at this point, the practice is only emerging, as other practices of recovery are attempted first, such as a community-based counselling service. In the following conversation, there is a perceived class difference between Kate and the counsellor, despite it being described as a working-class community-based service. As this seemed important to her, I asked, *"Do you think her being of a different social class affected the therapeutic relationship?*

> *Yeah, I would say so because I know she had no understanding of what I was talking about. Like she may logically understand, but she had no real felt sense of what that was like. Even just from the things she was saying back to me, not that I can remember, but I remember thinking like "what a gobshite", you know. As she was speaking to me, as if there was a choice available in lots of things and there wasn't, and she didn't understand that.*

In this short extract, subjectivity is reflected in the perceived incongruency of habitus between Kate and the counsellor. Language distinguishes Kate as other through the difference in shared sociocultural knowledge (*she had no understanding)*, emotionality (*she had no real felt sense),* and an understanding of conditions *(as if there was a choice available in lots of things and there wasn't, and she didn't understand that).* Importantly, the repeated linguistic references to this incongruency in subjective understanding (*no understanding of what I was talking about; the things she was saying back to me; as she was speaking to me)* highlight the incongruence of language and a perceived lack of authenticity and trust in the counsellor's skills (*what a gobshite)*. These habitus-guided perceptions are central to the rejection of this

potential practice of recovery due to the perceived impossibility of empathetic understanding. The rejection of the Other by the rejection of the signifiers that the counsellor offers affirms the habitus. Still, at this stage in her story, subjectification is not the primary practice of recovery, but only a means of trying on different subjectivities for identity formation, hinting at its development as a practice of recovery.

As the interview continues, different subjectivities emerge, and with the indication that this eases distress. Here I asked Kate, *"Can you give me a bit more detail about your depression, how it presented, or how you would describe it?"* In her response, the signifier "*depression*" is not in the text. Instead, other signifiers of her experience that were previously labelled as depression are present, as well as the contextual factors that the distress is focused on, again hinting towards a process of identity exploration and subjectification.

> *I just felt helpless. I felt I hated school, and I felt trapped, I felt hemmed in, I felt… like I couldn't be me, I felt like I was powerless in lots of ways. You know, not that it was the start of it, you know, environmental destruction, melting of the ice caps, I really felt all that stuff very strongly. And seeing that people weren't interested, and you know, the hole in the ozone layer. There was a lot of homelessness kind of crisis going on. It was maybe the start of the homelessness issues becoming more prevalent in the city. So, like I used to be like... ok. I took on a lot of social issues of the time, but was totally powerless to fix it. Like I could go around and collect hats and scarves and bring them into the city to the homeless people, but my mom and dad didn't like me doing that. They were like "oh that's dangerous" and this and that, so, you know, that got knocked on the head. Everything I tried to do got knocked on the head. Yeah, I just felt very, very controlled. And by others, and by authority figures. There was a horrible nun who used to run my school, and this creepy, controlling, religious, authoritarian feeling in the school, you know. I mean, when you're a kid and you're in school, that's your kind of main environment at that age, so, yeah, it wasn't nice at all. So, it was all those factors I suppose and not having access to phones or money, even though I worked, I worked in the local shop, I babysat for money, but even to get a bus there was crap bus service, so to get anywhere, to get out of the area, everything was such a palaver. And then…. I suppose at that age, you're 15 years old, especially back then, they weren't treated with respect by bus drivers, doctors, by whoever was above you. Everyone was shitting on the person below them. So, teenagers really got it, you know.*

From this extract, distress is framed as a subjective emotional state indicated by the repeated use of "*I felt*". It is here that there is the presence of a lack, the lack of control and power over life events and subjectivity, as indicated by the description of feeling "*helpless", "trapped", "hemmed in",* and *"powerless"*. Most revealing is the statement, *"I felt… like I couldn't be me",* situating the lack around an authentic subjectivity. Interestingly, as Kate continues, the dialogue changes away from subjectivity, but to "*social issues*", which she has no control over. This shift points to a desire for agency, if only symbolically and by the

construction of an equally symbolic identity focused on the fantasy of unachievable idealism. As a working-class teenager, she has little agency over her own life, describing "*not having access to phones or money, even though I worked",* and the disempowerment of youth by authority (*I suppose at that age, you're 15 years old, especially back then, they weren't treated with respect by bus drivers, doctors, by whoever was above you).* Within this context, the identity frame of an activist provides symbolic capital that differentiates her from others and the ego ideal (*people weren't interested)* to a more valued imaginary version of self.

There is also an enjoyment in these efforts despite her indicating that she was "*totally powerless to fix it".* This surplus enjoyment*,* at least in part, fills the lack, that of feeling "*helpless", "trapped", "hemmed in"* and *"powerless"*. Critically, this provides the identity frame to answer the demands of the ego ideal, that of an agentive person contributing to the betterment of the world. However, this identity is not acceptable to the sociocultural norms of her family (*but my mom and dad didn't like me doing that),* and the activities that shape her subjectivity are stopped by her parents. Again, there are limits to subjectivity due to the sociocultural norms of these generative social fields, indicated by the disproving by her parents and the use of "*totally powerless*" indicated in the text as the source of distress by "*I took on a lot of social issues of the time, but was totally powerless to fix it."* From this, subjectification and the associated enjoyment are castrated, producing tensions between who she desires to be, based on an idealistic ego ideal, and the ideal ego mirrored by others in her generative social fields and the guiding principle of her habitus.

Despite this tension, there is a continuation of the desire to end suffering, focused on subjectification as a practice that leads to recovery. In the following extract, there are further efforts at identity formation that bring agency, empowerment and control, at least over herself and lessen her distress. Here I ask Kate, "*What was your solution to that? What allowed you to come out of it?"*

> *So, it was like I did lots of reading to try to understand it better, to try to understand what it was, what was going on for me. I wrote, I wrote a lot about it, I thought about it to logically work through it in steps, trying to think it through and the options, umm. And then the things that really helped me or worked for me or climbed the ladder to getting well were alternatives. Alternative ways of thinking, alternative ways of being healthy, you know. Like that, I started to practice yoga and read Buddhist texts and all things about the creative mind, and it started to change my thinking. I knew I wasn't stuck and that I wasn't the servant of my mind and that I could make my mind my servant, and that I would choose my thoughts. Even though I felt very maybe trapped in my life, I could…I didn't have to be trapped in my own head. So it was that and just about moving the body and connecting with nature, I always loved nature, so I would*

try to be out, and get out and about in nature and go for walks, long walks and that kind of stuff, so it was again... I changed my food and all that kind of stuff, which is all so accepted now.

In Kate's description of this effective and thus primary practice of recovery, we see the engagement of new subjectivities through language (*did lots of reading, I wrote a lot about it)*. The questioning of previous narratives *(try to understand what it was, what was going on for me)* opens new signifiers of self (*Alternative ways of thinking, alternative ways of being healthy).* Here, it is useful to consider the discourse of the hysteric and the analyst as the practice questions previous signifiers and explores new ones through reading and writing. There is a further symbolic frame of recovery, the "*alternatives*", that are valued differently from previous symbolic frames. Not only are these "*alternatives*" to the sociocultural norms of the habitus, but also to the previous self whose discursive frames of distress came with devalued consequences. The self that felt "*helpless", "trapped", "hemmed in", "powerless"* and "*depression*" introduced in the first extract, is replaced with an agentive self, an alternative imaginary subjectivity. While this subjectivity is more valued, it is clear there is still a split subject in the differentiation between self and mind in the language (*I knew I wasn't stuck and that I wasn't the servant of my mind and that I could make my mind my servant; that I would choose my thoughts; I didn't have to be trapped in my own head).*

While the previous signifiers centred on a lack of control and choice, there are now "*options*" and the ability to "*choose my thoughts".* Yet, while these point to alternative practices of recovery (*practice yoga, Buddhist texts, connecting with nature; changed my food),* there is still a tension from her habitus. The phrase "*that is all so accepted now*" suggests a previous and perhaps current contention over the symbolic frames of recovery and subjectivity. The signifiers associated with the new subjectivity differentiate her from the sociocultural class distinction, aligning subjectivity to distinctions outside her habitus, while also distancing her from psychiatric discourses that were initially rejected. Considering the previous series of extracts, the practice associated with her past identity, that of working-class stoicism, psychiatric services, counselling, and activism, did not resolve her suffering, and so the associated subjectivity was abandoned. Instead, the new "*alternative*" practices provide a new and more valued subjective framing, one of agency and self-determination, if not personal responsibility over her mental health, a valued identity frame in neoliberal society.

From Kate's example, a practice of recovery through subjectification is indicated in the language that describes her account of mental health. Perhaps this account is that of typical

teenage rebellion and the exploration of identities common at this age. Yet, the narrative suggests something more, a self-directed exploration of identity frames that psychodynamically address suffering that is centred on subjectivity. More so, the exploration of identity is practised by adopting signifiers that are "*alternatives*" to the ideal ego and habitus brings approval from the Other by satisfying the ego ideal. These signifiers of self-foster an evolution of identity from a working-class teenager who felt disempowered and trapped to a valued agentive individual, in control of mind and body. The linguistic distancing from the devalued habitus and ideal ego, while providing recovery in terms of lessening the initial distress that was centred around the development of subjectivity and identity presentations, does so by maintaining an illusion of individuality and independent identity construction. Yet, the split subject remains, and while relying on subjectification as a practice of recovery brings relief from distress, it is psychically intensive and completely self-reliant, with continual re-subjectification needed to meet the ever-increasing and shifting demands of the Other.

In the previous accounts, subjectification served as an effective practice of recovery, at least in part, as it resolved distress associated with identity formation. However, subjectification did not always bring about recovery or even a reduction in suffering for all the participants who used this practice. Instead, subjectification maintains distress when the subject is caught in the repetition of the enduring drive to resolve a fractured subjectivity. This was the case with James, a 58-year-old man who came from a working-class background, but had some social mobility as he owned his home, had just bought a new car and was able to support his three sons through third-level education, something which he was very proud of. However, James had a very strong working-class identity and considered himself, despite his upward mobility, to be "the *common man*", a victim of class-based exploitation and marginalisation. In the following extract, the links between mental health, labour and classed identity frames that shape subjectivity are explored. In his answer to the question, "*Has your class background affected the quality of your life experiences?",* his subjectivity is derived through social comparisons based on status derived through occupations.

> *Umm… I think it's had a negative effect as far as this lack of confidence. I always feel like I could have gone places if you know what I mean. Umm…oh yeah, but this lack of confidence that I have, I have these cousins that were very successful, insofar as I have cousins who are a pilot, a detective sergeant, and a professor. Umm…. I reckon I have a high IQ, a little bit above average, I'm pretty good with my hands, but the lack of confidence doesn't stand well for me, and that's why I have been in so many jobs. Again, I broke my kneecap hurling, and so I have one bad one leg, and that's affected my career in as far as the experience I had with sledgehammer work, you won't probably*

know what I'm talking about, but it was heavy-duty stuff. And I was afraid I was going to whack my knee, and it actually turned me off following up the career ladder. I was in a job that I loved, and I could never hold onto it, and that was a postman. My uncle was retiring, and he got me in, and I absolutely loved it, and I loved being out and meeting the people, driving the countryside, outdoor work. But I didn't get it permanently, and I believe that was a political decision. The second time the job came up it was after 911, and there was dangerous stuff in the post, like this white powder, and I wouldn't do it, wouldn't take it. The third time I was working for a while, and I was to get the permanent position, and I was sure I was going to get it, and I was trained up on the rounds. But no, a retired garda got it! He had 27,000 a year before he got out of bed and an 80,000-severance package! But he got it. He didn't deserve that job, he had his family reared I still had my family to raise at the time. But again, disappointment! You know he got that because he knew someone who knew someone. It's still the same, they say it's not, but it is. But your reputation goes before you! Like, places wouldn't take me on because they said I'm a job hopper! If you leave a job, sadly, it can affect you. Like it is my own fault, but I just search and search and search for a good job. But if it's not the right job, you're never gonna be happy. I'm never gonna be happy. The only time I was happy was when I was playing music in Kerry, and that's the truth.

In James's account, subjectivity is based on signifiers as status indicators that provide symbolic capital. First, James describes himself in positive terms (*I reckon I have a high IQ; I could have gone places),* indicating an ideal ego based on an expected trajectory that would bring status indicators associated with his habitus. His habitus is indicated by "*I'm pretty good with my hands*", suggesting his ability to perform manual labour, a valued skill in working-class communities. Yet, his subjectivity is held in comparison to others, in this case, his cousins, labelled as "*very successful",* their success associated with status-valued occupations (*pilot, detective sergeant, and a professor),* illustrating a desired upward mobility in terms of acquiring an occupation that brings symbolic capital. The ideal ego is held by these familial trajectories and the habitus which guides the fantasy of the high-status job that will bring respect and prestige. Yet, the failure to gain this trajectory is disassociated from himself, while described as a "*lack of confidence*", it is framed as the "*negative effect*" of his working-class background.

He reconciles his positionality and lack of job which would bring him the desired status, as a consequence of unfortunate external circumstances of injury (*broke my kneecap),* age discrimination *(they gave the job to a younger man),* politics (*I believe that was a political decision),* cronyism (*a retired garda got it!)* and even geopolitical events and terrorism (*after 911 and there was dangerous stuff in the post, like this white powder).* In this imaginary rationale for his inability to maintain the postman job, there is *jouissance* in the blaming of others that brings momentary enjoyment in the transgression. There is also surplus enjoyment

in the suffering while chasing what he desires (job as a postman), which in turn provides him with recognition from the Other as a victim of the symbolic order, protecting his subjectivity and reinforcing the illusion of the ideal ego. This is evidence of self-sabotage and the framing of circumstances to continue the surplus enjoyment.

The final few sentences of the utterance are important as they link his ideal ego framed around the surplus enjoyment, the object of desire and his mental health. He states, "*Like it is my own fault, but I just search and search and search for a good job. But if it's not the right job, you're never gonna be happy. I'm never gonna be happy."* With the repetition of the signifier "*search*", there is the drive for the object of desire, "*a good job".* Yet the "*good job"* is differentiated from "*the right job*", the job that will bring him that which is desired and holds the fantasy of filling the lack, making him "*happy*" as the job that aligns him to his ideal ego, but also the symbolic capital of the approval of the other as a "*very successful"* worker. What is interesting is the linguistic connection between his mental health (*I'm never gonna be happy)* and the symbolic capital which comes from performing labour (*the right job).*

Finally, it is important to note the length and pace of the text. It is a long answer to a relatively simple question with deviations from the topic and repetition. This repetition hints again at the jouissance in the transgression of repeatedly blaming others, or in the surplus enjoyment that is derived from his desire for occupations that bring the fantasy of acquiring the Objet petit a*,* an acceptable subjectivity that will fill the lack. Yet, as discussed above, this may also indicate the surplus enjoyment derived from the pursuit of the object of desire. Here, in the repetition within the text, the surplus enjoyment is maintained by the repetitive linguistic framing of circumstances, protecting his ideal ego and maintaining surplus enjoyment and jouissance.

From the previous extract, James's subjectivity is dependent on the fantasy of the symbolic capital that a job may bring, and that on which happiness is dependent, while at the same time, it is the source of distress. In the extract that follows, James continues to describe the search for an occupation that will provide a subjectivity acceptable to his ideal ego and bring an end to his suffering, which is now framed as depression. His reply to my question, "*Can you tell me a bit about your own experience of mental health?"* provides insight into how subjectification drives his practice of recovery, yet does not bring an end to his distress.

> *I have depression. See, I have been diagnosed and take tablets for it. My wife's father often suffered from depression… and … it completely fixed him. He went from going*

out behind a shed, crying his eyes out, to being ok. And I said a tablet won't harm. My wife worked in the doctor's office before and knew what kind of made people into zombies, for lack of a better word. This wasn't that one. I can't remember the name of it, I can't even remember the name of the one I'm on now. Yeah, I have given them up before. I went off them myself slowly, and my wife advised me to do it slowly. So, I was on them about 5 years the first time. Then I started the work scheme (community employment programme), and to my workmates everything was normal, like when you're with people, everything is normal, but like when you're on your own… what you call it… don't get me wrong… I don't want to be insulting anyone… but I probably was on the wrong work scheme. Insofar as I was cleaning out toilets, right? Like, lads not flushing the toilets, right? Toilet paper, used toilet paper, thrown on the floor. And I think to myself, God, is this what I have ended up doing? Cleaning up other people's shit and piss? Now, if I were just mowing the grass, it probably would have never occurred to me. But the fact that I had a good council job at one time, but being a stupid ass, I left to go to another job. Like in 1999, I had a good job, and I left it, and I regretted it. Don't regret it now, but in 2019, it hit me. Here I am cleaning people's fecking shit, like, is this all I'm worth? Self-worthlessness kicked in. And my wife could see I was going downhill, and so she says, "Would you ring someone or talk to someone?" So, I went to the, actually, I got a card off the door of the community centre, Reach or some of them people, and I went in and only had 2 appointments. And I remember bawling me eyes out, you know, and it was a counselling service. And I went in there, and after about two appointments, she says, "I think you're over it". And I was like "right, ok?" and I haven't been back since. And I went to the doctors and been put on another tablet. So, I'm not too bad, but there are days you get down. The good thing about work is you're kept busy, no time to think. And it's a good thing for me in a way, mentally, because I have no time to be thinking about myself. Like I keep myself busy, and I like to keep ahead of the other workers. And I'm so busy… I don't have a minute, so 9 to 5 (whistle sound) gone. But I have been in the best of jobs, I've been in so many jobs I can't tell you. But it's down to my lack of confidence and boredom, I left one job sweeping the floor, you know? Yeah, but that hit me in 2019 that it was probably the best job I ever had, but I left it. I was a caretaker at a civic facility, handy job. I have no hesitation in changing my job like.

Again, it is useful to note the pace and length of the reply. It is long and repetitive, and the language repeatedly switches between the topics of mental health and work. This appears as a linguistic deflection away from the topic of mental health to return to the topic of past and present jobs. This could indicate a defence mechanism to steer the conversation away from the distressing topic of depression to the less distressing one of work. Or it may again be a link between his mental health and the identity frame that is connected to the types of labour he performs, similar to the structure of the first extract.

The link between the language of mental health and the identity as a worker is important, as his subjectivity is caught between these linguistic distinctions. Here, mental health is framed as "*I have depression*", indicating exposure to psychiatric discourses, but also "*I have",* suggesting ownership of the label as an element of his identity. This is followed by

"I have been diagnosed", a legitimacy-producing discourse (discourse of the university) supported by the truth-producing knowledge of the biomedical model of mental health, which gives validity to the statement "*I have depression*". This is supported by the discourses of others, of his wife and the example of his father-in-law, further legitimising the diagnostic framing of his suffering. These discourses strongly align his subjectivity with psychiatric labels. Here, "*depression*" is a signifier that absolves the individual from their distress-producing pursuits, as well as the contextual circumstances that generate the demand for them. Yet, this is held in contention as the text repeatedly returns to the topic of work, suggesting an unconscious rejection of this framing and pointing to something about his role as a worker as core to his subjectivity and suffering.

The experience of depression is interwoven with references to his job on a community work scheme. Here, there is a connection in the language between this position, his subjectivity and his mental health. The job is framed as menial labour in a subordinate service of cleaning up after others (*Insofar as I was cleaning out toilets, right? Like, lads not flushing the toilets, right? Toilet paper, used toilet paper, thrown on the floor).* This subordinate role is evaluated subjectively as he states, "*And I think to myself, God, is this what I have ended up doing?"* Here, in the language is the split subject is in the gaze of the Other. He holds himself to account for not meeting the ego ideal that the Other demands, but is also magnified by the ideal ego, with "*what I ended up doing"* indicating a failure to meet with a perceived trajectory of self. This is followed by the distinction in the type of labour that impacts his subjectivity as if he were "*just mowing the grass",* a more respectable labour to his habitus, "*it probably would have never occurred to me".* There is also the reference to another job (*caretaker at a civic facility*) that brought him even greater symbolic capital, fulfilling his ideal ego and ego ideal. Still a menial service job (*I left one job sweeping the floor)*, but one valued over others. Yet he quits this job as well, and again it impacts his subjectivity (*self-worthlessness kicked in),* highlighting the role of self-evaluations as the source of his distress.

Critically, the focus of his suffering is also the focus of recovery. While there are references to mental health services, medication and counselling, these are rejected or secondary (*I haven't been back since; And I went to the doctors and was put on another tablet)* in favour of the repetitive search for a job. The job is central to his practice of recovery in several ways. First, it provides a social outlet where he gains temporary relief (*with your workmates, everything was normal, like when you're with people, everything is normal),*

perhaps in the mirroring of others, mental health norms and his identity as a worker, are reflected and not his depression. It also provides a distraction from the ruminations on his subjectivity that cause the mental distress, as there is "*no time to be thinking about myself*". The reference to "*myself*" indicates that subjectivity is the source of distress. Finally, the different jobs meet the ideal ego, but only temporarily, as they are the object of his desire, (*I just search and search and search for a good job. But if it's not the right job, you're never gonna be happy. I'm never gonna be happy)* once obtained, the expected fulfilment of lack is lost with the unattainable Objet petit a shifting to the next job (*But I've been in the best of jobs, I've been in so many jobs I can't tell you; I have no hesitation in changing my job like).*

For James, the practice of recovery through subjectification works differently from the two previous accounts. Instead of providing an acceptable identity frame that gives stable subjectivity, it fails, and he is caught in the repetition of the practice. Here, the process of subjectification is halted, as there is never an acceptable subjective frame to base subjectivity on. No identity brought about by a job meets the demands of the Other and the ideal ego. As such, recovery, or anything close to recovery, is never gained and instead is replaced by the surplus enjoyment of his drive for an imaginary subjectivity that will provide him with relief from his suffering and recovery through an idealised subjectivity. In this case, the practice of recovery in itself maintains distress. The subject is caught in a double bind between subjectivity and suffering, preventing subjective destitution through repetition and the drive of the practice.

In the preceding section, the practice of recovery through subjectification was explored with three participant accounts. From a careful analysis of language, the forming of self-concept, identity and subjectivity was shown to be central to the experience of mental health and the associated distress framed as the signifier "depression". With Kate, it was centred around a tension between the habitus, the ideal ego and the ego ideal, the demands of the Other mediated by language. For Sarah, there was an incomplete ideal ego due to a lack of recognition from the parental other. As both participants' suffering was centred on subjectivity, a practice of recovery that addressed subjectivity addressed this suffering. However, for James, subjectification failed to produce recovery and instead maintained a fractured subjectivity, catching him in the enjoyment of his drive. Yet, as subjectification is a process of applying symbolic frames of identity (signifiers), an imaginary identity is only ever momentarily secured. A final subjectivity is never possible, which is evident from these accounts. As such, a practice of recovery through subjectification brings relief from suffering and symptoms of

distress, yet only temporarily. The subject will always be split by the very signifiers they apply to themselves, and a true recovery through subjectification is illusory, yet commonly performed by many participants. To break from this and bring about true recovery would mean to accept that the imaginary identity frames are only symbolic, gaining subjective destitution and breaking from the ideal ego of the habitus and the ego ideal of the Other.

6.5 Chapter Summary

The previous chapter explored participants' practices of recovery in their interaction with mental health services, by performative recovery and recovery through subjectification. The analysis of language showed that practices were mediated by signifiers of mental normality and identity that were either rejected or accepted, and often conflicted with their habitus. Consequently, participants practised recovery to fit with new or preexisting signifiers of recovery within different social fields, including family, community, mental health services and society. For some, signifiers of recovery were presented to them by mental health services and were either accepted or rejected based on a habituated congruency and the subjective recognition of their personal, contextual and sociocultural histories. For others, it was a performance of choice and labour, a valued sociocultural activity that signified recovery. In other cases, processes of subjectification, applying new identity frames, provided recovery when distress was centred on subjectivity. It is worth noting that there was an iterative nature to each of the practices. All participants interacted with mental health discourse, and had performative practices where subjectivity was central.

However, what was most evident from these accounts was the mediating role of language in these recovery practices. By carefully examining participant accounts of mental health conditions, the dynamic and dialogical nature of practice can be seen as an interaction of the intrapersonal, interpersonal and structural activity mediated by language. Additionally, recovery practices were an interaction between the habitus, fields and capital that operated as a sociocultural situated activity. Critically, discourses of recovery operate as a trans-subjective realignment to meet the demands of the Other, where recovery is framed as the participation in production and consumption, a symbolic recovery of neoliberal capitalist practices that are framed as mental health norms. However, it can be argued that for some, their practices of recovery did result in a lessening of their symptoms and suffering, particularly when they changed the circumstances that produced the distress. Or if their habitus was attuned to the

signifiers of recovery provided to them by services. In these cases, it can be seen that as there was a reduction in their symptoms of distress, a real recovery occurred. However, for others, these practices were no more than the adoption of signifiers of recovery, which, while aligning them to the demands of the Other, did not bring about a lessening in suffering.

7. The Practice of Subjectification

7.1 Introduction

This chapter explores the formation of subjectivity through the practice of subjectification and its dialogical relationship with the subject's mental health. Subjectification is a process where subjectivity is a product of socialisation as an internalised image that is relative to the subject's position in the symbolic order. This process is described by Deleuze and Struss (1991) as "the fold" or an enfolding of the outer social world that becomes the inner world of self. It is the moulding of subjectivity through semiotic mediation, as language forms the foundation of consciousness (Vygotsky, 1980, 2012), the unconscious (Lacan, 1936), and in part, the sociocultural schema of the habitus (Bourdieu, 1990). As covered in Section 2.6.2 of Chapter 2, the process of subjectification is an adoption of signifying chains with multiple and complex meanings, ideologies and values that shape the self within the constraints of the symbolic (Lacan, 2006). Consequently, structures of the symbolic are carried on the signifier, becoming internalised sociocultural knowledge of the habitus, forming subjects that are attuned to their contextual positionality in a shifting, fluid symbolic (Collins, 1998).

As subjectification is a continual process with no finalised outcome, an examination of the process itself is necessary to observe subjectification as practice. By employing a developmental method, the inner working characteristics (signifiers) and causal dynamics (the symbolic) of this equally psychological and social phenomenon can be observed and described (Wertsch, 1985). As such, the following is an exploration of a series of extracts from three participants to capture the process of subjectification in the language of their mental health accounts. The analysis of language is central as it gives access to subjectification practices because of the "structuring effect that language has upon the development of the subject, and because the truth of the subject can only be apprehended by means of it" (Baily, 2009, p.73). However, due to the semblance of language, there is no "truth" in terms of a real subjectivity that we can access, only the signifiers they use, and my interpretations to give an account of the processes within these practices of subjectification.

As such, the following chapter focuses on the formation of the subject through the practice of negotiating signifiers, where subjects manage, resist, reattach, and reorder signifiers of self in relation to the habitus, social fields, and the gaze of the Other. As with the other practices of resilience and recovery, the practice of subjectification comes with interesting

outcomes in terms of mental health, with direct consequences as it discloses vulnerability and risk, which in itself shapes subjectivity. While each account focuses on individual subjectification practices, the characteristics of these can be seen in the other participant practices, those of a performative self, a structured self and the Other as self.

7.2 The Performative Self

In all participant accounts, subjectivity had elements of performativity. Presentations of self were constructed with signifiers for the approval of the Other, not only in the presence of other subjects, but to meet with an internalised, the ideal ego and the social norms of the ego ideal. This also included an alignment of subjectivity to mental health signifiers within the context of social fields and habitus-guided evaluations of internal subjectivity and the external expressions of identity.

For example, Jeffery, an 18-year-old male who self-identified as middle class, struggled with depression and anxiety in his early teens and associated this with bullying he experienced while attending a private boarding school. He described his life as "*comfortable and privileged",* living in his parents' house, working part-time, waiting for the COVID-19 pandemic to end, before he pursued his ambition of becoming a pilot. Jeffery had desires for social mobility with ambitions of being "*one of the elites*" with class distinctions of owning a sports car and being financially successful. He idolises celebrities who have achieved similar social mobility, and describes this as the "*normal"* lifestyle that is portrayed in the media, which he aspires to. In the following extracts, we see his process of subjectification constructed around key signifiers related to his ego ideal, his experience of mental health and external mental health discourse. In the first extract, he responds to my question, "*What is mental health?*"

> *I'd say what I think it is, it's like a personality. So, like if someone's depressed, you see them as like really sad, they are probably on medication, maybe not. Someone who you need to keep an eye on. Like the same way you would keep an eye on someone who is a liar, who is distrustful. And you know if someone is anxious, you would have to keep an eye on them, just like someone who is a liar. Now it wouldn't be the exact same way, like you wouldn't be careful like with what you would say to them, like a liar, but like you would want to keep an eye on them. Like, check on them every now and then, but not the same way you would a liar. Like that's why I'd say it's something like a personality.*

First to note is how language frames his subjectivity in relation to mental health. Mental health, paired with the signifier "*personality*", is an image that organises self-perceptions and perceptions of others in a consistent manner that is relatively fixed and identifiable. The implication of this is a reduction of the dynamic mental processes of subjectivity and identity formation, as well as the complexity of mental health, to an identifiable, stable subject image. We'll see what the implications of that initial framing will be as we progress, but it is worth clarifying here. "*Personality"* also hints at elements of his subjectivity in its deflection, signalled with the indication of "*a*" personality. This "*a*" positions the signifier objectively, deflecting it away from his own personality, suggesting a tension in association with the analogy. This is followed by discourses of the university with a stereotype of depression framing mental health as illness, treated with "*medication*". This is then questioned with the discourse of the hysteric (*maybe not*), suggesting a complexity that points to an understanding of mental health that does not align with this medicalising discourse, perhaps reflecting his own account of mental health.

There are further contractions present with "*Someone who you need to keep an eye on*", which may insinuate distrust or that care and attention are needed, yet also someone "*who is a liar, who is distrustful*". This is followed by the caveat "*it wouldn't be the exact same way",* again hinting at a deeper understanding of the signifiers "*depression*" and "*anxiety*", but also deception and a masking of a self who suffers. This may indicate not someone who lies with devious intent, but lies to conceal the "*personality"* (the one initially framed as mental health) repeated at the end of the utterance. Here, the subject is concealed behind "*a personality",* one in need of care from others, indicated by "*keep an eye on them", "be careful"* and *"check on them",* but who hides this need behind falsehood.

In the next extract, when Jeffery is asked to describe someone who has poor mental health, there are further signifiers of performativity in relation to subjectivity. However, now there is the presence of the Other who is preformed to, and a destabilisation of his subjectivity in the gaze of the Other.

> *I'd say if I was to describe someone who had poor mental health, they would try their hardest to look normal and live normal. But when they get a second to be alone and be themselves, I'd say it's just like someone flicking a switch.*
>
> R: You said something really interesting, that people may try to appear normal. Is appearing normal what you would consider as good mental health?

Essentially yes. They will try to make jokes in their friend group and get a laugh, and try to let on that nothing is wrong. Try their hardest to mimic like a marionette, like a puppet, probably try to hop on like the abuse wagon, to make fun of someone, to appear like everyone else.

Again, mental health is indicated as a performance for others, which is associated with both normal and poor mental health. The language here, while objectively describing the experience of another, points to a subjective mirroring, suggesting perhaps a self-stigma and a masking of a self that can only be revealed when alone. There is an imperative to "*look normal",* performing mental health norms in the gaze of the others, but also encompasses daily activities, to "*live normal*". Here, the gaze of the Other is present, a gaze that demands performative, normalised behaviours. Subjectivity is then destabilised as the split subject, the one who suffers, is held to account by the ideal ego indicated by the phrase "*to appear like everyone else,*" with concealment as a natural and automatic response (*flicking a switch*). Again, a reference that holds duality in terms of visibility and performativity in the gaze of others, the embodiment of the Other.

There are also indicators of the mental labour in the performance of normality, with displays of humour and happiness. The performance of "*nothing is wrong",* a valuing statement that what is "*wrong*" is to show distress. The use of similes "*like a marionette*" and "*like a puppet*" suggests not only control by another, but also that of being false, a representation of self that must be performed and links back to his previous reference of "liar". A "*puppet"* or "*marionette"* is a representation of a living entity, often a person, that performs for others, controlled by a hidden other (big Other). In this case, language is the puppet master here, directing a performance of mental health norms to *"appear like everyone else*", the other puppets of language. While the language objectively hedges Jeffery away from this practice, the reference to bullying from a person with mental health issues (*hop on like the abuse wagon*), to achieve a positive reflection on themselves as normal or "*like everyone else*". This dialogical discursive framing points to elements of his own accounts described earlier in the interview, as it mirrors his own practice of projection of untrustworthiness onto sufferers of mental health conditions. We can make a reasonable inference that "*everyone else*" and "*friend group*" refer to his peers, suggesting that this is indeed a subjective account of a labour-intensive practice to conceal the split subject with a performative self.

In the previous extracts, we saw a practice of negotiating signifiers that position Jeffery in relation to performative mental health norms required by the Other and the labour of

maintaining those norms to protect the ego ideal. However, when Jeffrey's distress challenges this performativity, the practice shifts to applying mitigating signifiers, ones that continue to please the Other and protect the ego ideal, which maintains the aspired trajectory and an agentive ideal ego and habitus. This is shown when he answers my question, "*Can you tell me about your own mental health*?"

> *For a good while, my mental health just tanked, and I went down. I should have reached out for help, and eventually I did. But probably not to the level of which I should have. Like I never went and got diagnosed with anything, and probably not that the fact that I didn't want to, but the fact that I probably didn't really feel any need to. It was like I just wanted to fight through myself. And to be honest, and I know it's probably a bad thing to say, but like, let's say I did have anxiety or depression, let's say I'm happy I went through it. That it became part of me, and like it was horrible and instructive, but it became a part of me and my experience in my younger life. And now it's really changed who I am.*

The signifier "*honest*" in its differing points to the underlying motive present in the previous extracts, disguised truths about his own mental health. Signifiers push Jeffery towards accepting he is a split subject, which are then mitigated by signifiers that maintain his narrative of agency and performative mental health norms, pulling back towards the demands of the Other and his ego ideal. He got help, but not as he should have. The phrase "*let's say*" hedges the text hypothetically, suspending ownership of the signifier "*depression*", protecting the ego ideal. The practice that protects subjectivity, a clear negotiation of signifiers in a direct sense, is seen in the language that values self-reliance and agency over distress (*fight through me*).

The dual framing of anxiety and depression, that *"it was horrible and instructive",* mitigates the negative associations, placing a value on the suffering. This hedging defers subjectivity away from signifiers of mental health conditions that challenge his identity as agentive and capable of achieving the object of his desire, social mobility. Here we see a continuation of the performative practice that functions to protect subjectivity from being split, the truth of which is revealed by the contradiction of the statements "*it became a part of me" and "it's really changed who I am".*

From the above account, there is evidence of a performative practice of subjectification. By moving from one extract to the next, the ideal ego, attuned to his class positioning and the social fields he occupies, presents as the measure against which subjectivity is held. We see practice in the initial positioning of the subject to the signifiers of mental health norms. Then, a destabilisation of the subject by the distress of being a split, which is magnified by not meeting the previously indicated signifiers of subjectivity. Then the practice shifts to the labour

of concealment in order to meet the habitus attuned ideal ego. And finally, a repair strategy to bring subjectivity back to the ego ideal. The practice is hedged on signifiers that push and pull Jeffery's subjectivity between the acceptance of being split and the aspirational ideal ego. Performative signifiers mask the subject from their lack, pushing them to perform mental health norms whose only function is to meet the demands of the Other in the ego ideal. Yet, while he gains recognition from the Other with this performative practice, it comes at a cost. While signifiers maintain the ego ideal, they mask and silence his vulnerability, limiting help-seeking and perpetuating more suffering.

7.3 The Structured Self

All participants' practice of subjectification was attuned by the habitus to their position in the structures of the symbolic, the related levels of capital and associated sociocultural and socioeconomic conditions. The structures of the symbolic register, the structures of society and their institutional representation were social spaces where practices of subjectification were negotiated. Critically, the symbolic is embedded with power dynamics which generate a hierarchically structured society, including that of social class. While these hierarchical structures are illusory, produced and maintained only through social relationships, the effects of these structures exist and impact the quality of material conditions, but also the imaginary constructions of the self and others.

The effects of the symbolic register's structures not only impact quality of life but are internalised in the habitus and guide practices, including those of subjectification. In this regard, it is worth revisiting Bourdieu's (1977) remarks on the habitus as "structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations" (p. 72). In the following extracts, the operation of the habitus is focused on internalisation of the structuring structure that guides the practice of subjectification.

This structuring of self by structuring signifiers was strongly reflected in Ari's account. Ari was a 32-year-old who self-identified as non-binary, gender queer and working class, whom we encountered in Chapter 5 on resilience. The exploration of extracts below suggests the relationship between Ari's structural positioning and their mental health in their practice of subjectification, which is centred on signifiers of these two features that were expressed as

being very central in their life. Here I ask them, "*Does it (class background) affect you psychologically*?"

> *Uh, so I think that it is something that becomes a part of your personality, right? Either you don't have money, and you think about it all the time, or you have money, and you never think about it. It sort of becomes who you are as a person. And I think that it has a very deep impact on your personality, the way you view the world, the way you view other people in relation to yourself. Umm…yeah, I think there's no way for it not to impact you psychologically.*

The first critical insight in Ari's account is that "*Money"* functions as a master signifier in the text, but also for Ari, operating on the subject's unconscious (*you have money, you never think about it)* and conscious mental activity (*you don't have money, and you think about it all the time).* The practice here is repetitive and obsessional and is a central tenet of their subjectivity (*It sort of becomes who you are as a person).* The pairing of "*money*" and "*personality*" indicates the master signifier's organising power, that "*money*" has "*a very deep impact on your personality". "Money*" demands labour in the practice, to attend to all activity to acquire it as a structuring signifier. Yet, we see indicators of the master signifier operating relationally to the habitus in perceptions and evaluations of self (*view the world, the way you view other people in relation to yourself)*.

Following this response, I ask Ari, "*Can you tell me a bit about your own mental health?"* In their answer, the dominance of the master signifier "*money*" is even more present as it is repeated in the text 11 times. However, now the master signifier not only drives practice but is impacting mental health.

> *I worry a lot. Umm… anxiety is sort of just part of my personality at this point. I have a diagnosis for anxiety, right, so like I have anxiety. But also, I am an anxious person by nature. And a lot of it comes from being constantly aware of like how much money do I have, how much money do things cost, how much money am I spending, how much money am I willing to spend, can I save money? And so, I think about money literally all the time. Like, there is never a point in my day where I am not thinking about money, and it's not because I want to, it's because I have to, because I don't want to fall further down the ladder from where I am now and go back to where I was as a child. Uh, I don't like that kind of insecurity in my life, and I'd like to avoid it at all costs. So, I work really hard every day. I get up in the morning, my feet hit the floor and the first thing I'm thinking about is what do I have to do to be successful today so that I can be successful in the future, so than I can get a job at which I can be successful at so that I can make an amount of money where I don't have to worry about money anymore! Umm… which is a trick question because I'm always going to be worried about money, I'm never going to stop worrying about money!*

Here we see an escalation of the practice, where the master signifier drives anxiety, and vigilance becomes habitual and a key frame in which subjectivity is attached to "*personality"*. In the last extract, "*personality*" is associated with "*money*". Here, "*personality*" is now paired with "*anxiety",* but the anxiety is driven by the master signifier "*money*". With the master signifier attachment to subjectivity, Ari's daily endeavours are to acquire it, as there is anxiety associated with their past positionality, where "*money*" or the associated limited financial capital was linked to adversity, fear of which is carried by the habitus. While the text frames anxiety as derived from the master signifier, it is deferred by "*diagnosis*", suggesting the anxiety is a mental health condition and not generated by the drive to gain the valued master signifier. Thus, there is an awareness of its power, but without resolutions, Ari is caught by the master signifier in a double bind, the "*trick question"* that drives the split subjectivity and anxiety (*I'm always going to be worried about money, I'm never going to stop worrying about money!)*

This exploration of Ari's extracts points to a cyclical, but structured nature to their practice of subjectification that is driven by the master signifier "*money*". "Money", that which has power in the symbolic to structure capitalist society, is here internalised and drives a practice of subjectification that splits the subject. The Lacanian concept of capitalist discourse is a useful lens for seeing how the master signifier "*money*" functions as a repetitive organising signifier around which desire, anxiety, and self-evaluation circulate without resolution. In the text, there are the imperatives "*have to*" and "*all the time*", as well as the unanswerable '*trick question*", which formulations indicate a structurally endless orientation to the master signifier "*money*" rather than any stable endpoint. Here, the repetitive drive that structures the self around "*money"* splits subjectivity further as it can never be fulfilled. Instead, anxiety is centred around acquiring the master signifier to structure their subjectivity, as "*money*". Yet its value is illusory and can only momentarily be obtained in terms of subjectivity. Ari is caught in a cycle to obtain the valued capital that structures society to structure the self, in a practice of subjectification that never generates a secure subjectivity but one that is continually seeking what cannot make them whole.

7.4 The Other as Self

Throughout the practices of subjectification explored so far, the negotiation of signifiers has been fundamental to the participant's formation of subjectivity. This negotiation of

signifiers has been contextually situated by the class positioning of the subject. This practice operated in relation to interactions with other people, but also the Other in the social structures and institutions that formulate the symbolic register carried on signifiers. Signifiers of the Other are active, not only on an interpersonal level via discourse, but also in the signifiers of shared sociocultural knowledge of the habitus that transversely operates between the social and the individual by language. In what follows, the role of others, embodiments that give voice to the Other, is influential in this practice of subjectification.

Kevin, whom we previously encountered in Chapter 5 on resilience, has multiple voices from various others influencing his knowledge and attitudes about mental health and, consequently, his negotiation of signifiers of subjectivity. Crucially, Kevin's practice of subjectification is negotiated in the context of the shifting social fields of social mobility and the intersection of new social fields' doxa, forms of capital and his habitus. Yet, as before, we observe these practices occurring on interpersonal and structural levels of activity, and the negotiation of signifiers on the Imaginary register through intrapersonal practice. In the following extract, Kevin recounts a conversation with his father. It is important to note here that during the interview, when he quotes his father, he uses a strong working-class accent, which he also uses when recounting his internal dialogue.

> *I don't know if this is just an Irish thing, but there is this Irish thing of having notions, right? And I think that does come from class. Like, for example, I am planning a work meeting in Bali in two weeks' time, and I catch myself thinking "who do you think ya are!", you know? It's like "what are ya doin'?". And recently I was saying to me Da we are going out and he said, "Where ya goin'?" and I said, "Oh, this Thai place up the road", and he said, "It's far from Thai food you were raised, Son!" And so yeah, I think it affects your perception of the world. I would say I'm quite cynical in my thinking, and I can be a realist in my thinking to the point it can border on that negative mind frame. In some ways, I would say that I am super self-aware because when you grow up in these sorts of environments, you don't get to have notions, and your flaws are always put up for you to see, they are always reflected back on you. And so, I think that encourages some level of self-awareness, but also critical thought in terms of that inner voice not being the kindest. I think it encourages that kind of thinking, and I personally try to be better at that as well, you know?*

In the text, the judgment of others regarding aspirations and social mobility is framed as "*notions*". ("*Notions*" is a common Irish term for someone who displays delusions of grandeur, acts beyond their status or has grandiose attitudes regarding oneself). The signifier "*notions*" regulates Kevin's aspirations as it brings self-judgment. In Kevin's internal dialogue, we see the voice the habitus questioning his subjectivity and identity *(Who do you think ya are! ")* over his attempts to plan a work trip to Bali. This is embodied in the voice of the father,

which is perceived as judging him for dining in a restaurant outside his class norms. "*It's far from Thai food you were raised, son",* on the one hand acknowledges Kevin's success, while the other pulls him back, judging this success as it distinguishes him outside his habitus. The use of "*son*" to a grown man points to a position of dominance and judgment of the father holding him to account.

The evaluative signifiers operate internally as a subjective measure, as Kevin is "*super self-aware",* "*cynical*", and a "*realist*" in his self-evaluations. The "*negative mind frame"* holds Kevin to account by the sociocultural signifiers of his class, the "*inner voice"* that is the language of the habitus, which is critical of his deviations in class norms framed as "*flaws".* In this way, the discourses of his habitus act like an evaluative mirror in which Kevin is held by his ideal ego (the voice of his father) and an aspirational ego ideal and the sociocultural norms of the Other, those he encounters with social mobility. Self-acceptance and validation are never given as his achievements are conflicted by the transgression of sociocultural norms and class barriers, both in real terms with the comments of his father and the evaluative signifying schema of his habitus, the "*inner voice*".

As Keven continues, he describes his own mental health, and there is further tension with signifiers of self-criticism and self-acceptance linked to his background, but also his exposure to new social fields.

> *I think that there is a shame when you do have a mental health crisis, like "why can't I just pull myself up by my bootstraps, why can't I just get on with things, why can't I just get on with this by myself?" I think there's a shame because all you are told is "move along, we don't got time for all your bullshit". And that shame can turn into just a harsh voice, like it is imposter syndrome in some ways, like "why can't you get on with things, why are you different?" And I think that's not the case, and I have learned to embrace them, and for others, it's just more acceptable to embrace them. But in my upbringing, it just wasn't acceptable, and especially if I look at the male role models in my life. Like when my brother died, my Da barely grieved. Like he went back to work, and he was like to me, "you need to look after your Ma because she's not well and keep out of trouble now". There was no time to deal with my individual needs and wants, emotional strain, we all just had to get on with life and get food on the table, pay the bills. And that kind of carried with me, I think.*

Again, we note the reference to his father and the importance of "*male role models*" in the evaluative terms towards mental health, using the comparative example of his father's lack of grief and an expectation around how one should deal with not just daily stresses, but a "*mental health crisis*". The statement "*why can't I just pull myself up by my bootstraps"* is not only a class reference to bootstraps (those on the boots worn by labourers) but a practice of

emotional toughness, resilience and self-reliance associated with being working class. The evaluative frame "*bullshit*" categorises and devalues his suffering as a falsity and unworthy of attention. Interestingly, he stresses that this generates an "*imposter syndrome*", a reference to his lack of a unified self in relation to his mental health. His internal dialogue questions himself, "*Why are you different?*", holding him in contention for differing from the norms of his habitus.

There are also the generative socioeconomic conditions that formed his habitus, such as the lack of "*time*" to deal with mental health. "*Time*" is a valuable commodity needed for the everyday strains of providing for the family. This survival trumps all other activities and concerns, and again, Kevin uses the signifier "*bullshit*", but this time as spoken by his father. This points to the intergenerational transference of the habitus and the internalisation of signifiers that guide self-evaluations in terms of mental health practices. This is also present in the death of Kevin's brother, and the inability to grieve due to the demands of daily life and the struggles to "*put food on the table*", signifying the responsibilities of supporting a family, those who gather around his "*table*". Yet, there is a contradiction in the text, as Kevin accepts these norms, as indicated when he states, "*I have learned to embrace them",* a reference to his struggles with mental health. He acknowledges that for "*others*", perhaps with a different habitus, this may be an easier task, suggesting the effort of defying his habitus norms.

For Kevin, the very essence of his mental health is focused on his selfhood, so much so that the focus of his therapy was subjectification. Below, he describes how significantly his mental health was affected and the therapeutic process he engaged in when I asked him, "*When did you decide to get help, and who did you see*?"

> *Well, as I said before, I never reached a point where I was suicidal, but if suicide is a cliff, I was ten meters from that edge. And so, I felt that before it progresses, I need to do something proactive, and that's when I started therapy with a psychologist. And I think throughout that process I have learned a lot about like medication, journaling, I do a lot of journaling now, controlling that inner voice and making it be a little bit kinder. Knowing myself, setting boundaries for myself and all these things that I didn't do before that affected me negatively.*

Now there are elements of precariousness, as it is clear Kevin struggles with his self-concept, evident by Kevin's therapy sessions, which focus on a negotiation of signifiers by shifting his internal dialogue to more positive terms (*controlling that inner voice and making it be a little bit kinder*). However, his practice of subjectification is an intersection between the signifiers of his habitus (*inner voice*) and the voices of the Other from new social fields, including that of the therapist (*proactive, meditation, journaling, setting boundaries*). As such,

Kevin's social mobility and his availing of mental health services push him towards signifiers of self that are in line with the discourses of the doxa of those social fields, while he is still held by the signifiers of his background. As he continues, we see how these signifiers push and pull him between stigma and self-acceptance of being a split subject.

> *I definitely think there is a stigma in the lower classes with dealing with that, like dealing with your emotions. Like with getting professional help, and even to this day, like I wouldn't… I wouldn't share it with friends, and obviously, my wife knows. But like with people in my work, I'd share with them that I see a therapist regularly, but I wouldn't share that with my siblings. Umm... which is funny in some ways.*
>
> R: Why not?
>
> *There's a general umm… what's the word... I don't know… It's like notions, right, like "you pay how much to someone to talk about things!" I think it's that attitude towards it. I think there is an attitude where people feel… maybe I am projecting my own perceptions in some way, but I think people look at it, in my family, would look at it as a weakness, you know, like "deal with it yourself" kind of way.*

Importantly, this perception drives self-stigma and shame. Yet these are not the actual comments from others, but perceptions based on internalised signifying linguistic norms. Perhaps these comments were once heard in his generative social fields, but now they are internalised into his habitus, guiding negotiation of signifiers that construct the self. This self-stigma hinges on signifiers and class-based narratives (*you pay how much to talk about things! Deal with it yourself).* Here, getting help is framed as a "*weakness*", a deviation from the working-class masculinity and stoicism held by his habitus. Again, it is language that guides who is trusted to share his experience with (*wife, people in work*), and who is perceived as unsafe and will judge him (*friends, siblings, my family*) based on the perceived habitus of others.

From this series of extracts and references to Kevin's account of resilience, it is clear that his mental health is central to his subjectivity as he locates his identity around the management of his distress, negotiated between multiple competing signifiers. On the one hand are those of his sociocultural class background, embodied in the voice of his father, his siblings and his friends, internalised in the habitus. On the other hand, there are those of mental health services that provide him with alternative signifiers of mental health. These competing discourses intersect in his internal dialogue as he struggles with his subjectification and the development of a new identity after social mobility. In a Lacanian (1936) sense, we can see the splitting of the subject through competing narratives of self and what Bourdieu (2000) referred to as the cloven habitus, where social mobility generates a splitting of the habitus. This splitting

(of the subject and habitus) produces tension for Kevin that causes further distress. In turn, the distress from the tension of the signifiers of old social fields competing with those of the new is held to account again in a cyclical process of subjectification. Here, Kevin is torn between the demands of two others, that of the ideal ego and the ego ideal, where pleasing will fail to fulfil him as a lacking subject.

7.5 Chapter Summary

The preceding chapter discussed practices of subjectification and the associated effects in terms of mental health. Through the critical analysis of the language of a series of extracts from three participants, the processes in which the practice of subjectification occurred were accessible. For these participants, their practice of subjectification was an interaction between signifiers of their habitus, social structures, social fields and discourses of other social actors they encountered. Critically, this interaction was at all times mediated by signifiers. As the processes of subjectification operated as practice, the signifiers of subjectivity acted as cultural and symbolic capital, and were not only performed for others, but for the Other to meet the hegemonic presentation of mental health attuned to the social fields they encountered. When signifiers of subjectivity were not aligned with the habitus or the doxa of an aspired trajectory, tensions arose, splitting subjectivity and consequently affecting their mental health.

These accounts suggest that subjectification operates as a practice through which mental health is actively managed with the negotiation of and with the signifier. Participants do not merely express identities, but their subjectification is a mediation of signifiers that pivots on classed, gendered, and institutional demands. Mental health suffering emerges not only from adversity, but from the sustained labour of maintaining a viable subjectivity within an often-conflicting symbolic order. Importantly, this practice is presented in the data as a cyclical and dialogical process in which experiences of mental health influence subjectivity, which was then reciprocated with consequences for mental health. This suggests that subjectification is in itself a key feature of the practice of mental health, shown by the participants' practices of resilience and recovery that influenced their subjectivity, and reciprocally, their subjectivity shaped how they practice resilience and recovery. Yet, at all times, the vector of this practice was language, the signifiers that guided these accounts of mental health and subjectification.

8. Discussion

8.1 Introduction

This thesis argues that mental health lived experience, as interpreted through participants' own verbal accounts, is best understood as an actively performative practice that is intelligible with respect to social class habitus – constituted by fields, doxa, and forms of capital, and by the values that emerge through their interaction. This practice is bounded by material, economic, and sociocultural-historical circumstances that are productive of identities and dialogically constructed self-other narratives through structural, interpersonal, and intrapersonal discursive processes. The identities and narratives that emerge are negotiated within competing mental health discourses that express hegemonic tensions, particularly where distinct and often incongruent class habitus intersect.

Consequently, the expression and management of mental health symptoms are tied to discursively-formed identities and articulated within differently-valued discourse frames which are organised by hegemonically privileged "Master signifiers." Such signifiers do not merely represent suffering, but participate in its constitution and intensification by attaching semiotic value to the performed self-image in relation to the big Other. This indicates a desire for the signifier as enabling a valued (with respect to the Other) self-image, potentially superseding the desire for the reduction of suffering (e.g., performative "resilience" and "recover"). At the same time, participants' accounts reveal the structural limits of language, which both enable and constrain self-representation, producing a split subject whose identity remains incomplete and indeterminate. This constitutive incompleteness generates a structural lack that fuels the ongoing desire for symbolic recognition by the Other through the signifier.

The following is a discussion of findings that emerged from an integrated Bourdieusian-Lacanian analytic framework applied to class-based accounts of mental health. It summarises these findings and interprets them in relation to existing literature on mental health and social class and provides the implications for the theorisation of mental health as social practice. Implications include its usefulness in expanding the knowledge base regarding mental suffering and recommendations for social and mental health policy, institutional practices, clinical work and professional discourse. This chapter also addresses the limitations of this study that are productive tensions inherent to interdisciplinary and critical research, but can indicate future

directions for research and methodological development. This study offers an alternative conceptualisation of mental suffering that moves beyond the individualising narrative of frameworks dominant in neoliberal mental health discourse. One that is ethically centred and accounts for the individual's position within society and their exposure to inequality.

I argue that mental health is best understood as a socially situated practice rather than an individual psychological state, with the term *practice* used here in the Bourdieusian sense referring to activity structured by habitus, field (doxa) and capital, mediated by discourse and symbolic demand. In the analysis of participants' accounts of their mental health experiences presented in the preceding chapters, a Bourdieusian-Lacanian framework facilitated an interpretation of mental suffering – that emphasised the roles of (and interaction between) discourse and desire – as something produced and organised through habitus-mediated negotiations of and with key signifiers and within and between class-delineated social contexts. Practices of resilience, recovery, and subjectification, in particular, were shown to be shaped by hegemonic norms that traversed the psychological and social spheres. Subjects negotiated signifiers of conflicting expectations, identifications, and desires relationally within symbolic structures of social class. Analysed from this perspective, mental health is not only influenced by social and material conditions but structured by the sociocultural knowledge of the habitus. This presented as an ongoing dialogue with discursive and symbolic voices and structural pressures organised social and mental life, rendering suffering intelligible relative to the demands of the symbolic Other, rather than the lived terms of the (split) subject.

8.2 Summary of Results

8.2.1 Reflexive Thematic Analysis: The Mental Health Cycle

Chapter 4 presents the results of an RTA, which identified a mental health cycle occurring across three overarching phases of resilience, recovery and subjectification. These three phases were not distinct but appeared as a continual process where adversity is experienced, resilience is performed, it may protect or fail, and mental suffering occurs. Often, as a result of diagnosis, but also in the absence of diagnosis, recovery strategies were performed based on diagnostic signifiers acquired through mental health services or circulating in public discourse. The processes of the observed mental health cycle were a key facet on which subjectivities were formed. This suggests the impact experiences of mental health have on subjectivities in the processes between resilience and recovery. As such, they are cyclical, but

complex and ambiguous, anchored to the guiding principle of the habitus operating within classed contexts.

In terms of resilience, the themes implied that resilience is a socially valued and normatively expected practice that is nonetheless experienced as ambivalent and often psychologically costly. Similarly, recovery was a class-attuned social practice structured by diagnostic legitimation, normative expectations of coping, and differential patterns of help-seeking. Both resilience and recovery themes indicated a valuing of individual responsibility oriented toward outwardly showing socially acceptable mental and behavioural states rather than addressing structural conditions that exacerbated mental suffering. This ambivalence and nuance in terms of resilience and recovery imply that how these concepts are conceptualised in the literature may not fully capture all aspects of resilience and recovery experiences.

The final themes identified related to participants' formation and displays of subjectivity. Here, subjectivity was class attuned by the guiding principle of the habitus, but also from experiences of mental health. As such, there is a *nexus*, or point, where the social-cultural knowledge of the habitus and the experience of mental health intersect when producing subjectivities. Yet, at this same point, subjectivity impacts subjective mental health perceptions, showing how subjectivity reciprocally and dialogically intersects with mental health. This means that mental health and social class have a lasting and enduring effect beyond the initial performances of resilience, recovery, and class-based conditions, but that these experiences leave their mark, shaping subjectivities and future mental health outcomes.

8.2.2 Critical Discourse Analysis: The Practice of Mental Health

The cycle of mental health, comprising resilience, recovery and subjectivity, is a useful frame for understanding processes relating to mental health experiences. Yet, what was found with the RTA was significant ambiguity and complexity within the themes and subthemes on which the mental health cycle is conceptualised. While accounts regularly displayed this cycle, there were variations between accounts in terms of how resilience, recovery and subjectification were presented, suggesting a deeper level of analysis was warranted, in particular to explore the meaning and implications of such variations. While emergent themes resonated with those in the literature, they also highlighted the need for closer investigation of the structural and material conditions underpinning the mental health process. As such, the next stage of analysis was to critically analyse the language from participant accounts of mental health. Findings presented in Chapters 5, 6 and 7 showed not only the aforementioned mental

health cycle, but that the processes of this cycle can be viewed as social practice. The analysis suggests a habitus-mediated negotiation of *and* with signifiers that shaped resilience, recovery and subjectification practices within class-distinct contexts of social fields and capital.

Accounts of resilience reflected multiple practices, a negotiation of and with signifiers shaped subjectivities while dialogically mediated by the habitus, fields and associated doxas as well as various forms of capital. This reflects the contextual boundedness of resilience that was noted by Chisty et al. (2021) and Unger (2008,2011), and potentially could explain why there are such variations in resilient practices across cultures, as reported by MacLachlan (2006). This highlights the variations in signification associated with signifiers of resilience that are likely to exist in different cultural groups, including those of social class, due to the variations in meaning tied to language that would produce diverse negotiations of signifiers and related outcomes.

Yet, while this negotiation of and with signifiers that guided resilient practices, it was a continuous attempt to capture that which has no fixed meaning and cannot express the truth for the subject due to what Lacan (1977) described as the semblance of language. In this regard, resilience can be viewed as a practice that is often best characterised as a performance of identification with "resilience", the signifier. These practices were attuned to the habitus but were also held by the demands of the Other reflected in the ego ideal, especially when social mobility was a factor. This illustrates how the signifier, "resilience," operates as a master signifier and a site of tension between classed dispositions and symbolic demands, particularly under conditions of social mobility. Across various accounts, resilience was shown to be a finite resource and a costly practice to maintain. In this regard, distress centred around the desire for the master signifier "resilience," yet the semblance of signifiers in the negotiations to shape subjectivity produced tension between the ideal ego and the ego ideal. While practices were performative of resilient norms, this intensified distress rather than alleviating the strain that the practice intended to address.

Similarly, the concept of recovery was often framed as less of a state defined in relation to a change in the presence or severity of suffering, but a practice of gaining and maintaining recognition through identification with the "recovery" and other related signifiers. This was particularly the case with participants' negotiations of mental health services, where signifiers of the biomedical model set recovery norms and aims that participants strived for, often seemingly regardless of whether the practice resulted in a lessening of distress. On the one

hand, the alignment to recovery norms brought initial relief from distress due to the alignment with the Other. This is similar to what Szasz (1979) discusses, in relation to the benefits of diagnosis by affirming one's suffering, which, for some, may have the potential to promote recovery initially. On the other hand, as this is an alignment with an Other which has significant power to shape mental health norms, the discourse of the biomedical model is similar to the warnings that Foucault (1976) gives regarding biopower and how discourse can shape subjectivities through mental and behavioural adaptations to these norms.

In other words, recovery practices were structured around biomedical signifiers that prioritised normative functioning over the alleviation of distress. These were often performative practices done to meet the demands of the Other, carried by discourses of recovery from capitalist mental health norms, such as the performance of choice. Subjectification was also practised as a means of recovery. Here, new identity frames, hinged on signifiers that provided recovery when distress was associated with identity and shifting subjectivities, which in some cases provided an initial recovery when subjectivities aligned with ego ideal demands. Yet these were transient as the demands of the Other, in terms of subjectivity, are always shifting around signifiers and the lack. While recovery practices centred psychologically on negotiating signifiers, the other elements of practice were the grounds for this negotiation in the social fields of mental health services, in the interactions with others, and in the internal dialogue of the individual participants.

While subjectification was a key feature of some recovery practices, it was explored as a distinct process of the practice of mental health in itself. Across analyses, subjectification was a central structuring process linked to mental health experiences and outcomes. Subjectification is viewed as a critical practice in the mental health cycle, consisting of identification with key valued signifiers that shape self-concepts and identity frames, influencing subjective evaluations of mental health with cyclical consequences in terms of self-esteem and self-stigma. For example, where acquired signifiers conflicted with participants' imaginary identifications, or what Lacan (1977) refers to as the ideal ego, tended to be organised around a performative compliance with the expectations of the Other and the classed dispositions of the habitus in terms of mental health and behavioural norms. In other accounts, it was the signifiers that structured society, those of class distinction, that also structured internal subjectivity and identity frames. Subjectivity was also shaped through the influence of the Other, as interpersonal relations carried signifiers that structured participants' ego ideals and expectations of self. Across accounts, practices of subjectification centred on this

negotiation of and with signifiers, generating tension where symbolic demands conflicted with imaginary identifications within the constraints of the habitus, producing or exacerbating mental suffering. This, in many ways, is similar to what Bourdieu (1997) describes and the incongruence of habitus when a split, or cloven habitus, develops due to social mobility.

8.3 Interpretations of the Practice of Mental Health

This study is situated within a well-established body of research regarding the relationship between social class and mental health. While research suggesting this relationship has informed social and mental health policies leading to the development of interventions to address the issue of mental health inequalities of class, the inverse relationship is still reported in research. Marginalised class groups continue to have higher rates of diagnosis with mental health conditions (Barnett et al., 2023) and associated poorer overall mental health outcomes and higher mortality rates (Chen et al., 2025). This suggests that the relationship between mental health and social class needs further inquiry and conceptualisation in a manner that accounts for the influence of social class beyond the level of socioeconomic measures (Cohen, 2017). Currently, the biomedical model hegemonically theorises mental health as an individual neurological and psychological phenomenon, and social class as an external socioeconomic context linked to risk factors. This study proposes something different. It argues that what is commonly understood as 'mental health' is more productively theorised as a social practice involving the continual negotiation of and with signifiers on multiple levels within class-based contexts and class-distinct positionalities.

This new conceptualisation of mental health was derived from this study's theoretical framework were the facets of the mental health-social class relationship were accessible from different and deeper angles. Here, the habitus could be viewed in its action as a guiding principle shaping experiences psychologically, socially, and structurally. It wasn't just that the habitus functioned as a guiding principle on mental health experience, which was already a precedent, as Bourdieu (1977) argues that the habitus does so on all experience and activities that comprise practice. But *how* the habitus guided practice was not fully addressed by Bourdieu, particularly on a psychological level, despite his claims as to the cognitive nature of the habitus. However, by incorporating Lacanian theory to explore the mechanisms and processes of practice carried on language in relation to these mental health accounts, practice in itself as a concept is developed further. Not only does this theoretical and methodological lens reveal that language mediates practice, but it does so in a dialogical relationship where

structured tensions between signifiers organise experience across psychological, relational, and structural contexts.

Signifiers acquired through social discourse operated psychologically, framing how participants understood adversity and distress and critically how they viewed and valued themselves. For Lacan (2011a), this process of signification was more than the simple adoption of signifiers that shaped experience, but was constitutive of the subject itself, in a seamless linguistic relationship between the subject and the symbolic. In many ways, this is akin to how Bourdieu (1977) argues the habitus is formed, yet he views it as the conditioning effects of socioeconomic conditions and the socialisation of class culture, without noting the mechanism for the transference of the external social world to internal psychological planes. With the addition of Lacan's (2011a) theory of the subject, we can now see how language is the vector that brings the external social world to the internal psychological plan to operate as the shared sociocultural knowledge of the habitus by the unconscious formation of the subject by signifiers of the symbolic.

While the incorporation of a Lacanian lens allows for insight as to how the subject and the habitus are formed, it also applies to how practice operates or what Bourdieu (1990) refers to as the "logic of practice" (p. 23). For Bourdieu (1977), practice was a complex interplay between the habitus, social fields (and their doxa) and the various forms of capital. This was very evident in terms of practice, even in relation to mental health practices observed in these participants' accounts. For example, how much financial capital participants had determined the types of mental health services they accessed, and their habitus guided their interactions with mental health workers and their negotiations of the social fields and doxa of these institutions. Yet, here again, the picture in terms of practice seems incomplete if we consider how capital and social fields are only symbolic and do not exist outside the relationships of social reality. Likewise, the habitus operates on signifiers of the symbolic, as argued above, and thus practice in its logic, or operations, as Bourdieu (1990) describes, is tied to the symbolic power of language, and this we see in the participant accounts negotiation of the symbolic by a process of signification.

However, it is vital that, in terms of practice, we must not assume that these processes and negotiations happen on neutral terms, but rather on symbolic terms that are comprised of hierarchical power structures symbolically formulated, but with real outcomes. The outcomes show the connection between the Symbolic registers as symbolically maintained relationships

result in consequences in the psychical world as described by Zizek (2014). Here we see this when the symbolic generates real lived effects in the material conditions of class and the psychical manifestations of suffering, as we saw reported in the participant accounts. As such, the negotiation of signifiers that account for practice is where power operates, is maintained and reproduced. By employing the critical analysis of language as I did here, the power structures of the symbolic relating to class that operated through practice to produce suffering were revealed and found to be carried on the signifier.

In these accounts of mental health, certain key signifiers could be seen to possess social value for the subject and thus served as desired objects of identification to achieve the recognition of the Other. In other words, to have a signifier such as “resilient” linked to one's identity is desirable regardless of one's actual capacity for resilience. Furthermore, participants were oriented towards them in a dialogical relationship where meaning was subjectively derived and guided by the habitus. However, signifiers do not have power in themselves, but are acquired through symbolic values that are given to the signifier by the subject, but only by those who have acquired the habitus that enables a recognition of the signifier's symbolic power relevant to the social field and associated doxa. Bourdieu (1991) stresses this symbolic power that language has within the social realm and the associated consequence of failing to recognise this symbolic order. When a participant's habitus was lacking in the sociocultural shared knowledge to recognise the symbolic power of a signifier, specifically classed attuned doxa carried on discourse, symbolic violence occurred with distress. This is similar to what Charlesworth (2000) argues, as symbolic violence has a profound effect on the individual’s sense of identity and how they value themselves, a reflection of how they are recognised and valued in society.

Considering this power given to the signifier and the associated effects of symbolic violence, we can see how a practice that is mediated by a negotiation of the signifier impacted the mental health experiences and outcomes that we saw in this study. This was particularly the case with the master signifiers “resilience” and “recovery,” as these were powerful signifiers with socially ascribed value and thus desired by participants. However, what each meant in terms of structuring the subject and their practice was dependent on habitus-guided significations set within the social fields they occupied. As the split subject desires recognition and identification with the Other, they attached their subjectivity to these master signifiers, and as such, the power of the signifier is driven by the lack, that which the subject desires to fill.

Consequently, the power associated with the signifier is given by the identification with the signifier by the participant and thus has powerful effects in terms of subjectivity and individualised practices of mental health. So, on the one hand, due to the classifying nature of the distinctions in habitus to form class groupings as was argued by Bourdieu (1987a), these practices could be considered as class distinct. Yet here I argue this cannot be taken for granted as the habitus is distinct to the individual and if practice is a subjective negotiation of signifiers, the practice is distinct to the individual subject and their position in the symbolic, as Lacan would argue (1977, 2011a). As such, power first operates by the transference of public discourse, such as with master signifiers, but the individual must recognise this power. Secondly, signifiers can have power that is only relevant to the individual subject's Imaginary that is guided by the habitus and a personal sociocultural and historical history. In this way, power operates within the structures of practice but is attuned to the individual subject.

Throughout the participant's practices of resilience, recovery and subjectification, the consequences of power given to signifiers were clear. The signifier was not simply naming an object of desire but served itself as the object of desire, a stand-in for the Objet petit a, defined in terms of lack (Lacan, 1977). Thus, signifiers held participants to account, requiring them to conform and perform norms associated with resilience and recovery that may or may not align with their generative habitus and ideal ego. Desire was for signifiers which shaped subjectivities that would answer the what Lacan (2011c) refers to as the "Che vuoi" of the Other, demanding the aligning subjects to the symbolic order, but always relationally to their position in the Symbolic. As stated before, in terms of one's symbolic positionality, this is intersectional and related to any manner of socially constructed categorical characteristics of subjectivity. The positioning characteristic that was focused on in this study was social class (as understood as distinctions of habitus) set within the context of a neoliberal economic and social Symbolic order, where practice dialogically operated.

8.3.1 Mental Health as a Dialogical Practice

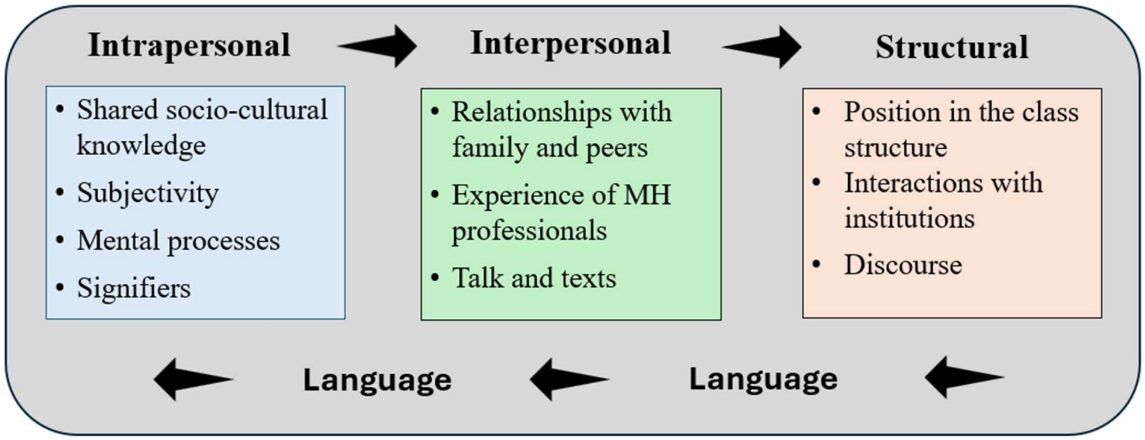
Building on the preceding conceptualisation of mental health as a signifier-mediated social practice, here I specify the dialogical processes through which practice operates, articulating how signifiers traverse psychological, relational, and institutional contexts to organise experience and produce or exacerbate suffering and mental distress. As I suggested that mental health is a practice, this means that it functions relationally to class-specific environments and circumstances. While Bourdieu (1977) provides the structural-relational features of practice, he does not go as far as to state the processes and mechanisms by which

practice operates. However, by applying this study's synthesised framework, particularly the addition of Lacan's (1977) work on the three registers, I extended Bourdieu's work but also applied it in a manner that proves useful when combined with other theoretical positions. Here, Bourdieu's (1977) theory of practice is synthesised with Lacanian theory (Lacan, 1977), but also gains insights from Foucault (1969) on discourse and power and Vygotsky (1980) on the language-mediated internalisation of sociocultural and historical facets. With this theoretical synthesis applied to a methodological framework, the analysis gave new, theoretically driven insights that provide a different conceptualisation of mental health. One viewing mental health as practice where the dialogical relationship between social and psychological phenomena is understood with depth, as well as capturing aspects of these accounts of mental health in their activity in the imaginary, symbolic and real registers (Lacan, 1977).

Figure 7 provides a useful visualisation summarising the theoretical conception of practice as a dialogical relationship between intrapersonal, interpersonal and structural realms that are a socioculturally situated and language-mediated activity. On the intrapersonal level, mental processes are consciously and unconsciously negotiated by and with signifiers. Yet, signifiers are acquired by interpersonal interactions in social fields, particularly through talk and texts. Even engaging in language itself is an interpersonal dialogical process, as when we use language, we are always addressing another, that being language itself (Bakhtin, 2010). As language functions as the primary medium through which practice is negotiated, enacted, and reproduced, it is an interpersonal yet structural process, as by language we engage with the Other. However, the Other is not simply reducible to language, as doing so risks reification, as it is also the symbolic order carried on language in institutions, laws, knowledge and societal norms. When subjects engage with language, they do so in relation to the Other, encountering symbolic demands that structure social relations, institutions, and hierarchies, traversing the symbolic to the psychological, which are then reproduced by practice.

Figure 7

The Dialogical Practice of Mental Health



While the theoretical concept of transference of sociocultural phenomena to psychological by language is common within social constructivist and sociocultural approaches (Bruner, 1990; Geertz, 1973; Vygotsky 1080, 2012), it is from the critical analysis of the language performed here that the dialogical nature of *practice* emerged, illustrated by the processes through which a *signifier-mediated practice* of mental health operates. Signifiers carry the symbolic structure of social fields into interpersonal interaction, mediating classed norms, expectations, and forms of capital. These signifiers are subsequently internalised as part of the shared sociocultural knowledge of the habitus, shaping mental processes and providing the conditions under which desire is driven, and mental suffering emerges. Furthermore, the internalisation of signifiers comes from a fluid and shifting Symbolic, and therefore it is a continual process rather than a finalised state (Lacan, 2011a). Through these dialogical processes, tensions arise, driving subjectivity to further evolve as it pursues the fulfilment of the desired Objet petit a, which is an illusion created by the Other and will not fill the lack within the split subject. As such, the process is never finalised, and suffering is continually reproduced by the dialogical process between the Symbolic structures and subjectivity, resulting in the splitting of the subject by language.

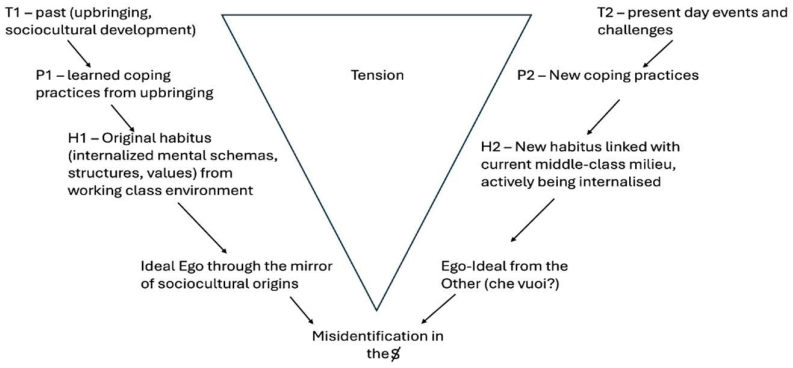
8.3.2 The Cost of Practice

The above discussion highlights how what is known as mental health is less of an individual psychological phenomenon and more so a social practice attuned to sociocultural

contexts and class positionality. However, the practices of resilience, recovery and subjectification were not devoid of consequences and came with some associated costs. For example, across all practices explored, performativity aligned the subject with mental health and class-based norms in ways that generated additional mental, social, and material costs, furthering distress. For example, if there was an incongruence between class district norms and signifiers of mental and behavioural social norms, then tensions between the differences intensified subjective divisions as subjects attempted to sustain coherence under incompatible symbolic demands (see Figure 8). Again, this can be related to what Bourdieu describes as the split or cloven habitus, where competing doxa from new and old social fields are internalised, creating conflict within the habitus. In the cases seen here relating to mental health, the very practices that were supposed to mitigate distress, those of resilience and recovery, instead generated or magnified distress while aligning subjectivities to these performative norms.

Figure 8

Illustrative diagram showing the practice of mental health in the context of social mobility.



Note. T1 and T2 refer to past and present time points, P1 and P2 refer to distinct practices, and H1 and H2 refer to distinct presentations of habitus.

A further cost came from the alignment to signifiers that, in their performance as practice, supported and reproduced the very inequalities that generated the distress, or what Charlesworth (2005) refers to as "social suffering". Similarly, Chandler and Reid (2016) argue

that neoliberal capitalism, both as an economic and social system, requires greater levels of resilience through adaptation to ever-increasing demands. Yet, as we saw from the analysis of accounts in this study, meeting these demands resulted in vulnerability, as performativity compounded the distress that the performative practices aimed to address. Through practice, hegemonically valued signifiers associated with mental health biomedical models reframed socially produced suffering as individual pathology, responsibilising subjects for their limitations of resilience and recovery and extending engagement with often ineffective interventions. Not only does this generate stigma, but often the engagement with pharmaceutical and therapeutic interventions, which are found to be ineffective and can come with significant side effects (Moncrieff, 2008), prolongs suffering, and the engagement with the service, at high financial and personal costs.

This aligns with Cohen's (2025) reference to "neorecovery", where neoliberal ideology infiltrates mental health services, shaping recovery to be performative of the market logic. While this resonates with earlier critiques of biopower (Foucault, 1976), this study extends such accounts by suggesting that specific signifiers mediate these processes at the level of practice, linking social discourse directly to psychic suffering. Participants in this study were found to be bound to a painful repetition oriented around maintaining symbolic recognition that was partial, ambivalent, and costly. Here we see what Lacan (1977) refers to as Jouissance in many of these accounts in the excessive and painful satisfaction derived from the labour of maintaining identification with the symbolic. Desire is sustained by lack that is structured around the signifiers that formulate subjectivities, but with Jouissance emerging from the repetition and suffering that accompany the attempts to live up to the structuring signifiers.

Critically, it is the surplus enjoyment that the Other derives from this repetition in the chase for desire (desire that is of the Other) that results in the subject having to be more resilient, recover faster, work harder, consume more and conform subjectivities to the market logic of the neoliberal Symbolic order. Ultimately, the cost of this practice is paid for by the individual subject while the Other profits. It is this surplus enjoyment or the profit derived from this repetition of the practice of mental health that drives inequalities and suffering that maintain the Symbolic order of neoliberal capitalism and the hierarchical class system by the internalising of capitalist discourse as subjectivities (Vanheule, 2016). This has significant implications, not only for how mental suffering is addressed on an individual level but also for how this suffering is addressed on a societal level.

8.4 Implications and Recommendations

The implications for this study's theoretical contributions not only expand on the knowledge of how mental suffering is understood, but also practical applications that could be implemented in mental health services and therapeutic interventions, as well as informing mental health and social policies that would at least reduce the suffering described in the previous section that is associated with these practices of resilience, recovery and subjectification. Below, I explore these implications and make recommendations as to how this study's contributions can be used on a practical level, and critically, how this study's findings can foster social change.

8.4.1 Research, Knowledge and Discourse

This study broadens the knowledge by creating alternative narratives and discourse regarding mental health, but also social class. It suggests the influence that economic and material conditions have on mental health experiences, which contributes to the existing mental health literature that makes this claim. It also highlights the sociocultural influence of class on these experiences, particularly class-based values and norms and the mediating role of the signifier in suffering associated with mental health accounts. These findings develop on the literature that has found the inverse relationship between mental health with both SES and SSS indicators (Businelle et al., 2014; Das-Munshi et al, 2012; Faris & Dunbar, 1939; Muntaner et al., 2000; Muntaner et al., 2004) as well as lived experience research on mental health (Morris, 2016; Varela et al., 2017; Sartor, 2023) and social class (Charlesworth, 2001, 2005; Willis, 2017). However, this study is a reinterpretation of this knowledge as it focuses on the internalisation of sociocultural knowledge, values and norms operating psychodynamically via language rather than as an external confounding variable and thus explains the mechanisms and processes that establish the relationship between mental health and social class reported in literature.

This study suggests that when mental health is conceptualised as practice, we see how what is understood as "mental health," framed as a psychological phenomenon, is actually interconnected with all the dialectical features of society through language. This means that an individual cannot be held solely or morally responsible for the presentation of their mental health, shown here to be reflective of the social forces shaping affluence and inequality. This stands in contrast to dominant biomedical and individualised models of mental health, acting as what Lacan (2007) refers to as the discourse of the hysteric, as through its alternative

narrative it questions this dominant knowledge. As such, this interpretation of mental health as practice offers a mode of resistance in line with Gramsci's (2007) counter-hegemony, where dominant groups' power and ideology are challenged by creating alternative narratives that question and undermine the existing social, political, and economic order. As such, theorising mental health as practice has valuable implications for reducing social and self-stigma, fostering more equitable interventions and informing mental health and social policies, which may challenge the neoliberal social order that contextualised the mental suffering explored in this study.

8.4.2 Mental Health and Social Policies

This study focused on phenomena related to mental health inequalities associated with societal class structures. Policy reforms are recommended to be from a bottom-up approach, community-led, with representation from marginalised groups and greater access to the democratic processes that generate policy. Changes to policies, at a minimum, could help to mitigate the effects of adversity associated with social inequalities that contribute to mental health inequalities. For example, fairer taxation, a living wage, enhanced social welfare supports, and access to high-quality, social and affordable housing would lessen adversity related to abject poverty and substandard living conditions. Supportive pathways would provide equality of access to individuals from lower socioeconomic backgrounds to engage with employment and education, thereby facilitating social mobility.

However, the critical theorisation of mental health argued here and the literature that stresses the limits of social mobility in terms of mental health benefits (Bottero, 2013; Das-Munshi et al., 2012; Islam & Jaffee, 2024; Kim et al., 2023; Simandan, 2018) suggests the constraints of policy reform within capitalist social relations. Considering the forms of social suffering identified in this study that are not only structurally reproduced but intrapersonally and interpersonally maintained, as illustrated by the signifier-driven responsibilising and performative practices, social policy reforms would be limited in their effect. This is because neoliberal ideology is embedded in what Fisher (2009) refers to as “capitalist realism”, which operates as the acceptable and common logic and knowledge, and according to Fisher, is beyond the reach of social policy changes.

Perhaps then, where most benefits can be derived with real effects, is by reforming mental health policies to encompass community engagement and participation. By moving away from the biomedical model’s focus on management of an individual’s symptoms of

distress and instead focusing on social and structural determinants identified by those within communities, supports could then encompass multifaceted interventions that account for an individual's life conditions that are socioculturally and structurally attuned and address the contextual adversity that generates risk factors and distress. Crucially, mental health policies must secure funding for these services and supports so that there is equality of access for all communities. As stated above, greater diversity in representation and participation within policy reform, not only in terms of social class groups, but also informed and co-created by service users, would reduce the hermeneutical injustice where those from marginalised backgrounds and with mental health issues are failed to be understood by those who generate and reform mental health policy. Doing so will foster more effective, if not ethically sound, mental health supports at all societal levels.

8.4.3 Clinical Practice

While the above policy recommendations suggest systemic changes and a community-based approach, this must be equally adopted in mental health services. As this study showed, participants, particularly those from underclass or working-class communities, found mental health services inaccessible and/or unacceptable. This aligns with findings from Sareen et al. (2007), where socioeconomic inequality of access is both structural, in the ability to afford services, but also relational in the attitudes toward services regarding their appropriateness and acceptability. These findings support a call for community-based mental health services and supports that are, firstly, publicly funded and accessible free of charge and not for profit, as well as provided on a local community level, and if relevant, cultural level. Secondly, services and supports should be designed and implemented by community members. However, these can be informed and guided by an interdisciplinary team of experts who are trained in cultural and structural competency to limit epistemic and hermeneutical injustice, but also to maintain rigorous evaluations of implementations and ethical standards.

Throughout this study, many participants' accounts displayed hermeneutical injustice, where a perceived lack of intersubjective understanding occurred due to a perceived incongruence of habitus in therapeutic relationships within mental health services of various types. This hermeneutical injustice was centred around habitus perceived distinction of class difference as well as an incongruency in linguistic habitus where negotiations of signifiers mediated the evaluations on intersubjective understanding. This highlights the linguistic contextuality of mental health, where suffering is socioculturally and structurally experienced through signifiers that are interpreted by the guiding principle of the habitus, which compounds

the already existing semblance of language as argued by Lacan (2011a). In this regard, it is not just the habitus of the service user but the habitus of the mental health worker active during the discursive events of the therapeutic relationship.

It is recommended that mental health workers account for these sociocultural contextualities by gaining insight into the contexts that the suffering may be rooted in, but also gain knowledge of the sociocultural elements of these contexts. It would be beneficial for mental health workers to have access to social supports that service users could be referred to if their suffering were deemed to be contextually driven by inequalities. This would provide for a more holistic service, enabling the mental health worker to address not only the symptoms of suffering but also the contributing factors. Additionally, as mentioned above, cultural and structural competency training would be beneficial in part, but also providing access to education and training for mental health workers from marginalised backgrounds, facilitating representation, both between and within communities at the service level.

As I employed a Lacanian-informed theoretical positioning in this study, I view the individual as a subject whose mind is structured yet split by language, where suffering is inherent to the human condition. However, therapeutic intervention can address and ease suffering when it is approached in a critically informed manner. This would mean taking a radical bottom-up approach at the therapeutic level and limiting reliance on objectifying conventional diagnostic resources and methods, and supplementing these with therapeutic approaches, not necessarily Lacanian, but any that recognise subjectivity, sociocultural and structural positioning, the influence of the habitus and the mediating role of language. On the one hand, this would provide for a more effective service, but also would function to reduce epistemically derived suffering associated with mental health inequalities not only in terms of occurrence and outcomes (Businelle et al., 2014; Das-Munshi et al, 2012; Faris & Dunbar, 1939; Muntaner et al., 2000; Muntaner et al., 2004) but also inequalities in diagnosis (Grab, 1997; Henderson et al., 1998) and treatment (Evans-Lacko et al., 2018; Kirkbride et al., 2024; Kohn et al., 2004).

As Parker and Cuéllar (2021) argue, change on a social level is an insurmountable challenge, especially for an individual mental health worker. Yet a critically and ethically informed therapeutic intervention can reduce suffering by altering the subject's orientation to signifiers, generating alternative narratives that challenge the hegemonic discourse operating *within and on* psychological and societal structures (Parker & Cuéllar, 2021). Critically and

ethically aligning therapeutic interventions in this manner has the potential to empower individuals within their communities, fostering potential liberation from oppression on both an individual and group level. These critically aligned interventions delivered equitably at a community level by ethically guided and socioculturally informed mental health workers will help to address the mental health inequalities that are maintained or produced by the current structure and function of many current mental health services and interventions, but also the context of the neoliberal symbolic order.

8.4.4 Future Directions

The implications and recommendations outlined above suggest that, in terms of the contributions this study makes, some future directions and developments can evolve from this research. On the one hand, if the recommendations were to be implemented, those of generating more community-driven and service user-informed policies and interventions, these would need to be evaluated in terms of their effectiveness, which would then develop the knowledge base further by either confirming what was argued in this study or that there is more research needed and more insights can be gained. One area where more development is needed is translating the complexity of findings in a manner that informs practice and policy to have a real impact. This is particularly relevant regarding the dialogical nature of practice in itself, but also the cyclical nature of the mental health cycle identified through RTA.

On the one hand, interventions, whether that be social policy or mental health interventions, should have dialogical effects in terms of structural, interpersonal and intrapersonal elements of practice, regardless of whether they are policy or clinical. For example, the development of structural competency training for mental health workers has the potential to change interpersonal practice for service providers and receivers, but also intrapersonal and structural practice through a change in the discourse of mental health when the structural determinants of mental health become part of the language in which mental health is discussed. This could have the potential to inform policy when they are service user-informed and community-led, which in turn changes the discourse which policies are informed by. However, any structural competency training programs, or other clinical, community or policy interventions developed would need to be researched and tested to ensure they are effective, ethical and equitable and operate to the greatest advantage for all stakeholders, but are particularly focused on those who are most disadvantaged and marginalised. Developing, testing, and implementing these recommended implementations that arise from the complex theoretical findings from this study is an area that I intend to develop further.

Importantly, the methods applied in this study could be used to investigate any number of other phenomena that are centred around socially constructed categorisations that shape the quality of lives, such as gender, sexuality, race, ethnicity, age and disability. In the same vein, as the synthesised theoretical framework presented here and the methods are a combination of existing and developed approaches, further research should apply them to evaluate their usefulness in their own application or combined with others. Bringing this research in future directions will develop the theoretical and methodological contributions further, but expand knowledge not only regarding mental health, but also other facets of the human condition.

8.5 Limitations

Like all research, this study has some limitations, and it is essential to consider these for transparency and rigour. Also, as this study's methodological and theoretical framework has yet to be applied elsewhere, and its theoretical contributions have yet to be challenged, stating the limitations can only support further research developments that will refine the arguments made here. Highlighting this study's limitations is valuable as it contextualises the arguments and provides clarity as to the challenges that arose in the application of methods, overall approach and the limitations of the implications of the theoretical conceptualisation and applications of the methodological contributions.

While this study had rich data that led to the theoretical contributions, these came from a relatively small sample of 14 participants. This could be viewed as limited, as a larger sample may have produced broader results, making the findings applicable to wider populations. However, as Boddy (2016) stresses, the sample size in qualitative studies is determined by the research design and contextual factors attributed to the data. Ahmed (2025) suggests that a sample size of 10 to 15 participants is acceptable when the research aims to capture the depth within individual accounts and experiences, and not observation across accounts and experiences. In this regard, this study examined *in-depth* the accounts of mental health within Western Anglophone countries, and interviews were on average three hours in length. As such, significant data was collected that held replication in terms of observations in the processes of practices, observed in the language of these rich texts.

While the sample was small, it had good representation in terms of age and gender identification and was suitable for the research question and aims of the study. However, there were some limitations in terms of a representative sample of class groups. While self-identified

lower-class, working-class and middle-class groups were represented equally, including several participants who had social mobility, I was unable to obtain participants who identified as members of upper-class or elite groups, despite efforts to directly recruit these cohorts. This in itself is an interesting finding that could be a fruitful area of future research, as these groups often are underrepresented (Bukodi & Goldthorpe, 2021).

A further limitation in terms of the sample was the lack of diversity in race, ethnicity or cultural variations, as all participants who responded to the recruitment campaign were Caucasian, English-speaking, and of Irish, English and American nationality. Despite the limitation in terms of sample size and representation, I argue that the mechanism and processes that pertained to the practices of mental health observed here, that of the mediating role of signifiers, are theoretically robust across contexts and populations, as it is a feature of human language. However, it is worth noting the limitation inherent to all studies that apply a qualitative method, the findings cannot be generalised to the general population, as they are distinctly related to the sample.

The critical approach taken here does come with a political and ideological stance. This could be interpreted as bias that skews the study to align itself with political and ideological predispositions. However, a critical approach was appropriate and necessary to deal with the subjects at its focus, as they are embedded within power structures and are not neutral phenomena. To address these features, this study intentionally operates under critical principles and acts as a form of social activism to highlight inequality, which is customary to the critical psychology approach (Fox et al., 2009; Parker, 2007) that this study adopts. It is fair to say that the critical approach does have limitations, as it contains researcher bias. This biased position is not denied here, and I argue that it is an inescapable, if not beneficial, feature of this study, as is the researcher's subjective positionality, which motivated the research design and provided for deeper insights. However, to monitor the analytic influence of this bias, it was reported for subjective transparency and reflective rigour, which is discussed in detail in Section 3.8 of Chapter Three.

It is worth discussing the challenges that come with the application of Lacanian theory to research that takes a critical approach and is inherently political. Lacan's (1977) theories were conceptualised with the intention of therapeutic use in clinical settings, primarily for psychoanalysis performed between the analyst (clinician) and the analysand (patient). Lacan was a psychiatrist, and it has been noted that despite his theories, such as the four discourses,

having elements of power as key components, he was not a political theorist and had little interest in his theories being applied as a radical theory justifying political activism (Newman, 2004). However, it can be argued that Lacan's theories prove useful within critical research as they place language at the centre of social relations, and thus this language can be analysed, providing insights into phenomena that are overtly political (Cuellar, 2018). In this regard, Lacanian concepts have been reformulated in line with critical discourse analysis principles, as has been done in the formation of the LDA methods of Cuéllar (2018), Neill (2013), Parker (2013) and Parker and Cuéllar (2014) and applied to politically topical issues such as apartheid (Hook &Vanheule, 2016), food insecurity (Swales et al., 2020) and climate policy (Tolis, 2023).

However, there is debate around the application of Lacanian theory in terms of its limitations in scope, with the application of what was conceptualised for the analysis of individual subjects' language not transferable to discourse relating to political practices and institutions. For example, Robinson (2005) criticises the use of "constitutive lack" in its applications in political theory. He argues that for Lacan, it was the subjectivity of the individual subject that was derived from lack, and by applying it to political phenomena, that of the social and not the psychic, distorts and stretches its utility. Robinson argues that when those who apply Lacan politically make this sublimation, there are not only ontological risks, but "political consequences, because they rule out the possibility of achieving substantial improvements" (Rodman, 2010, New Paradigm section). In this regard, not only are there limitations in terms of the scope and political applicability of Lacan's theories, but doing so comes with consequences.

In this study, Lacan's theories proved useful as they were applied to the analysis of the internalised political, the language of the habitus. In terms of using Lacanian-informed critical discourse analysis, this differed from the other politically centred forms of discourse analysis, such as Foucauldian, as its focus was not explicitly on power carried in language. Instead, the Lacanian-informed critical discourse analysis applied here examined the power *of* language itself, which structures the subject as much as it does the political elements of the symbolic. This was done not only by the analysis of power operating through language, such as noting hegemonic discourses and master signifiers, but also by an analysis of the structure of language itself, such as the structure of the four discourses. LDA is still a relatively new and developing method, and even in this study, it was necessary to develop it further to capture the power of language within its structure, extending and developing the method. However, there are still

questions as to its applicability in terms of being used as a critical and political method, which are beyond the scope of this thesis, but have been noted in its analytic process.

Finally, it is worth noting the limitations of the MacArthur scale in terms of accurately capturing the subjective social status of the participants. This was particularly relevant regarding participants who had upward social mobility as the measure captured their current positionality in terms of the resources they had at the time the questionnaire was given, their perceived rank and subjective social class identity. If, for example, the participant came from a working-class background and had a working-class habitus and practices, the scale did not accurately capture these features as their social mobility reflected middle-class resources and perceived rank. When, during the interview, this became apparent, the MacArthur scale was then useful as a prompt, and I asked the participants, "How do you think you would have answered the questionnaire at an earlier point in your life?" or "How would your parents have answered the questionnaire?" There were also some limitations within the questionnaire items themselves when social mobility was present. Again, in these instances, this was noted, and the MacArthur scale was used as an interview question prompt, where I then asked the participant to explain why they had answered the questionnaire as they did, which led to further insights. However, this highlights the applicability of the MacArthur scale for capturing the nuanced nature of subjective social status, particularly when social mobility is a factor.

8.6 Conclusion

This critical investigation led to some theoretical contributions expanding and elaborating on what is commonly known as "mental health." While literature has highlighted the inverse relationship between mental health and social class, as well as class-associated mental health inequalities, it has yet to explore the processes of the inverse relationship. This suggests not only a clear gap in knowledge about mental health experiences, but also the social justice issue regarding mental health inequalities. To address this gap and social justice issue, a qualitative investigation was designed that aimed to answer the research question "Does social class habitus affect the lived experience of mental health, and if so, in what ways, amongst a sample of participants identifying as lower class, working class and middle class?" However, the complexities and congruencies within themes arising from a single sample led to a further research question of "How does language shape the experiences of mental health described in the participants' accounts?" To address this question, I critically explored the

accounts of mental health from 14 participants of various social class backgrounds using reflexive thematic analysis and a Bourdieusian and Lacanian-informed critical discourse analysis.

However, as this study evolved, it was clear that what was being observed in the language of these accounts was far more than habitus-guided experiences of mental health. While the initial methods provided some valuable findings, these seemed incomplete at capturing what was evident in the data, as within and between accounts, there was contradiction and ambiguity. To address this, I expanded and adapted the theoretical and methodological framework, developing a Bourdieusian and Lacanian-informed critical discourse analysis that enabled the inquiry to go beyond the reporting of class-associated descriptions of mental health, but to understand them on a deeper psychological level, that of the signifier. As a result, deeper insights were indeed gained, and these had far greater implications than the original qualitative observation of class-based accounts of mental health. In the texts of these accounts of mental health, in the very language in which participants spoke about their suffering, critical and meaningful insights emerged with the critical discourse analysis.

This thesis makes three interrelated contributions. Conceptually, it reframes mental health as a socially-situated practice, mediated by social class habitus and key signifiers, through which mental suffering is symbolically structured, negotiated, and articulated without being fully exhausted by them. This repositions the current and hegemonic conceptualisation that poses mental health as an individual psychological state, influenced by social factors as external confounding variables. While I do not argue against this, I elaborate and expand on the psychological-social relationship of mental health. Methodologically, this study highlights the value of an adaptive framework where integrating RTA as an exploratory method and then incorporating a Bourdieusian and Lacanian-informed critical discourse analysis, not only as a response to the emerging themes, but also to the gaps, contradictions, and residual questions that arise from the RTA. This approach highlights how close attention to language, specifically an analysis at the level of the signifier, can reveal the processes by which social and discursive conditions are formative of the ego and the habitus, shaping the practices associated with the distress of the split subject. In this regard, this study's methodological approach is an example of interdisciplinary and flexible qualitative methodologies that provide for more in-depth and holistic insights, particularly when addressing phenomena that are analytically messy and complex.

Critically, this study contributes to debates in psychology and mental health by challenging individualising and reductive tendencies of prevailing biomedical attitudes that frame mental suffering as located in the individual, shaping the diagnosis criteria and treatment of "mental health conditions." Instead, this study's conceptualisation of mental health as practice provides an alternative narrative that locates responsibility as distributed across personal, sociocultural, and structural relationships, which encourages ethical, clinical, and policy interventions that might address not only symptoms of suffering, but the conditions under which suffering is produced and sustained. As well as this, it also raises the question of how normative mental health discourse, as viewed here through a focus on the effects of specific signifiers, leads individuals to be complicit in practices of mental health that in themselves generate and compound suffering.

The contributions this study makes come with significant implications as they bring into question the dominant model of mental health operating within research, clinical spaces and public discourse. Framing mental suffering as a social practice shifts responsibility to be less so on the individual and distributes it to the inequality that often lies behind suffering, which can be obscured by the biomedical and biopsychosocial models of mental health. This has implications in terms of social and mental health policy as well as clinical applications such as community-based and informed interventions. This study's methodological and theoretical contributions also have implications relevant for future research, with further applications suggested relating to other social inequities situated around social constructions of subjectivity.

To conclude this thesis, understanding mental health as a socially situated practice highlights how sociocultural and socioeconomic class conditions shape how (split) subjects relate to mental health discourse and key signifiers that organise suffering within unequal symbolic structures. Thus, it shifts conceptual attention away from a model that implies individual deficit and personal responsibility, towards one that acknowledges the social discursive conditions that shape mental distress. By theorising mental health as social practice, one in which power-laden signifiers operate as truth-producing mechanisms that reproduce inequality and suffering systemically, interventions can be adapted on an individual and societal level that can reduce suffering while maintaining the irreducible complexity of human subjectivity.

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Appendix A. Ethical Approval

MAYNOOTH UNIVERSITY RESEARCH ETHICS COMMITTEE
MAYNOOTH UNIVERSITY,
MAYNOOTH, CO. KILDARE, IRELAND

Dr Carol Barrett
Secretary to Maynooth University Research Ethics Committee

24 May 2021

Rachel Brown
Department of Psychology
Maynooth University

Dear Rachel,

The Social Research Ethics Sub-committee has reviewed the ethical protocol for your project: **The Effects of Social Class Habitus on the Lived Experience of Mental Health** and we would like to inform you that ethical approval has been granted.

Any deviations from the project details submitted to the ethics committee will require further evaluation. This ethical approval will expire on 30/05/2024.

Kind Regards,

Dr Carol Barrett
Secretary,
Maynooth University Research Ethics Committee

C.c. Dr Michael Cooke, Department of Psychology

Appendix B. Participant Information Sheet

Purpose of the Study. Hello, I am Rachel Brown, a doctoral student in the Department of Psychology at Maynooth University. As part of the requirements for my PhD, I am undertaking a research project under the supervision of Dr Michael Cooke. The purpose of this study is to investigate how social class habitus affects a person's experience of mental health.

What is the Study about? This research project investigates how people's experiences of mental health are affected by a person's social class habitus.

- **Social Class Habitus:** Social class can be understood as the grouping of people who share similar economic resources, such as income, the type of job a person has and their level of education. These economic resources shape a person's lifestyle, such as their values, activities, identities, and relationships, which are often similar to those in the same social class group. These values, activities and identities affect the way people think, feel and act, and are known as social class habitus.
- **Experiences of Mental Health:** Mental health is often understood as whether or not a person has a mental health condition. However, mental health is more than this, and includes emotional, psychological, and social well-being as well as how we handle stress, relate to others, and make choices. These lived experiences of mental health include a person's quality of mental health, their ways of coping, their access to mental health services or treatments and their experience of stigma. Everyone has their own individual experience of mental health, and this can be affected by many different things, both positive and negative.

What will the study involve?

- **Questionnaire:** You will be requested to complete a brief questionnaire about your age, gender and what social class you identify with.
- **Interview:** The study will involve an interview in which I will ask about your personal experiences relating to social class, mental health and your opinions, thoughts, and feelings on these experiences.
- **How long will the Interview be?** Interviews will be approximately an hour in length, but I ask you to give an hour and a half to allow for completion of the questionnaire and setting up. If you feel that you would like to have more time for this interview, you can request up to a maximum of two hours.

- **Where do the Interviews take place?** Interviews will take place at Maynooth University or at an agreed location that the participant and the researcher are comfortable with. In the case of COVID-19 restrictions or inability to travel, interviews may take place using Microsoft Teams video call software. Interviews will be audio-recorded and transcribed. The transcripts will be analyzed to investigate how social class habitus influences the lived experience of mental health.

Who has approved this study? This study has been reviewed and received ethical approval from the Maynooth University Research Ethics Committee. You may have a copy of this approval if you request it.

Why have you been asked to take part? You have been asked to participate because you are an individual with experience of social class and mental health generally. No specific selection criteria have been used other than that you are over 18 years of age, a speaker of the English language and not currently experiencing an acute mental health state, as indicated by yourself.

Do you have to take part in the interview? No, you are under no obligation whatsoever to take part in this research. It is entirely up to you to decide whether or not you would like to take part. If you decide to do so, you will be asked to sign a consent form and given a copy and the information sheet for your own records. If you decide to take part, you are still free to withdraw at any time without giving a reason and/or to withdraw your information up until the research findings are published. A decision to withdraw at any time, or a decision not to take part, will not affect your relationships with the researcher or Maynooth University.

Who should not take part?

- **Sensitivity to Topics**. For some people, social class and mental health are sensitive topics and talking about them and their experience may cause distress. If you feel you may become distressed talking about social class, mental health, and your experiences of these topics, please do not take part.

- **Experience of Acute Mental Health Crisis**. If you are experiencing or have experienced an acute mental health crisis in the past 6 months, then you should not participate. An acute mental health state means you have experienced significant psychological or emotional distress, suicide attempts, self-harm or have been

hospitalised for a mental health condition. This may also include experiencing a recent bereavement or trauma that will make you psychologically and emotionally vulnerable. If you feel you are sensitive to the topics being discussed or have experienced an acute mental health crisis within the past 6 months, then you should not participate in this research, as the interview may cause you significant distress.

What information will be collected? General demographic information will be collected, such as age and gender, as well as details of the social class you identify with. This will be done with a short questionnaire that will ask you for these details. The interview will collect information about your attitudes, reflections, and personal experiences on the topics of social class and mental health. Audio of the interview will be recorded and used for writing interview transcripts. The recording will be stored securely and deleted once the transcript of your interview has been typed and securely stored.

Will your participation in the study be kept confidential? Yes, all information that is collected about you during the course of the research will be kept confidential. No names will be identified at any time, and pseudonyms (fake names) and all personally identifiable information will be made anonymous. All hard copy information will be held in a locked cabinet at the researchers' place of work. Electronic information will be encrypted and held securely on MU PC or servers and will be accessed only by Rachel Brown. No information will be distributed to any other unauthorised individual or third party. If you so wish, the data that you provide can also be made available to you at your own discretion.

It must be recognised that, in some circumstances, confidentiality of research data and records may be overridden by courts in the event of litigation or in the course of investigation by a lawful authority. In such circumstances, the University will take all reasonable steps within the law to ensure that confidentiality is maintained to the greatest possible extent.

What will happen to the information which you give? All the information you provide will be kept at Maynooth University in such a way that it will not be possible to identify you. On completion of the research, the data will be retained on the MU server. After ten years, all data will be destroyed (by the PI: Principal Investigator Rachel Brown). Manual data will be shredded confidentially, and electronic data will be reformatted or overwritten by the PI at Maynooth University.

What will happen to the results? The research will be written up and presented as a summary report, and will be discussed at internal group meetings, may be presented at national and international conferences, and published in scientific journals. Confidentiality and anonymity will be maintained as per the consent form from the original study. A copy of the research findings will be made available to you upon request.

What are the possible benefits of taking part? By participating in the interview, you will be contributing to research that will allow for further knowledge about the relationship between social class and mental health. Research of this nature has the potential to aid further research and inform policies regarding social inequality and mental health.

What are the possible disadvantages of taking part? It is possible that talking about your experience may cause some distress, as social class and mental health may be sensitive topics for some people. If you feel that these topics are sensitive to you and would cause you considerable distress, please consider not taking part. If you choose to take part and you do feel distressed because of the interview or questionnaire, please see the next section for details of what you can do.

What if there is a problem? At the end of the interview, I will discuss with you how you found the experience and how you are feeling. In the event you experience any distress following the interview, you are encouraged to contact the support services listed on the support services page attached to the support services page and contact your GP. You may contact my supervisor, Dr Michael Cooke by email (Michael.Cooke@mu.ie), if you feel the research has not been carried out as described above.

Any further queries? If you need any further information, you can contact me: rachel.brown.2017@mumail.ie

If you agree to take part in the study, please complete and sign the consent form.

Thank you for taking the time to read this.

Appendix C. Consent Form

I……agree to participate in Rachel Brown's research study titled The Effects of Social Class Habitus on the Lived Experience of Mental Health.

Please tick each statement below

The purpose and nature of the study have been explained to me verbally & in writing. I've been able to ask questions, which were answered satisfactorily. ☐

I am participating voluntarily. ☐

I give permission for my interview with Rachel Brown to be audio recorded. ☐

I understand that I can withdraw from the study, without repercussions, at any time, whether that is before it starts or while I am participating. ☐

I understand that I can withdraw permission to use the data right up to publication. ☐

It has been explained to me how my data will be managed and that I may access it on request. ☐

I understand the limits of confidentiality as described in the information sheet ☐

I agree to quotation/publication of extracts from my interview ☐

I do not agree to quotation/publication of extracts from my interview ☐

I confirm that I am currently not experiencing an acute mental health state that would make me vulnerable or sensitive to the topics being discussed. ☐

Signed……. Date…….

Participant Name in block capitals ……...

I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a manner that they could understand. I have explained the risks involved as well as the possible benefits. I have invited them to ask questions on any aspect of the study that concerns them.

Signed……. Date…….

Researcher Name in block capitals ……...

If, during your participation in this study, you feel the information and guidelines that you were given have been neglected or disregarded in any way, or if you are unhappy about the process, please contact the Secretary of the Maynooth University Ethics Committee at research.ethics@mu.ie or +353 (0)1 708 6019. Please be assured that your concerns will be dealt with in a sensitive manner.

For your information, the Data Controller for this research project is Maynooth University, Maynooth, Co. Kildare. Maynooth University Data Protection Officer is Ann McKeon in Humanity House, room 17, who can be contacted at ann.mckeon@mu.ie. Maynooth University Data Privacy policies can be found at https://www.maynoothuniversity.ie/data-protection.

Appendix D. Participant Recruitment Flyer

Maynooth University
National University of Ireland Maynooth

Participants needed for Psychological Research

Hello, I am Rachel Brown, a doctoral student in the Department of Psychology at Maynooth University. As part of the requirements for my PhD, I am undertaking a psychological research project. The study is concerned with how social class influences the lived experience of mental health.

- What's involved?

  Participants are needed for interviews to discuss their experiences of social class and mental health. You will also be asked to complete a short questionnaire regarding your age, gender and social class.

- What will my interview be used for?

  Interviews will be audio recorded, transcribe and analyzed and used as part of a report. The report will be discussed at departmental meetings and may be published in academic journals.

- Who can take part?

  Participants must be 18 or older and have fluent English.

- Who shouldn't take part?

  For some people social class and mental health are sensitive topics and talking about their experiences may cause distress. If you are currently experiencing an acute mental health crisis you may be vulnerable to sensitive topics. In these cases, you shouldn't participate.

- Is it Confidential?

  Yes. Information collected will be kept confidential and your identity will remain anonymous.

If you are interested in participating or would like more information, please contact me by email at rachel.brown.2017@mumail.ie

Appendix E. Participant Questionnaire

Age: _____

Gender: _____

1. **Please complete the two activities below:**

   Activity A: Please mark the number that matches your choice on the ladder.

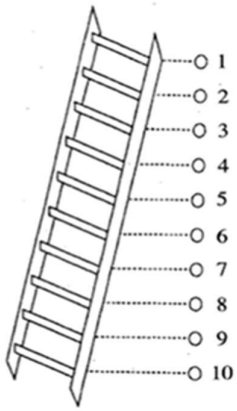
   Activity B: For each category of food, money and things, please circle your answer.

A

Imagine that this ladder is a picture of how (YOUR COUNTRY) is set up.

- At the top of the ladder are people that have the most money, the highest amount of schooling, the best jobs, and the most respect.
- At the bottom are people who have the least money, little or no education, no jobs or jobs that no one wants, and the least respect.

Now think about your family. Tell us where you think your family would be on this ladder?



B

Compared to most families, my family has:		
Nicer house	Same house	Less nice house
More food	Same food	Less food
More money	Same money	Less money
More things	Same things	Less things

2. **Which social class group would you consider yourself a member of?**
   a. **Lower Class**
   b. **Working Class**
   c. **Middle Class**
   d. **Upper Middle Class**
   e. **Upper Class**
   f. **Elite**
   g. **Don't Know**

Appendix F. Sample Interview Questions

Q: Can you please tell me a bit about yourself?

SQ: What is your profession, family status, marital status, and where do you live?

Q: Can you tell me about your upbringing?

SQ: Where did you live?

SQ: What was it like where you grew up? The neighbourhood, neighbours, your school, your friends?

Q: Considering the social class background of your childhood, do you think you are of the same social class as an adult or a different social class?

SQ: Why do you think it has stayed the same? Why has it become different?

Q: Considering the social class that you identify with, in what ways do you think this affects the person you are?

SQ: Does it affect or influence your tastes in clothing, music, art, film or sports?

SQ: Does it affect or influence your everyday activities?

Q: Overall, do you think that your social class has had a positive or negative effect on the quality of life you experience?

Q: What is mental health?

SQ: How would you describe "normal" mental health?

SQ: Who do you think decides what is normal mental health?

SQ: Could you describe mental illness?

SQ: Who do you think decides what mental illness is?

Q: Can you tell me a bit about your own experience of mental health?

Q: When you were struggling with your mental health OR if you were to struggle with your mental health, what did you (would you) do to cope?

SQ: Did you find these ways of coping effective?

SQ: What other coping choices were open to you?

Q: Have you ever contacted mental health services, or if you were to need them in the future, would you contact them?

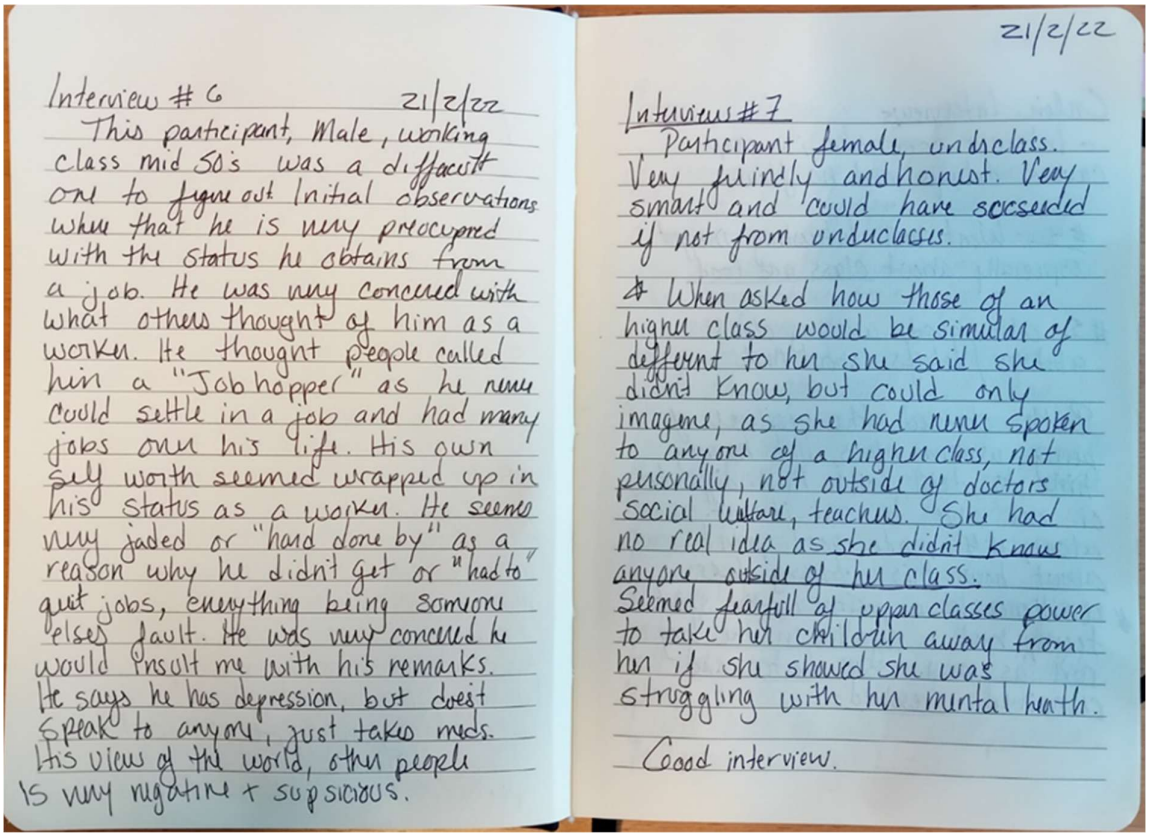
SQ: Can you tell me about what your experience of mental health services was like?

Q: (If participant used services) In your experience of mental health services, do you think that class was a feature or played a role?

Q: Do you think that your social class affected your experience of mental health?

SQ: If yes, in what ways and if no, why do you think that is?

Appendix G. Reflective Journal: Interview Reflections



Interview # 6 21/2/22

This participant, Male, working class mid 50's was a difficult one to figure out. Initial observations when that he is very preoccupied with the status he obtains from a job. He was very concerned with what others thought of him as a worker. He thought people called him a "Job hopper" as he never could settle in a job and had many jobs over his life. His own self worth seemed wrapped up in his status as a worker. He seems very jaded or "hard done by" as a reason why he didn't get or "had to" quit jobs, everything being someone elses fault. He was very concerned he would insult me with his remarks. He says he has depression, but doesn't speak to anyone, just takes meds. His views of the world, other people is very negative + suspicious.

21/2/22

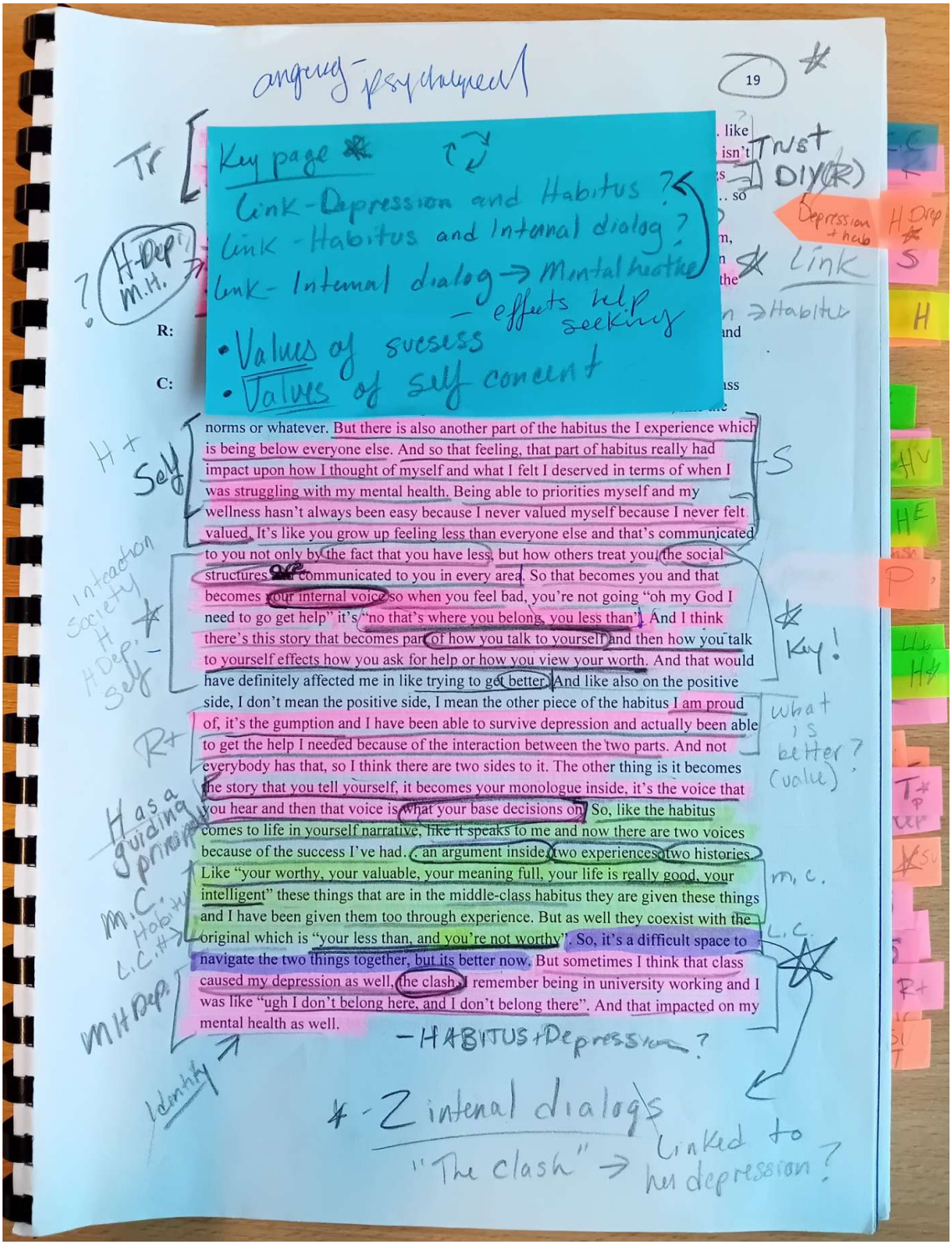
Interview # 7

Participant female, underclass. Very friendly and honest. Very smart and could have succeeded if not from underclass.

* When asked how those of an higher class would be similar of different to her she said she didn't know, but could only imagine, as she had never spoken to anyone of a higher class, not personally, not outside of doctors social welfare, teachers. She had no real idea as she didn't know anyone outside of her class. Seemed fearfull of upper classes power to take her children away from her if she showed she was struggling with her mental health.

Good interview.

Appendix H. Sample of Coding



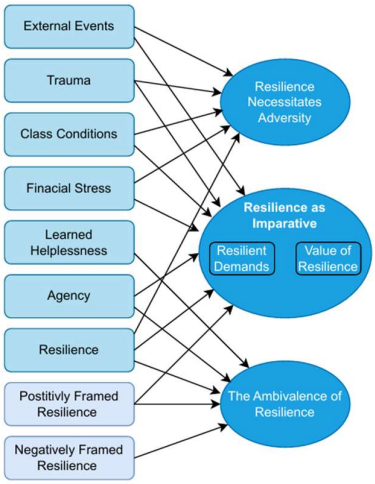
Appendix I. Code Book

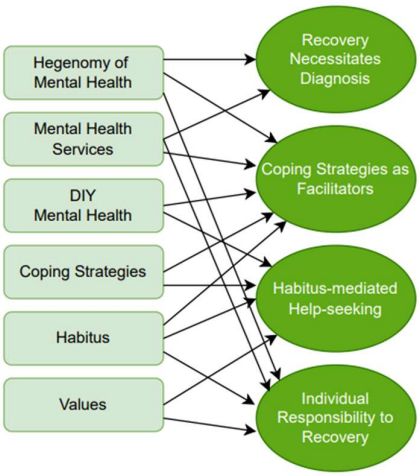
Table 9

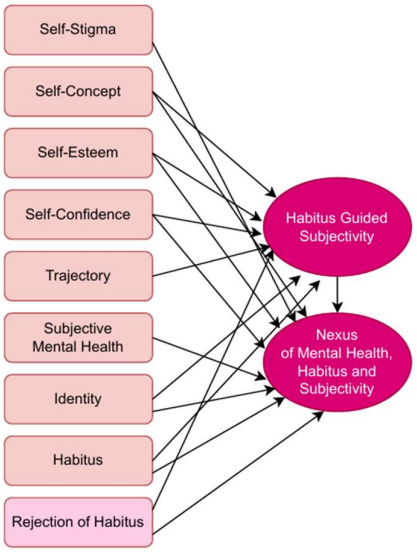
Codes and Descriptive Code Names

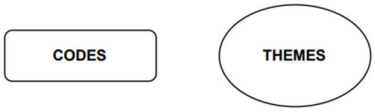
Code	Descriptive Code Name
PD	Participant Demographics (age, gender, race, ethnicity, culture, sexuality)
FD	Family Dynamics
FS	Financial Stress
SC	Self-Confidence
LH	Learned Helplessness
TR	Trajectory/perceptions of life trajectory
ID	Identity
S	Self-concept
SE	Self-esteem
V	Values
SV	Experiences of mental health services
R	Resilience
(R+)	(*positively framed resilience)*
(R-)	*(negative framed resilience*)
SMH	Subjective mental health
MH-Heg	Hegemony of mental health
MHP	Perceptions of mental health
Mhex	Mental health is influenced by external events.
TR	Therapeutic relationships
DIY	Do it yourself, mental health.
CS	Coping Strategies
CH	Choice
TRA	Trauma
T	Trust
ST	Stigma
(SST)	*(Self-stigma)*
P	Power
(P+)	*(empowerment)*
(P-)	*(disempowerment)*
A	Agency
IDC	Indicators of class
CC	Class conditions
ED	Education
H	Habitus
($H^{L)}$	*(Linguistic habitus)*
($H^{bh)}$	*(Bodily hexus)*
(H^{t})	*(Habitus distinct tastes)*
(RH)	*(rejection of habitus)*

Appendix J. Theme Trees for Reflexive Thematic Analysis

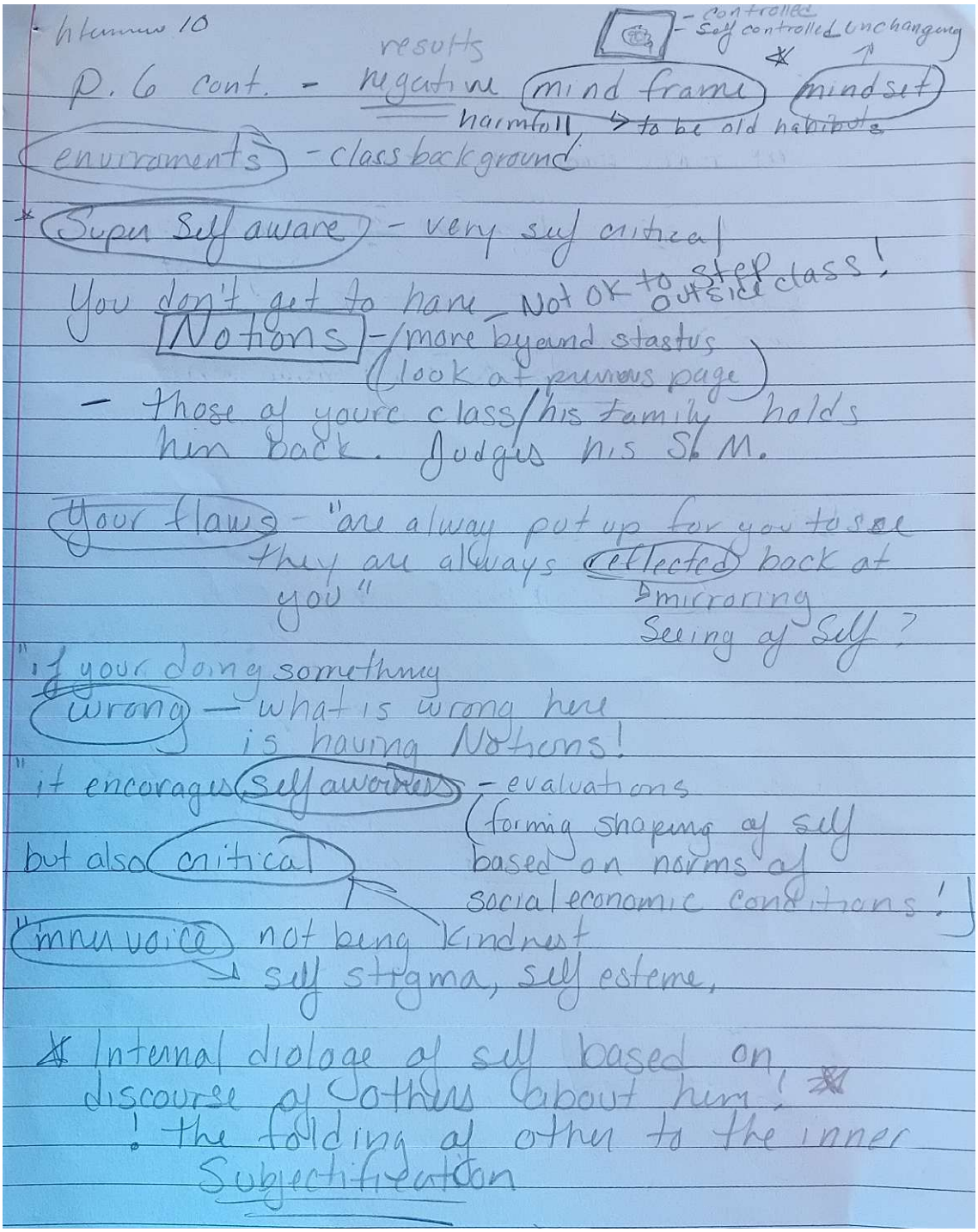








Appendix K. Rough Work from Lacanian Discourse Analysis



Appendix L. Research Audit Trail

Table 10

Audit trail showing analytic process from raw data, provisional themes and insights to final themes.

RTA Data (Kevin: Questions and Response)	Provisional Themes	Final Themes
I'm curious about what you said about imposter syndrome, as you say, you are aware that you have stepped out of your class upbringing. Would you say that has affected how you view yourself or how you value yourself? *Absolutely one hundred per cent. I always think of things in root cause, and the services are not readily available to these people, and nobody is coming to help you! No one is gonna walk in here and help you, so you need to help yourself. I think that's a lot of where this comes from. Like, if you don't get up and get on with it, the bills aren't gonna get paid, there won't be food on the table, you don't have time to get sick or to be dealing with a mental health crisis. So yeah, I absolutely think it's an attitude of "no one is coming to help you, get up and on with things, do it yourself". And seeking out help gets in the way of providing, and that's part of the mentality of being working class.*	• Resilient demands related to socioeconomic hardship and lack of time. • Impact on attitudes towards mental health. • Us and them mentality	**Resilient Demands**: Habitus-derived interpretation of resilient demands is expressed in the attitudes that linguistically frame resilience, not only arising from class-based conditions (financial needs, time limitations) but also the shared sociocultural knowledge and attitudes towards the signifier "*mental health*" and the subjective identification and othering with the use of "*I*" and "*nobody*". Here, resilient demands are not only derived from socioeconomic conditions, but attitudes and values (*mentality*) about resilience and help-seeking. *Resilient demands associated with habitus require further analysis.
Ok, as an overall reflection, has your social class had a positive or negative impact on your life experiences? *I think there is both, but I think the positive outweighs the negative. I think some of my experiences when growing up led*	• Positive effects of resilience • Negative effects of resilience • Habitus/fields	**The Ambivalence of Resilience:** Ambivalence and duality in the attitudes towards resilience (*positive outweighs the negative*). Presence of habitus (mindset).

to me being of the mindset that I am. And it built a lot of resilience, and I don't think that I would be where I am in my professional career if it wasn't for the upbringing that I had.		*Ambivalence indicated further analysis was required.
Does your social class affect the way you perceive yourself? *In some ways, I would say that I am super self-aware because when you grow up in these sorts of environments, you don't get to have notions and your flaws are always put up for you to see; they are always reflected back on you. I feel there's no beating around the bush in a family of 12, if you're doing something wrong, you're gonna know about it. And so, I think that encourages, in some ways, that encourages some level of self-awareness, umm… but also critical thought, like in terms of that inner voice not being the kindest as well.*	• Self-awareness • Family dynamics/norms • Self-stigma	**Habitus Guided Subjectivity:** Norms of the habitus (*notions; flaws)*, represented by the judgment of others from his generative social fields (*these sorts of environments; family)*, remain present with him as a self-evaluative measure (*self-awareness; critical thought; inner voice).* *Strong links between subjectivity and habitus required further analysis.

Note. * indicates the rationale for conducting a textual analysis (socio-cognitive critical discourse analysis, Bourdieusian analysis, and Lacanian discourse analysis) on the participant account, which is displayed in the table below.

Textual Analysis Data (Kevin: Question and Response**)**	**Provisional Insights**	**Final Discursive Themes**
How did those attitudes (about mental health from his working-class community) affect how you dealt with things, like stress or if you were upset about something, how did you deal with it? *Like growing up, it was like, don't sit there and wallow in it; you need to fix it. And I think that in some ways, that builds resilience. So, my emotional reaction to things is ok, this is*	• Signifiers developed (*builds resilience*) to habitus and generative fields (*growing up*) • Habitus guided attitudes towards coping/resilience	**Practice of Resilience- Performative Resilience:** A distinct practice of resilience relating to an action-oriented resilient response to adversity, driven by habitus norms and attitudes that are mediated by signifiers from the shared sociocultural language of his habitus, derived from his generative social fields. The practice is held by value-laden signifiers that have judgment

not the end of the world, and you kick into problem solving, you kick into ok, how do I fix it?	(*wallow; problem solving; fix it*) • Action-oriented response favoured over MH effects (*fix it* vs *wallow*) • Orientation outward (*it)*	within his language that hold him to account for his practice, which must be performative to be congruent with his habitus.
"How do you cope with stress now?" *I think I lean on things more, like I do a bit of meditation. I try to tackle the root cause of why I'm feeling a certain way, as opposed to the action or the immediate thought in my head. Umm… I'm getting better at going back and saying, "Oh, this is what's wrong with me; this is why I'm having a bad day." And I am taking ownership over my mental state, and that's a lot better because before, I was "I feel this way because you made me feel this way," whereas now, I feel this way because I haven't dealt with something I need to.*	• Difference to previous coping and resilience strategies (*lean on things; meditation; tackle the root cause)* • New judgement frame (*getting better; wrong with me)* • Change in orientation and responsibility of distress inward (*I haven't dealt with something I need to)* • Influence of mental health/therapeutic discourse (contextual note)	**Practice of Resilience-Performative Resilience:** Now, there is a new performative practice of resilience that originates from social fields of psychotherapy that holds judgment over its previous practice, causing distress (split subject) by the discourse of therapy. There is a change in orientation and blame for the emotional response to adversity from the previous practice. Where before it was externally orientated and a fixable problem, now it is the internal response that is adjusted, and the external adversity is absolved. Crucially, the new practice is held in favour over the previous as it aligns Kevin to the doxa of his new social fields since he gained social mobility, yet holds him in contention as it is incongruent with his habitus, causing internal tensions, splitting the subject further and showing the psychological costs of performative practices of resilience.

Has this mentality, which you say is part of being working-class, does that affect how you emotionally react to things and how you cope with your emotions? *Yeah, absolutely, it still does. And I would say that I am quite the empathetic person, but definitely, there are bouts of impatience, and I think to myself, why is that a problem for you? Why make a big thing of it? And I detach the emotions from it and do what I have to do. And I find I do that with my kids, my wife, and at work. I do it less so than before, but I still do it. I'm still a product of that upbringing or that mentality. And as I said, sometimes it is a positive thing, it's resilience in some ways, but at some point, there is a negative aspect to it, there is a point where it isn't a positive, and you're just not dealing with it. Like I don't blow up small problems, and if I'm stressing about something, it's usually a big deal. But I would say absolutely, I am still of that mentality. The natural instinct is to go to that, I almost have to fight against it and to try and deal with it in a more productive way.*	• Emotional repression/suppression used as a coping strategy (*detach emotions from it; not dealing with it*) • Evaluative frames of the habitus (*why is that a problem; big thing)*. New evaluative frame incongruent to habitus (*negative; deal with it; productive way*) • Habitus guided practice (*product of my upbringing; mentality*; *natural instinct*; *fight against it*) • Positive and negative consequences (*a positive thing, it's resilience in some ways, but at some point, there is a negative aspect to it)*	**Practice of Resilience-Repression as Resilience:** Repression of emotions used as a coping strategy that is labelled with the signifier "resilience". This is guided by the habitus and shared sociocultural attitudes about emotionality. While it functions as resilience, there are clear costs in terms of the negative aspects of not dealing with emotions and the generalisation to other aspects of his life where emotionality would be valued.

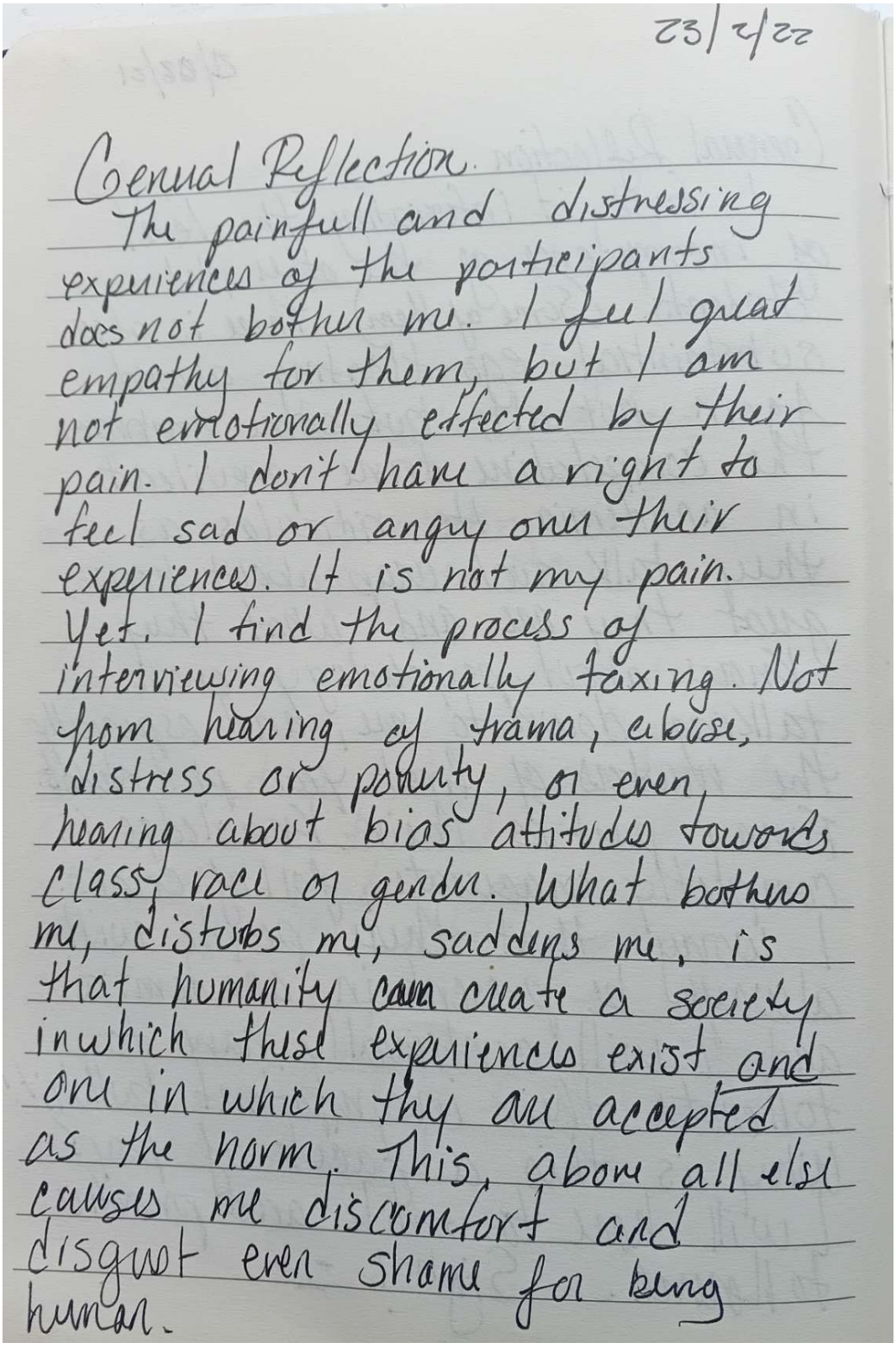
	• Generalisation (*my kids, my wife, and at work)* • Impact of floating signifier (*it).*	
Does your social class affect the way you perceive the world? *I don't know if this is just an Irish thing, but there is this Irish thing of having notions, right? And I think that does come from class. Like, for example, I am planning a work meeting in Bali in two weeks' time, and I catch myself thinking "who do you think ya are!", you know? It's like "what are ya doin'?". And recently I was saying to me Da we are going out and he said, "Where ya goin'?" and I said, "Oh, this Thai place up the road", and he said, "It's far from Thai food you were raised, Son!" And so yeah, I think it affects your perception of the world. I would say I'm quite cynical in my thinking, and I can be a realist in my thinking to the point it can border on that negative mind frame.*	• Cultural specific reference of social judgement (*notions*) • Voice of the Other (*who do you think ya are?)* and others/habitus (*It's far from Thai food you were raised, Son!)* • Internalisation of Other and others (*I'm quite cynical in my thinking; you don't get to have notions; negative mind frame)*	**The Practice of Subjectification-The Other as Self:** Internalisation of the signifiers of the habitus to his internal dialogue operates on his subjectivity and the processes of subjectification that are evaluations of self and produce a self-stigma when practices do not align with the generative habitus. The splitting here is done by two dialogues from different potentialities originating from his social mobility. Here, it is the very language (signifiers) of competing habitus that cause distress and tension in his subjectification practice.
So this continues with what you are saying, like the internalisation of social class, would that have been an influence on your mental health, and you kind of say this with the resilience side of it, but if there are any other ways you feel it has affected your experience of mental health, either positively or negatively?	• Presence of shame indicating internalised judgement and stigma associated with habitus (*shame; why can't I pull myself up;*	**The Practice of Subjectification-The Other as Self:** Internalisation of intergenerational class-based mental health norms act as the guiding principle of the habitus as an evaluative frame on which subjectivity is valued. Socioeconomic circumstances condition the mental health

I think that there is a shame when you do have a mental health crisis, like "why can't I just pull myself up by my bootstraps, why can't I just get on with things, why can't I just get on with this by myself?" I think there's a shame because all you are told is "move along, we don't got time for all your bullshit". And that shame can turn into just a harsh voice, like it is imposter syndrome in some ways, like "why can't you get on with things, why are you different?" And I think that's not the case, and I have learned to embrace them, and for others, it's just more acceptable to embrace them. But in my upbringing, it just wasn't acceptable, and especially if I look at the male role models in my life. Like when my brother died, my Da barely grieved. Like he went back to work, and he was like to me, "you need to look after your Ma because she's not well and keep out of trouble now". There was no time to deal with my individual needs and wants, emotional strain, we all just had to get on with life and get food on the table, pay the bills. And that kind of carried with me, I think.	*why can't I get on with things; get on with this by myself)* • Presence of judgment from Other (*harsh voice*) • Family dynamics mental health norms (*male role models; Da barely grieved; Ma-not well)* • Intergenerational mental health norms (*no time; emotional strains; get on with life)* • Internalised in habitus shaping subjectivity (*carried with me)*	norms from Kevin's background, and while he has achieved social mobility and no longer lives with these circumstances, his habitus enables him to perform these practices, which, when deviated from, generate shame and self-stigma. Critically, these are mediated by class-specific signifiers such as "*bootstraps*" and "*get food on the table*". Here, the signifiers of others act as the Other, in a practice that shapes subjectivity to align with working-class norms.
When did you decide to get help, and who did you see? *Well, as I said before, I never reached a point where I was suicidal, but if suicide is a cliff, I was ten meters from that edge. And so, I felt that before it progresses, I need to do something proactive, and that's when I started therapy with a psychologist. And I think throughout that process I have learned a lot about like medication, journaling, I do a lot of journaling now, controlling that inner voice and making it be*	• Use of mental health/therapeutic signifiers (*suicide; therapy; psychologist; medication; journaling; boundaries*	**The Practice of Subjectification-The Other as Self:** Now there is the presence of a new Other (mental health signifiers) that are incongruent to those of the previous (intergenerational other and generative habitus). Where before emotionality was repressed, now it is embraced but also controlled into an acceptable practice that

a little bit kinder. Knowing myself, setting boundaries for myself and all these things that I didn't do before that affected me negatively.	• Implementing control over self as the aim of intervention (*something proactive; controlling that inner voice; knowing myself; setting boundaries for myself)* • Evaluative frame preferencing this practice over the previous (*something; proactive; before that affected me negatively; a little bit kinder)*	aligns with mental health norms from psychological services that her is now able to access due to his increase in social status. Critically, the language is evaluative and judgmental of his practice that aligns him with his generative habitus, creating tensions in his subjectivity.
Can you tell me a bit more about that experience, about getting help and what motivated you or prevented you from getting help sooner? *I definitely think there is a stigma in the lower classes with dealing with that, like dealing with your emotions. Like with getting professional help, and even to this day, like I wouldn't… I wouldn't share it with friends, and obviously, my wife knows. But like with people in my work, I'd share with them that I see a therapist regularly, but I wouldn't share that with my siblings. Umm... which is funny in some ways.* ***Why not?***	• Class-associated stigma around emotionality and help-seeking from mental health services (*dealing with your emotions; getting professional help)* • Differential with those within the new social field of work and his family (*I'd share with*	**The Practice of Subjectification-The Other as Self:** Dialogical discursive relationship between self and others holds Kevin to account from both class positionalities, social fields and doxas. On the one hand, we see in the first example that he is held by the generative habitus and norms originating from his family. Then, as he gains social mobility, a new doxa from social fields normalises therapy, and he adopts the mental health discourses of psychology, and we see evaluative signifiers towards the original practice. Finally, we see

There's a general umm… what's the word... I don't know… It's like notions, right, like "you pay how much to someone to talk about things!" I think it's that attitude towards it. I think there is an attitude where people feel… maybe I am projecting my own perceptions in some way, but I think people look at it, in my family, would look at it as a weakness, you know, like "deal with it yourself" kind of way.	*them that I see a therapist regularly, but I wouldn't share that with my siblings)* • Stigma is internalised (*projecting my own perceptions; deal with it yourself)*	a judgment from his generative habitus towards the new practice of help-seeking through mental health services. Throughout these extracts, there is always the presence of signifiers of the Other (through others' dialogue and Kevin's internal dialogue), shaping his subjectivity, split with tensions from a split habitus. For Kevin, his mental health and habitus are the shaping force of his subjectivity, which in turn creates tensions that generate more distress, splitting the subject further. This duality explains the ambiguity that was observed in the RTA in terms of his accounts of resilience.

Appendix M. Reflective Journal: Reflective Entry



23/2/22

Coenual Reflection.

The painfull and distressing expuiences of the participants does not bother me. I feel great empathy for them, but I am not emotionally effected by their pain. I don't have a right to feel sad or angry over their expuiences. It is not my pain. Yet. I find the process of interviewing emotionally taxing. Not from hearing of trama, abuse, distress or poverty, or even hearing about bias attitudes towards class, race or gender. What bothers me, disturbs me, saddens me, is that humanity can create a society in which these expuiences exist and one in which they are accepted as the norm. This, above all else causes me discomfort and disgust even shame for being human.