

Life History and Narrative Analysis: Feminist Methodologies Contextualizing Black Women's Experiences with Severe Mental Illness

MARYA R. SOSULSKI

Michigan State University
School of Social Work

NICOLE T. BUCHANAN

Michigan State University
Department of Psychology

CHANDRA M. DONNELL

University of North Texas
Department of Rehabilitation, Social Work,
& Addictions

This paper discusses a methodological approach to research that enhances critical analysis by contextualizing qualitative research findings within participants' individual experiences. We demonstrate the combined use of life history methods and feminist narrative analysis to explore Black women's everyday experiences with mental illness, from their perspectives. These interpretive methods reach beyond pathologized conceptions of identity and adjustment that often narrowly characterize mental illness among Black women. Instead, these methods holistically describe a participant's experiences and strategies she uses to pursue goals and enhance her life. The use of the methods is illustrated with examples from the life narrative of "Maria," a Black woman living with serious mental illness. Our findings underscore the need for rigorous, culturally appropriate methods and further research to evaluate participants' standpoints and needs, and

interventions to facilitate understanding and improved outcomes.

Key words: black women, mental illness, identity, feminist narrative analysis, life history methods

For Black women, the reality of living with mental illness is stark and complex. Psychological distress in Black populations has increased considerably over the last decade, with an eight percent increase between 1993 and 2001 (Zahran, Kobau, Moriarty, Zack, & Giles, 2004). Women experience higher rates of mental illness than men, and women of color face more mental health-related hardship than White women (Zahran, et al., 2004). Given the limited knowledge about the hardships faced by Black women living with severe mental illness and other aspects of their quality of life, there is a need for research that holistically represents their experiences and perspectives.

Life history methods and feminist narrative analysis techniques can be used to reach beyond pathologized conceptions of identity and adjustment that often narrowly characterize mental illness among Black women. These interpretive methods help to holistically describe the study participants' experiences—both beneficial and harmful—and identify the strategies they use to pursue their goals and enhance their lives while living with severe mental illness. The results can then be translated into chronicles of the women's lives. In the current study, life stories of Black women with severe mental illness were collected and analyzed in order to promote their use by other Black women also attempting to frame their own life stories. With such information, researchers can enhance our basic understanding to inform practice, policy, and future research. These strategies will help ensure that resources are available to women who combine the experience of living with a mental illness and the fulfillment of multiple roles as mothers, workers, and community members. This article provides a framework for research methods that delve into sensitive research questions with marginalized populations and present women's life experiences through the use of life history and feminist narrative analysis.

First, we provide a brief literature review with insights into evolving perceptions of Black women's experiences

with severe mental illness and how these perceptions fit with emerging notions of recovery. We then describe our conception of feminist life history narrative methods, with a brief analysis of one major theme in a case study of "Maria" (a pseudonym) to illustrate. Maria is a Black woman living with severe mental illness, struggling with the effects of early childhood abuse, navigating welfare systems and work, and raising her family in a racially diverse and economically distressed social environment. With her life history narrative, Maria provides insights into her own experiences and suggestions for policy and practice. We conclude with lessons learned from the use of these methods, benefits garnered from analyzing life histories, and future studies of individuals from similar populations.

The "Problem": Representing the Lives of Black Women with Mental Illness

Recovery from mental illness is a primary theme in mental health literature and research, but the notion of recovery has historically taken various forms and served multiple purposes. Jacobson (2004) describes the development of "recovery" as a fluid concept and demonstrates that over time ideas about recovery have shifted significantly. Early observers acknowledged that "real" or full recovery was rare and an impractical goal. Instead, the focus shifted to "'practical' or 'social' recovery" (Jacobson, 2004, p. 48), which focuses on minimizing the impact of symptoms and enhancing functioning in society despite the continued presence of the illness (Jacobson, 2004).

The idea of social recovery provides hope for many people. Increased functioning in terms of social participation is appealing to those living with mental illness, their families, and their communities. However, social recovery research often identifies mental illness as an individual affliction with recovery as a goal, rather than a process, and tends to neglect the influence of the environment or social structures as targets for change. These assumptions predictably lead to a focus on individual treatment and a somewhat narrow definition of success. This approach further presumes a medical model that prioritizes treatment and the eradication or stabilization of symptoms, rather than a functional assessment of strengths and strategies

used to establish and maintain relationships in the absence of formal treatment (Raja, 1998). Both full recovery and social recovery perspectives imply that the person needs formal treatment to recover, and assume that individuals should change to fit into society, rather than considering how communities might change to accommodate people with mental illness. Such perceptions may emerge from generalizations about mental health consumers' behavior, based on practitioners' reports and agency-based data rather than first-person interpretations of the experiences of people living with chronic mental illness.

Other research has appropriately identified important roadblocks to mental healthcare access, such as stigma, improper diagnoses, problems associated with finding childcare, and economic barriers (Nicki, 2001; Nissim-Sabat, 2002; Rosen, Tolman, & Warner, 2004; Takeuchi & Kim, 2000; Wilson, 2001). However, such research often represents narrow slices of the women's lives where "barriers" revolve around the women's willingness, or lack thereof, to comply with treatment and professionals' prescriptions for adaptation and assimilation. Implicit in these models is an assumption that addressing individual personal and health issues will result in improvement (e.g., overcoming barriers), if not full recovery (Jacobson, 2004). Social interventions are rarely emphasized and mental health consumers are infrequently consulted about their perceptions of quality of life (Bentley, 2005; Goh, 2005; Raja, 1998). Thus, beyond barriers to recovery, little is known of the diversity of experiences of Black women living with mental illness.

Even more structurally-focused mental health research in social work, psychology, and public health primarily considered whether people of color were accessing services, concluding that the solution was increasing access to culturally-appropriate treatment (Bentley, 2005; Rosen, Tolman, & Warner, 2004; Takeuchi & Kim, 2000; Wilson, 2001). Cultural competence models serve as an important starting point for addressing the needs of different groups, but emphasizing access to treatment that leads to "social recovery" tends to measure the efficacy of the process (e.g., accessing services) dependent on the result (e.g., functioning at higher levels), which returns the focus to

change in the individual. Seeking individuals' interpretations of their own experiences is necessary for holistic treatment that addresses the diversity of cultural interpretations presented by intersecting race, gender, class, and mental health status. Notable exceptions in more recent research have increased our understanding of individuals' experiences with mental illness and treatment (Deegan, 2003; Jacobson, 2004), but the narratives are limited in terms of racial and gender diversity, and the type of mental illness represented.

In more recent research on disability, mental health researchers are emphasizing the importance of consumers' authentic voices: There is an "... attempt to re-author experiences that have historically been excluded ... and rearticulate fresh and flexible diasporic modes of subjectivity" (Roets & Goedgeluck, 1999, p. 86), and the roles of social environment and socio-economic status are becoming ever clearer. The needs of Black women, their families, and their communities are unique and may require alternative institutional and policy responses; thus, they must be studied with particular intention. For example, Black women with mental illness also face the same social pressures as women without mental illness (Mowbray, Oyserman, Bybee, MacFarlane, & Rueda-Riedle, 2001). In addition to these stressors, stereotypes about Black women with mental illness abound, with potentially serious consequences for individual women, the community, and the mental health field (Beauboeuf-Lafontant, 2005; Nissim-Sabat, 2002; Raja, 1998; Randolph, 1999; Wilson, 2001). Social connections are a primary source of support and are important for encouraging people of color to seek and remain in treatment (Takeuchi & Kim, 2000); yet, this also can present a significant obstacle for Black women, who may feel that seeking help conveys weakness and threatens personal and community relationships (Takeuchi & Kim, 2000). Intersections of sexism, racism, and stigma associated with mental illness have lasting negative effects on families (Nicki, 2001; Raja, 1998).

Black women living with mental illness are rarely consulted when policies and services are determined. Although more inquiry is needed to understand precisely why, the reason lies perhaps in the stigma related to certain

characteristics of clients or the choices they make. Despite their training and efforts to avoid bias, some researchers, policymakers, and practitioners may lack similar experiences and empathy that are most helpful when relating to women with mental health problems (Sallmann, 2005), resulting in less participation of Black people with mental illness (DHHS, 2001). In addition, nuanced depictions in popular culture, news, and research of high functioning Black women who live with mental illness are rare. As a result, the reality of severe and persistent mental health problems among Black women is hidden, as are the myriad ways in which these women successfully live and contribute to their families and communities (Wilson, 2001). It is difficult for Black women living with mental illness to find others like themselves in the news, literature, and scientific studies that truly describe their experiences. This is especially frustrating for women seeking models of health and accurate representations that reflect their own experiences. To authentically present their perspectives, we need research methods that use their language and expression (Roets & Goedgeluck, 1999), rather than re-presenting their stories from our own vantage points, for our own purposes (Cary, 1999).

Theory: Lifespan Research From a Feminist Perspective

There are few strict guidelines when undertaking life history research (Tierney, 1999); multiple incarnations of life histories are informative and compelling. As the experiences of Black women living with mental illness are unique in many ways (Gibbs & Fuery, 1994), examining women's life histories from their own standpoints captures elements that may be distinctive, as well as variation among those experiences. We employed the method to examine mental illness as a flexible concept best understood as situated within the context of women's broader life experiences.

The feminist life history model used in the current project, which will be referred to as the "Living Many Lives (LML) Project," engages multiple definitions of recovery in Black women's lives, as they define it for themselves. Jacobson (2004) notes that experiences of mental illness are frequently categorized using a medical model, articulating symptoms and assessing functioning relative to people's social and

occupational success. This focus on illness (ill/less-ill/not-ill) restricts the capacity of Black women living with chronic and unremitting mental illness to see themselves, or be perceived by others, as normal and fully-functioning. Life histories allow a spectrum of experiences to emerge—negative and positive—within the context of the person’s whole life. The results are not “victory narratives” that merely articulate successes, that is, stories of women’s “... triumph over adversity and redemption” (Cary, 1999, p. 413); nor do they simply talk of woe and failure. Instead, a complicated set of stories emerge that may be unexpected, even changing the nature of the research. These techniques transform gaps and misunderstandings in mainstream research created by the absence of the standpoints of marginalized people, such as Black women living with mental illness (Roets & Goedgeluck, 1999).

Examining significant events over the lifespan helps us uncover resiliency at different stages, across various developmental ages and events (Deegan, 2003; Sigelman & Shaffer, 1998), including both macro-history (e.g. societal-level events such as the attacks on the World Trade Center on September 11, 2001) and micro-history (e.g. individual-level events such as sexual assault) (Deegan, 2003; Simons & Thomas, 1983) to show how they converge and shape a person’s development. Anthony (as cited in Deegan, 2003) posits, “the lived experiences of people in recovery, their narratives and their creativity should also take a prominent position” (p. 374). Jacobson (2004) further notes that “... recovery is a way of being in and of the world that can only be known subjectively. ... recovery becomes an existential phenomenon” (pp. 70-71). For Maria and for the Black women participating in the LML Project, life narratives are particularly important in presenting the daily experiences that give rise to personal understanding, highlighting individual differences and the social/contextual factors that influence their recovery process. Lysaker, Lysaker, and Lysaker (2001) describe personal narratives as connecting the multiple identities of our lives into a pattern that explains sense of self and ultimately “lends coherence to identity” (p. 55).

While there have been recent advances, the mental health system must better incorporate, respect, or understand the

unique experiences of women and also the diverse “histories, traditions, beliefs, languages and value systems of culturally diverse groups” (Ida, 2007, p. 50). At the same time, understanding the diversity of experiences within groups can prevent overgeneralizations about individuals’ needs. Key cultural, structural, and individual elements can be considered using a life history perspective, which allows the ownership and reclamation of self and women’s experiences with mental illness (White, 2008). The enhanced awareness of the impact of daily issues in the lives of women of color with severe mental illness can facilitate “culturally competent *recovery-oriented services*” [emphasis added] (Ida, 2007, p. 50), addressing the recovery needs of African American women who might be doubly disadvantaged because of their mental illness and the cultural stigma surrounding their illness.

Our conceptualization of life history is distinctively feminist, joining with marginalized women to contribute to a body of knowledge centered on their interpretations of their lives. The method explicitly acknowledges that the women in the LML Project are the true experts on their life experiences and express authentic subjectivity and agency (Roets & Goedgeluck, 1999). This methodology is grounded in a Black feminist epistemology, which recognizes the reality of women’s lives as informed by their socio-cultural histories and personal experiences related to unique intersections of race, gender, social class, and mental health status (Collins, 2000). The women in the LML Project—Black women, often poor, and with severe mental illness—have a “perspective advantage” (Ladson-Billings, 2000) because their reality is informed concomitantly by that of the dominant culture, Black culture, experiences of women, and experiences of those with severe mental illness. This multiple and layered consciousness results in a more accurate interpretation of their world and the world around them (Collins, 2000). Knowledge and knowledge production are situated within social relationships across groups and the collective histories and contemporary experiences of the multiple social groups within which one belongs (Collins, 2000; Harding, 1993). As such, Black women have a unique perspective, or standpoint, as a result of their multiple struggles in relation to gender, race, social class, and—

in this study—mental illness. Those who do not share these characteristics, histories, and experiences may not fully understand these realities (Collins, 2000). Without this insight, those who study their lives do so from the outside; as a result, interpretations are limited in depth and validity, more likely to be based on a pathology model (Krumer-Nevo, 2005).

Method: Combining Life History Techniques with Feminist Narrative Analysis

Life story techniques introduce the opportunity to collect rich data textured by the respondents' own interpretations of their experiences and the social circumstances in which their story has unfolded, and the ways in which they continue to be active agents (Atkinson, 1998; Gluck & Patai, 1991; Roets & Goedgeluck, 1999). Feminist life history methods serve a political purpose, to "... negotiate openness, expose hegemonic power arrangements and inherent silences, highlight secrets of oppression and resistance, and revalue knowledge that risks being disqualified in current social sciences" (Roets & Goedgeluck, 1999, p. 85). When combining methods, the techniques must be appropriate to the questions asked and transparent enough for others to interpret and evaluate them (Sosulski & Lawrence, 2008; Tierney, 1999). An important feature of combining life history techniques with feminist narrative analysis is that it provides a vehicle to reflect the women's standpoints, but it does not lead to particular findings or predetermine outcomes based on the researchers' frames of reference. This study privileges the narrators' (i.e., study participants) interpretations by examining their actual language and symbolic meaning, and presents an overview of the connections the narrators make as they weave their stories into the whole narrative construction. The following overview of the techniques demonstrates these aims.

Research question. In the present study, our research questions centered on women's self-representation, documenting noteworthy events identified by the women and contextualized within their whole life experiences. The primary research questions in the LML Project ask: (1) "How do Black women diagnosed with severe, chronic mental illness

conceptualize their life experiences and mental health challenges?" and (2) "What experiences stand out in the lives of Black women living with severe mental illness?" The question, "what stands out for you in your experiences?" is posed to the women, expressing the idea of prominence and framing the question in terms of events that first come to mind when they think about their lives. These events may or may not be directly related to experiences with mental illness.

Data and sampling. Case studies provide information about individuals in greater depth than other methodologies. Life narratives improve on this method by providing women's analysis of their own situation rather than a chronology of events to be interpreted by others. Many cases may be included and aggregate coded data employed to determine trends and understand variation across and within cases, but a single case may provide abundant examples and fertile interpretive ground (Atkinson, 1998). The choice depends on the project goals, the nature of the sample, and—in the most pragmatic sense—the available data.

Nearly all of the women in the LML Project were referred to the project through mental health agencies and are either in active treatment or counseling programs or have access to such support, as a condition of participation in the study. The women self-report their diagnoses because the study focuses on the women's descriptions of the long-term conditions of their illnesses rather than details of their clinical diagnoses or records. The center point of the study is the women's interpretation of their experiences with mental illness, rather than professional perspectives on them. For the LML Project, data collection and analysis are part of an iterative process where data from new and continuing cases inform continually evolving conclusions; recruitment is ongoing. The women's experiences are unique and dynamic, and there is no theoretical "saturation point." However, available resources for recruitment and interviewing affect the rate of data collection.

Procedures and data gathering. Data collection is multi-method, and may include first-person narrative interviews, observations, writing and informal contacts with respondents, and ethnographic research (Roets & Goedgeluck, 1999; Tierney, 1999). The primary concern is that information contributes to

the overall picture or frame for the life history and provides insights into the individual's standpoint. As data are introduced through new cases, follow-up interviews, or new data types, the methods of investigation and analysis may be altered to satisfy the research questions (Sosulski & Lawrence, 2008).

Full, informed consent to participate in the interviews and be audiotaped is essential. In the LML Project, consent includes a study overview, an explanation of benefits and compensation (\$10 per hour of interview), an explanation that risks are minimal, and an explanation of how the data will be used. One half-hour screening meeting, one face-to-face interview, and one follow-up interview are the minimum standard for participation. The first interview usually lasts two to eight hours; the follow-up interview is usually one to four hours. Other forms of data include summaries of the narratives, timelines, and original creative works produced by respondents, such as stories, poems, or songs if participants offer them to more fully communicate personal stories.

Interview techniques. Questions in life history interviews can range from an initial, broadly posed request for respondents to describe their lives to specific follow-up questions or probes that structure the histories (Atkinson, 1998; Morse, 1998). In the LML Project, interviews are taped, transcribed, and analyzed as texts; field notes are summarized when recording is not feasible. Following the explanation of life history method and the purpose of the project, the women tell their "life stories" in whatever way they like and describe notable events that they believe define their experiences (Todres, 1998)—in this case, as Black women with mental illness. Probe questions inquire about the timing of specific events or asking them to speak to thematic categories that are significant in the extant literature, such as relationships with people or institutions. Timelines may be constructed to account for events in the women's lives.

Feminist narrative analysis. Our method presents the respondents' own perspectives, assuming that they are the authority on what has happened in their lives, what they need, and what solutions might assist them. We use a dialogic strategy from the data collection stage on, first through conversation with participants during the interviews and in later conversations with them if they choose. The analysis is also a dialogue

among the research team members, who discuss the texts on three levels: (1) the literal meaning of the women's speech as they describe events; (2) the symbolic meaning or why they believe certain events occurred or why they are particularly significant; and (3) the researchers' understanding of the socio-cultural environment that connects themes across interviews or in the literature. Data and themes are compared across cases or aggregated to demonstrate trends and variation; the data also provide examples of respondents' standpoints and political dimensions of their life stories (Collins, 2000; Krumer-Nevo, 2005). Finally, respondents may comment on the researchers' interpretations of their individual interviews, aggregated findings, and overall trends.

The LML Project research team conducts thematic analysis of the interview texts as a group. The current team includes two Black women and one White woman, all of whom identify as middle-class. One researcher is a clinical psychologist; another is a certified rehabilitation counselor and professional counselor; and two researchers are licensed social workers. As a group, the researchers have first- or second-hand experience with many of the prevalent themes in the interviews, such as growing up in a working-class family, experiencing discrimination, witnessing the effects of mental illness, and/or interfamilial abuse. The narrative analysis centers on the study participants' analysis of their personal, community, and institutional relationships as well as their suggestions for local and societal change. The participants indicate how their racialized and gendered experiences differ from conventional depictions of people living with mental illness (Gluck & Patai, 1991). The researchers understand that their own perspectives are marginal, but carefully reflect on how their interpretations are likely influenced by disciplinary training and personal standpoints. The research team has no expectations about what kinds of stories might emerge from the interviews (e.g., some women may talk about childhood trauma, but we do not assume that all of them will). Yet we draw on disciplinary theory to explain structural influences (e.g., services the women receive and interactions with institutions like welfare and schools) and psychological phenomena that may be related, and to highlight areas of divergence

from the literature. Because one of the team members' training is in social policy research and the other two are skilled in individual counseling methods and interpretations, disagreements about the women's literal language and interpretations of their stories can be controversial. The team reasons through the points of disagreement toward explanations that contribute to a comprehensive final disposition. The results are related to respondents, who further add to the exposition. The circular, iterative process allows for working with the data several times and interrogating various potential interpretations, "... asking questions of it, proposing ideas about its meaning, considering what really stands out from the descriptions and pondering on what might be absent" (Mackey, 2004, p. 183).

Maria: Living Beyond Barriers

Overview of Maria's Story, in Her Words: An Example of Feminist Life History Methods

Maria is a 36-year-old African American woman living in a small Midwestern city. She is married, with four children and a steady, part-time job. Since childhood she has been "seeing visions" and hallucinating (which she describes as two distinct types of episodes). Maria said that events or others' actions could "trigger" her to be extremely sexually active or "fight people"; as a teenager she attempted suicide following a sexual assault. Despite these challenges, Maria earned a high school diploma, has taken some adult education courses, and hopes to attend college. Her early childhood before her diagnosis, her teenage years and early adulthood are marked by incidents of abuse, misunderstanding, and some self-destructive behavior. In her early twenties she was diagnosed variously with bipolar affective disorder, major depression, and multiple personality disorder. Of Maria's four children, three have been diagnosed with serious emotional disturbances. Because of her illness, Maria is sometimes unable to work and it takes all of her energy to stay as healthy as she can and patch together resources from social services programs (e.g., Food Stamps and welfare) to care for her family. As a result of finally understanding that she had actual clinical mental health issues, her

personal and socio-political awareness grew significantly; but her life has not improved materially.

Maria's life history narrative shows that despite her desire to fully participate in society, her disabilities disproportionately affect her ability to work and participate in other aspects of social life because social structures are not set up to accommodate her disability or support her attempts at recovery. Though she sees her mental illness as only one piece of her life, it seems to dominate others' perceptions of her, defining who she is to those around her. In addition, she continues to struggle with many of the same everyday issues that many African-American women without mental illness face—marriage, parenting, work, community and church relationships, and gender and racial discrimination. She says that she tries to be proactive, looking for information about her illness and ways other women have struggled and survived.

For Maria, one of the most frustrating aspects of recovery is the lack of accurate representations of Black women who are in her situation. Both academic and popular representations of "women like her" (Maria's words) lack a sense of women's whole lives and everyday experiences with their illnesses, families, communities, histories, and recoveries. She has unsuccessfully searched for answers about her illness that are specific to Black women; she has found little evidence of "women who look like her" living whole lives, coping with the challenges and benefits of living in her community—work, school, church, and her own family—in healthy ways. To her, participating in the LML Project is an attempt to help fill gaps in knowledge about the real experiences of Black women with potentially debilitating mental health diagnoses.

Maria was the first respondent to complete interviews in the study, and hers is by far the longest interview, with over 23 hours of dialogue. Her relationship to the project reaches back to 2001, through her participation in a study of poor women pursuing higher education. During the prior study, it became apparent that Maria's experiences with severe mental illness were primary, but among many facets of her history that intersected. She was disturbed that her diagnosis could determine her opportunities. From her standpoint, struggles with mental illness and recovery do not define her as a worker or parent;

yet they were integral to who she is. In fact, they provided her with insights and could help her uniquely contribute to the community and society.

Maria's interviews. Maria's life history was collected through confidential in-depth, face-to-face interviews at four time points, between 2001 and 2007. The interviews were conducted with the principal investigator, who is a married, childless, middle-class, White woman with a doctoral degree who is close in age to Maria. Preliminary consent for Maria's participation was based on the agreement that only the primary researcher would conduct the interviews: Maria noted that this preference resulted from the already-established relationship, rapport, and trust between her and the researcher during her participation in a previous study and her desire to contribute to understanding how racial identity and mental illness intersect. She completed all of the confidentiality and informed consent procedures. Maria also provided stories and poems that she wrote to describe her situation, with the hope that they would help the research team understand her narrative and someday other parents could see them and better understand the experiences of children with emotional disturbances. The following examples are excerpts from two days of interviews.

Maria began her narrative spontaneously after the interviewer explained that the results of the project could be written into journal articles or possibly a book:

I wish I could have got into that. Nobody ever told me that I could do certain things. So, I'm 34 years old, and I wish I could go back, knowing now what I know because I would've been successful. Especially like that ... books and stuff because my life is just too complicated. People don't believe that. But I have the proof (she laughs) ... in the medical records....

Maria went on to talk about why she wanted to participate in the LML Project:

I need relief. Believe it or not, from the family that I come from, this [mental illness] was not supposed to ever happen. And it's still not acknowledged. ... I did a lot of sinful things, which went unexplained;

so ... this is to be a testimony and help me get over some of the things that I've done ... now knowing and understanding why I've done it. 'Cause people and all the doctors, they look at me and they ask me for my history. And then when they find out ... they cannot believe the diagnosis. ... and it hurts my feelings a little bit. ... they mean it as a compliment, but I don't take it that way. ... In public, as long as I'm calm and no one sets me off, I'm typical. But (she laughs) ... people are harsh and they are unforgiving, too.

In this first set of interviews with Maria, an exemplary major theme directly related to the overarching research questions emerged: how she perceived the "origins of her mental illness" as they are situated within the context of the rest of her life experiences, from her standpoint. This theme helps tease apart the potential effects of intersections of gender, race, and mental illness on her well being. It provides clues to the roles that personal barriers, systems, and structural inequality play. Exploration of how Maria constructed the narrative provides insights into how she thinks about and represents her experiences.

Origins of mental illness. Throughout all of her interviews, Maria talked about her beliefs regarding the origins of her mental illness. She presents her mental illness as an inherent trait, with genetic explanations. Separately, she describes a "gift" that she believes was divinely instilled in her, through which she can see and communicate with God and the devil. Although these "visions" may be hallucinations, she describes them as distinct from and more "real" than her psychotic hallucinations, which she recognizes as part of her illness. Though frightening for her, she also understands the visions as protective, and a way for her to connect to her church community. For example, Maria says that the visions are often premonitions, and other people have witnessed her predictions coming to fruition. Throughout her narrative, Maria carefully distinguishes between these genetic causes of her mental illness and her "gift." Tracing the different ways that Maria talks about the hallucinations, visions, and incidents of violence in her past provides an opportunity to understand her standpoint and current situation. From a practice perspective, there may be

several interventions that could be considered at times when Maria experiences a mental health crisis: For issues that Maria relates to as mental illness, medical or psychiatric counseling may work best for her. For issues related to visions or spirituality, interventions such as pastoral counseling (perhaps in connection with professional therapy) or work with church elders or members who understand and are conversant with mental health issues may be the best route in her recovery process. Intervention may include helping Maria individually with her symptoms, but also intervening in the community to promote acceptance, support, and integration. These findings further reinforce the potential of broader measures to inform and educate mental health professionals about the importance of spirituality and religion in clients' lives, and also to inform spiritual leaders of all faiths about mental health issues, to draw connections among these institutions.

Furthermore, in this narrative, it is essential to understand that Maria sees what appear from the outside to be hallucinations very differently, depending on the context (i.e., visions vs. mental illness). One important aspect of reconceptualizing mental health and mental illness is that they are multi-faceted, from the standpoint of clients. While the client's experiences are often seated in culture and group affiliation (e.g., religion, race, gender, or class), Maria's interpretation of them is individual and unique. Thus, a method such as case narrative is necessary to understand what her interpretation is, and life history promotes further understanding of references and connections she makes, both factually and their relative importance to other events.

Genetic causes. Maria has thought a great deal about why she has mental illness and behaves the way she sometimes does. She is convinced that her illness is inborn. At the outset, she says:

I'll take you through the beginning, 'cause maybe you'll understand. ... In my heart I believe I was born with this disorder, and I knew that there was something wrong with me, even as a child. ... as time went on, I was able to understand different things and see the differences within myself versus the other children.

The second day Maria talked more about this: "... [mental illness] had to get there some kind of way. I don't honestly believe that a person can just wake up one day and say something is wrong ... I just don't believe it is something you're not born with or there's not a genetic link." Maria believes that many other family members also lived with mental illness, in particular her grandmother, with whom she was very close: "There were a lot of conversations and actual events that would lead me to believe that my grandmother, and I loved her so dearly, had this disorder." At an earlier point, Maria described her grandmother as "... a strong Black woman, for real! You didn't mess with her (she laughs). She did some things! I think that's probably where I get some of ... that temperamental stuff from, because she ... (laughs again). God bless her, ... she was a good woman."

Maria demonstrates the closeness she feels, as she describes her grandmother's behavior in similar terms as her own, including "wild," risky behaviors and sudden, violent outbursts:

[S]he did some wild things that I wasn't even aware of until I became an adult. What I meant by wild is, ... she was very outspoken. She said it the way it was and if you made her angry or not, she'd actually do things physically to show you that she was going to be in charge. I mean, it's not normal little stuff, you know.

Here, Maria refers to the idea that other people or events can serve as triggers for violent behavior. Maria said that in an angry outburst when she thought her own husband was cheating on her, she cut up his clothes and set them on fire. They also fought physically. Maria learned later that her grandmother had done similar things:

I remember hearing a story about her cutting up my grandfather's clothes and he's the pastor of a church. I heard about the angry episodes and the fights. And how she was very—she would be so sweet and calm and loving, ... But in a matter of seconds, change into something totally different. ... But, then it's just like we knew that there were some things you just don't talk about.

Maria was always calm, considerate, and engaging (i.e., “sweet”) during the interviews, making the parallel to her grandmother’s behavior striking. She says she suspects that other family members also live with severe mental illness, including her father and second cousin:

I do believe that there is a genetic link, I really do. Because if I look at my grandmother and then I look at my father Now that I understand what is wrong with me for real. I know he had that. . . . because my dad is crazy, . . . so messed up. He’s so cruel, it’s just like he has no conscience of what he does.

She also says,

[I]t’s a coincidence how [her grandmother’s] sister’s daughter had some of the same genetic stuff [behaviors, now attributed to genetics] that I have. And then there were a couple of other [relatives] that . . . should have probably been diagnosed with something too, because they had been hospitalized. As a child, you don’t know how to look for that. All I knew was something was wrong with how my brain worked.

Maria is convinced that she has passed on mental illness to three of her four children who have been diagnosed with learning disabilities and serious emotional disturbances (SED). She prays that her fourth child, a four-year-old girl, will not be diagnosed; she said that she does not see symptoms in her youngest daughter, so she is hopeful. However, her oldest daughter, at 13, has already experienced psychotic events, aggravated by stress. Maria attempts to help her cope: “And I tell my daughter, we’re just different, that’s all. . . . And I talk to her on that. I tell her our brain just doesn’t work like other people’s, because that’s just the truth of it all.” To Maria, if her children cannot avoid symptoms, she wants to normalize their experiences by explaining that there is just something different—not wrong—about them.

The “gift.” There is a second way that Maria describes experiences that might appear to be symptoms of her mental illness. She said that according to people in the Pentecostal

church where she grew up and where her grandfather is the pastor and her father is a deacon, her visions are a special gift. From an early age, she said that she saw visions of angels and demons, and that some of the visions were premonitions: "I was what they were calling 'anointed.' Anointed means that you're kind of like ... you're special and when you speak and say things and do things ... it goes out and it really reaches somebody." Though the visions attracted attention, Maria says that she was mostly scared by them; she also believes that the visions could be triggered by outside stressors, but was not aware of how the stress affected her in childhood. An example of an early church experience illustrates:

My cousin did something that set me off. ... And I told her there was a black spirit standing right in the door. ... I saw it. I told her, you may not want to take your ass out there, I went off. ... Even the church women freaked. I freaked out so hard. And I was crying and jumping up and down because I told her you go out there and you, you goin' die, you goin' die. Because I saw it there. We ... okay, everything calmed down. Everything relaxed within myself. We go to the damn door and ..., lo and behold, this same black spirit that I had saw [was there] and I was screaming at the top of my lungs so everybody ... knew that I had saw something. That same spirit that I saw went to Mother Chapman [a pseudonym] ... and laid on top of her. I was standing and screaming and do you know, she collapsed? She collapsed, that's on record, you can verify that story. That woman had to leave on a stretcher, they had to call the paramedics, they revived her in that auditorium. And I'm watching the black thing lay on top of her...

Maria asserts that the congregation believed that she had seen the devil,

And from then on, it's just like, if I said anything or saw anything and said anything about it, nine times out of 10 people would somehow have a guard up 'cause that was not the only time I had said something and something had responded out of that ... so everybody kind of thought it was a religious thing with me, you know. God gives gifts to certain individuals.

Maria went on to explain that while she was not always sure that it was a “gift from God,” she is never quite sure how to feel about her “visions,” because “it kinda felt like it all tied into that religion part.”

The utility of the life history method is evident in this theme, because had the research question been focused solely on experiences of mental illness, Maria might not have discussed her visions, because she tends to think of them as separate, not part of the psychotic disorder. Maria may have also opted to maintain this separateness because of contradictory views of the Black church about mental illness. There exists a natural incongruence with “the church’s” view on mental illness, and mental health services’ conceptualization of the nature, course and treatment of psychiatric disorders (Blank, Mahmood, Fox, & Guterbock, 2002). This incongruence can often lead to conflicts between the values of the church and the person seeking treatment for mental illness, or may even pre-empt a church member from seeking treatment for mental illness. Given this divergence, the research team concluded that it is possible Maria has couched her visions as a separate, spiritual concept because that is a more acceptable reality for a member of the church body. This is reasonable, given Maria’s desire to return to her church someday.

Deconstructing the interview. The quotes presented here are examples of the literal language and symbolic meaning that Maria used to tell her story. She also constructed her story consciously to represent the meaning and the role that mental illness plays in her life. Through the analysis of her transcripts, it appears that her stories follow an intriguing pattern with respect to time. She began with her perspective on why she is participating in the LML Project. Then, she told a story from her early childhood. A story from her early adulthood followed, and another from her early childhood, followed by one from the present, and finally returning to early childhood. She ended the first day of the interview with a present-time story. Most stories centered on childhood, either her own or that of her children. It seems that she is conscious of both of these trends on some level, as she talked around the issue of whether she would have children if she had known that mental illness has a genetic component:

I: When we talked before ... you told me that you wouldn't have had the kids ... at all?

Maria: I don't think I would have. It's just ... let me explain it. I am scared to cross that bridge, so I will weave around it a little bit.

I: Sure. We'll come back to it.

She deferred, but then answered the question with a story of her own childhood experiences. She did weave her stories, consistently returning to stories of childhood every other story. In this case, she moved from a story about the present to one about her late childhood/early adolescence, when she was raped by an acquaintance and became pregnant. She never disclosed what happened to that pregnancy, because it was too painful, she said. The story of that pregnancy was the only story that she explicitly declined to tell, and apparently it is the only year of her life that is missing from her narrative.

It is unlikely that Maria structured her story in response to the interviewer's questions, which throughout the interview were for clarification, such as "Can you tell me more about that?" or "Can you explain what you mean?" rather than leading to specific times in respondents' history. Life history framework allows respondents to relate the stories in their own particular order. Thus, strategies for the narrative or unintentional patterns emerge. When strategies or patterns are noticed, they may be included in the analysis and/or discussed in follow-up interviews for further interpretation. There are several emerging patterns in the LML interviews, such as the roles of risks, protective factors, and access to opportunities (e.g., work and higher education) that warrant further investigation.

Discussion

Life history method assisted Maria in constructing her own narrative. She focused primarily on her childhood, including painful and joyous memories, developing consciousness about her mental illness through her stories about children and childhood. She related lessons she has learned about herself, her family, her community, and institutions that she relies on for

help and sustenance. She believes that mental illness is a part of “the way she is,” and that there are many other people who were born like her. Her behavior is mediated both by her reactions to memories of stressful and traumatic events and by the importance she places on being calm and present for her children. Yet she also recognizes the responsibility of her family, community, and professionals as entities that should have seen her mental illness and helped her get treatment; should have told her that mental illness is genetic, so she could make an informed choice about whether to have children; and should have stopped her violent outbursts and protected her from the violence that was perpetrated against her. Yet at other times in her narrative, her family helped her find treatment, information, and even presented her with a potentially protective perception that some of her “visions” are a gift that she can appreciate and perhaps provide her with power and status within her church community. Most of all, the collection of stories and the way in which they are told help us formulate insights into Maria’s standpoint and how mental illness fits into the complex chronicle of events in her life.

Practice Implications. There are significant practical benefits of using life history methods combined with feminist narrative analysis to uncover effective practice modalities. These methods highlight the women as subjects in their narratives. They are reflective in representing and interpreting stories, which account for whole-life, everyday experiences and paths of—rather than to—“recovery.” When treatment is necessary, the women must be involved to the greatest extent possible. In some cases, traditional forms of mental health treatment may be altogether inappropriate, or may need to be modified according to the women’s experiences and expectations. At other times, working with families, communities, and institutions to help include people living with mental illness and acceptance of their standpoints is the primary goal.

In Maria’s case, the hallucinations belong to her mental illness and are symptoms from which she would like relief; on the other hand, her ‘visions’ provide a special place for her in her church, which she may not want to give up. Multiple solutions could include helping her find another way to contribute to her spiritual community that is valued, if the visions

somehow ceased. Alternatively, helping her and her community come to terms with all of her hallucinations may be another way for both Maria and her community to change and become more tolerant and inclusive. Furthermore, while the mental illness is an aspect of her life that can be troubling and has triggered behaviors that she has recently been able to stop with treatment (e.g., occasional violence and sexually risky behaviors), the “genetic link” is also a way that she relates to her family members. Her relationship with her father is still problematic, as he continues to be violent and has excluded her from the family; however, Maria cherishes some memories of her grandmother and needs ways to connect to the positive aspects of their relationship and her childhood. To the extent that her visions and hallucinations do not trigger outbursts and that she feels as though she can work and parent effectively, individual intervention may be limited to maintaining her own functioning and community intervention expanded to working with her church community and family to maximize positive interactions. Finally, while Maria is afraid that her children’s diagnoses with SED and expresses remorse for possibly passing mental illness on to them, she also recognizes that she will be able to help them cope with it, given her understanding and reflections on her own experiences. She counts this as a strength.

Policy Implications. The gaps in the literature regarding race, gender, and mental illness bear out Maria’s observation that there is a dearth of information about what living with severe mental illness is like for Black women in America. The power of life history methods and feminist analysis is of the power that circulates in society, from Maria’s and the other women’s standpoints. Maria’s narrative reaches beyond issues of “access to treatment” and medical models of mental illness that tend to consider women while they are in crisis. More recognition must be given to the ways in which women of color routinely juggle many roles and must assume multiple responsibilities, including work, family, and community involvement. Living with severe and persistent mental illness complicates these efforts; if not addressed quickly and competently, difficulties managing episodes of poor mental health can put women and their families at increased risk, especially when gaining access

to essential services is delayed (Takeuchi & Kim, 2000; Wilson, 2001). These are crucial issues to address, but these questions may only speak to a small piece of the story of these women's whole lives.

Applying Deegan's concept of recovery as an "existential phenomenon" (Jacobson, 2004), Maria's concept of ideal recovery does not embody a return to normalcy according to medical or social standards, but a kind of being in the world where she defines her own priorities in terms of her health and caring for her family. Her recovery involves working toward her own goals, maintaining employment and being a strong model for her children, even though she struggles economically as a result. Her ongoing participation in social programs (e.g. welfare) shows that she can navigate systems and institutions, but these programs are not user-friendly for people with mental illness. Throughout the life histories in this project, Maria and others resist conformity to social norms of mental health, and the idea that their priorities should be set by others, particularly authority figures within institutions such as churches and mental health systems.

Research Implications. For this study, the feminist life history methods fulfilled our expectations, and helped accomplish the goals of presenting Black women's experiences with mental illness as a part of their whole lives. It is not a goal of the project to conclude whether Maria or the other women in the LML Project have succeeded or failed in their attempts at recovery. Instead, Maria's multidimensional interpretation of her own stories facilitates understanding of how the events touched her personally and how they both affected and were influenced by her family and community, as well as ways that social norms frame the etiology of mental illness and shaped her experiences.

Feminist life history methods exemplify increasing trends toward collaborating with participants to amplify their subjectivity and agency (Sosulski, 2009). This method stands beside other multidimensional approaches in presenting holistic views of experiences, rather than small slices of decontextualized data; but it additionally integrates the women's standpoints in the process. Using life history methods combined with feminist narrative analysis treats the texts of both

the women's narratives and the extant literature differently, in that it takes into account the history and social context of not only these individual women's lives, but also their group affiliations, communities, and social location. Thus, three central goals of the project are met: first, to represent the lives of Black women with mental illness holistically, capturing the nature and impact of the illnesses within the scope of their whole lives; second, to represent the women as people, rather than as problems to be solved; and third, to identify the illnesses and experiences as part of the women's stories, rather than as anomalous to their lives or as barriers that can be removed so they can "recover" and be "normal."

To improve service delivery and inform policy, more accounts of Black women's experiences with mental illness must be gathered to represent the complexity and richness of the women's lives. It is equally important to provide models for Black women that reflect ways in which they successfully navigate programs, services, and daily concerns along with difficulties they encounter living with serious illness and the risk of negative social and economic consequences. Future research must continue to answer basic questions regarding how Black women living with severe, chronic mental illness frame their experiences within the context of their whole lives. Of particular interest are the myriad influences on women's lives and well-being (e.g., family, community, education/work, trauma, recovery, spirituality), including institutional responses to individual strategies they use to maximize their life chances and power of social and political communities they form with the potential for changing how mental illness and recovery are conceived.

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