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Methodology and mental illness: resistance and restorying

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Accessible summary

- This paper compares two post-modern methodological approaches, post-structuralist and narrative, and considers their usefulness in relation to emancipatory research in mental health.
- The paper finds that post-structural analyses can be useful in deconstructing oppressive practices and in indicating emerging forms of resistance.
- Narrative approaches potentially offer greater emancipatory scope than post-structuralism as they enable people with mental health problems to restore their lives and enact their own subjective transformation.
- However, narrative templates may perpetuate injustice if they erase the complexity of people's stories. This raises ethical issues in relation to narrative interpretation.

Abstract

Concerns with social justice have been traditionally associated with a modernist concept of the individual whose actions express an underlying, essential and unified self. This paper compares the usefulness of two methodologies (post-structuralist and narrative) that are based on a rejection of identity of a unified self and compares their usefulness in relation to the development of a social justice paradigm within mental health. It considers how professional forms of knowledge may be deconstructed by post-structural analyses, arguing that these have also been used by service users to articulate more enabling discursive alternatives. The notion of agency is central to our understanding of social justice. We question the commonly held assumption that although post-structuralism deconstructs power and challenges its legitimacy, it is nevertheless unsuited to facilitating the necessary agency to put forward viable alternatives. The second half of the paper considers how narrative research offers greater emancipatory potential by enabling the research subject to author their stories and thereby brings about their own subjective transformation. Nevertheless, the interpretation of people's stories by researchers may result in the imposition of narrative templates that erase complexities and contribute to the perpetuation of oppression. This raises ethical implications in relation to how people's stories are interpreted.

Introduction

Concerns with social justice have traditionally been associated with moral and emancipatory agendas embedded in modernist truth narratives. The agent or subject of modernist narratives is the individual whose actions express an underlying, essential, unified self. Marxism for example, is

a project of modernity: first, in the sense that it is premised on the notion of unified subjects (the proletariat and the bourgeois); second, it draws on a narrative of truth (class injustice); and third, it is based on the moral assumption that social injustice should be combated. Importantly, modernist agendas presuppose that there is a real world 'out there' that we can understand and improve through

the application of rationalism. In contrast, our focus on social justice within mental health interrogates two methodological approaches, namely post-structuralist and narrative, that reject modernist interpretations of identity in favour of what have been termed post-modern or 'bundle formulations' of subjectivity (Holloway & Freshwater 2007). Post-modern approaches have sometimes been received critically for closing down the potential for agency and for social change (see Francis 2000). We, however, take the view that post-modern scepticism regarding the unified subject of modernity can prompt ways of conceiving of identity that open up new approaches to thinking about mental health. Furthermore, we question the value of labels that define people on the basis of medical diagnoses. The fact is that categories of sanity and insanity are more fluid than is often supposed. In other words, 'the sane' are not sane all the time and, conversely, 'the insane' are not insane all the time.

The main objective of this paper is to consider post-structural analyses and narrative in order to highlight the role language, in particular the notion of 'recovery', may be applied to either perpetuate or combat oppressive practice in mental health. Our interest is in how identities are constructed, deconstructed and restored in post-structuralist and narrative approaches. Our starting position is that the self is not a unified and relatively fixed entity that has thoughts and feelings but that identity is created through interconnected thoughts and feelings (Elliot 2005). In other words, identity does not precede thoughts and feelings; it is thoughts and feelings that create a sense of self. This is not the same as claiming that the identity is an illusion, rather it supports a view of identity as dynamic and reflexive rather than based on enduring psychological characteristics. As Hoggett (2001, p. 42) argues, there are 'powerful integrative forces at work within subjectivity', so that each is both one and simultaneously many. The notion that identity is fluid rather than fixed is a key to understanding how the identities of people with mental health problems can be reconfigured within post-structural and narrative approaches.

The dominant discourses in mental health are largely drawn from a scientific experimental model that identifies mental disorder or distress in terms of either a biologically/genetically based, or alternatively as a psychological, mal-functioning (Lees & Freshwater 2008). In this paper, we consider how medical and professional knowledge can be contested by post-structural analyses. We believe that this is particularly important in a context in which service users are increasingly expected to behave as discerning consumers who pursue and take responsibility for their own well-being. What is often overlooked within the discourse of consumer choice and empowerment is that experiencing

oppression may undermine people's sense of self and therefore their agency and capacity for positive self-transformation [Bourdieu 1984 (1979)]. The notion of agency is central to our understanding of social justice. Post-structuralism has tended to emphasize a view of identity as constituted within discourse; nevertheless, we consider that post-structuralism opens up the potential for agency. Finally, we turn to narrative, which we view as offering perhaps the most potential for the facilitation of emancipatory change through restoring the experiences of mental illness.

Defining the terms

Before proceeding further, we first take some time to define our use of the methodological and epistemological terms that are applied in relation to the two methodological approaches we discuss in this paper. We note that conflicting definitions are commonplace and that usage may vary across disciplines. In some cases, terminological challenges, for example defining how 'discourse' differs from 'narrative', seem to be more about personal preference than anything else. While recognizing the difficulties inherent in applying precise definitions here, we use the term 'narrative' to denote a recognizable cultural template relating to the narrator's identity that is applied in personal stories, for example the 'heroic narrative' or the 'narrative of restitution' that people tell to construct and maintain a sense of self; 'stories' on the other hand refer to more personal accounts. Our definition of the term 'discourse', derived from Foucault (1980), relates to how systems of representing knowledge and social roles are constructed and maintained in language. Not as long as stories, discourses are taken here as embedded within segments of language, usually longer than a sentence, and they establish meaning that is related to the exercise of power. The medical discourse, for example, establishes an area of legitimate knowledge as well as constructing the respective roles that should be played by physicians and patients. Whereas a story *should* be ongoing and open (Frank 2005), the Foucauldian perspective is most commonly equated with the idea that discourse is inextricably linked with gaining and preserving power and therefore seeks foreclosure by resisting change and unanticipated deviations. This position is, however, questioned in this paper.

We note that the term 'discourse analysis' is often used synonymously with post-structural analysis, and although the boundaries between the two are not always clearly delineated, it is worth pointing out the differences. Post-structuralism is an epistemological, ontological and methodological perspective that focuses specifically on how language constructs claims to truth. Post-structuralists

argue that practices and identities, including those of researchers, are always constituted and immersed within language; therefore, researchers cannot analyse language as objective scientists who stand outside it. In contrast, discourse analysis may incorporate a range of methods and epistemological approaches within the social sciences (Yates 2004). Wetherall *et al.* (2001, cited in Hui & Stickley 2007, p. 418) have identified three broad categories of discourse analysis: social interaction (conversational analysis), identity and sense-making (discursive psychology), and culture and social relations (post-structuralism). This latter perspective, which is the one that concerns us in this paper, can be divided into at least two distinct types: first, critical discourse analysis (CDA) that involves drawing inferences from structural and linguistic features in text as well as relating these to macro sociopolitical concerns (Fairclough 1992); second, post-structural analysis (which is sometimes also referred to as discourse analysis) that does not necessarily involve close textual or linguistic analysis but shares CDA's concern with the relationship of language to social relations and to how language operates within power relations (Taylor 2004, p. 436).

In the context of this paper, we turn our attention to the similarities rather than differences between CDA and post-structural analysis. Although some studies are clearly definable as part of the CDA tradition, CDA and post-structural analysis are not discrete categories, and post-structural studies often include at least some attention to linguistic features. Furthermore, both approaches draw on similar theoretical perspectives (often Foucault, but also Lyotard and Derrida) that do not seek to discover the 'truth' or an objective reality. With its rejection of the neutrality and objectivity of professional knowledge to determine what is 'normal' and what is not, post-structuralism seeks to expose and critique invisible forms of power, shrouded in a veil of 'commonsense' and legitimized within professional discourses. To take an example from mental health, attention is not directed to whether or not a diagnosis such as schizophrenia reflects an objective reality; the focus is on revealing how such categories, which label and objectify individuals, are constituted within discursive practices. Critical discourse analysis and post-structural analysis (the two approaches are hereafter jointly referred to post-structural analyses; the use of the plural is to recognize the differences) seek primarily to reveal veiled exercise of hegemony (meaning how power is exercised over people with their tacit consent) (Fairclough 1992, p. 93).

Post-structural analyses

Since the 1980s, there has been a policy emphasis on encouraging service users (and the general public) to be

active in shaping public-sector services, particularly in relation to the delivery of health and social care [see for example, Department of Health (DH) 2000, 2008]. This has been justified by an ideologically based expectation that positioning service users as consumers would result in higher standards of treatment and care. At the same time, giving service users more influence was seen as a way of encouraging more active citizenship and extending democracy (Lewis 2009). Furthermore, the incorporation of the European Convention on Human Rights into UK Domestic Law in 1998 has led to the provision of care being increasingly considered in relation to human rights, leading to greater emphasis on the principles of dignity, equality, respect, fairness and autonomy (DH 2007). The discourse of mental health policy has changed to reflect the consumerist and human rights agenda. In *New Horizons: a shared vision for Mental Health* (DH 2009) and in the subsequent mental health strategy, *No Health without Mental Health* (DH 2011), the language of 'recovery' is employed. This is based on a recognition that people should be in control of their lives. However, less attention has been paid to describing the type of professional/service user relationships necessary to achieve this. We turn now to consider how the ostensibly emancipatory articulations have been interrogated within the post-structuralist paradigm.

Hui & Stickley's (2007) study, with its specific focus on service user involvement, finds that although a broad consensus on the value of service user involvement has been reached, quite different ideological understandings of what service user involvement means are being articulated in differing discursive strategies. In government policy documents, the benefits of service user involvement are often extolled within the context of partnerships; however, the service rather than the service users are identified as the main source of power. Power is thus represented as a resource or a commodity, which can be partially devolved to service users. References to service user involvement appear tokenistic, with service users generally referred to at the end of policy documents, almost always after discussion of the role of statutory bodies. Semantic continuities with past practices are also telling: people with mental health problems are invariably referred to as 'patients', 'service users', 'users', but rarely as 'people'. As Hui & Stickley point out, 'If service users are at all perceived as partners within these documents, they seem to be a very silent partner' (p. 422).

Studies based on post-structural analyses are sometimes interpreted as useful for revealing the vested interests that lie behind dominant discourse while being less helpful in pointing to emancipatory alternatives. The argument is that if individuals are simply 'docile bodies' constituted through the effects of power, this leaves no room for

resistance to power (Fraser 1989). Equally, if all principled positions can be deconstructed, the purpose of social research becomes uncertain. In other words, a denial of independently justified norms cannot be consistent with an emancipatory agenda. For Fraser (1989), for example, Foucault provides a normatively neutral stance on power that limits the value of his work for feminism (and presumably other modernist projects that seek to challenge injustice) because it fails to provide a basis for the development of new agendas for social change.

Does this mean that post-structuralism can be justifiably indicted as a conservative and reactionary paradigm that is supportive of the status quo? Certainly, this has been a view held by many, although not all, feminists (see Francis 2000). However, what tends to be overlooked is that Foucault saw power as *produced* by human agency; he referred to power relations rather than power as a unified entity (Foucault 1980). While understanding that relations of power have cruel consequences, Foucault (1988, p. 98) emphasized that power can circulate, and individuals are 'vehicles of power' not merely sites where power is exercised. While Foucault's earlier work is primarily concerned with the institutions in which subjection takes place, in his later works, he (Foucault 1987, 1988) turned his attention to how people can make choices with regard to their own self-constitution. Although the self is always constituted within discourse, Foucault emphasized that people can exercise choices as to how they are subjected. There are choices in relation to the disciplinary practice we subject ourselves, for example, fitness, dieting, learning or psychotherapy, all of which offer their own 'regime of truth' that can be chosen. Frank & Jones (2003) point out that this does not stem from false consciousness;¹ instead, it represents self-subjection – the subject decides which technologies she or he will be subjected to for the purposes of ethical and aesthetic transformation. At the same time, the subject can also exercise a certain freedom over the terms of their subjection. For people with mental health problems, therefore, freedom does not necessarily entail a wholesale rejection of the medical model, some of its benefits are real, but it leaves scope for a service user to decide whether or not they are willing to take on the role of 'a patient with its all essentialising assumptions' (Frank & Jones 2003, p. 185). The notion that post-structuralism is capable facilitating agency is often overlooked and is an important aspect of this paper, which is addressed in the discussion that follows below.

¹False consciousness is a term taken from Marxist theory. It describes a state of mind that prevents people from being able to see exploitation and oppression.

Having previously addressed how, in government documents, interpretations of service user involvement are inflected with discursive constructions that suggest continuities with the symbolic violence of past practices, we now return to the study by Hui & Stickley (2007) to consider the counter-discursive strategies employed by service users. Among the several examples of discursive 'subversion' provided, one involves a tactic of placing a far greater focus on past practices. Effectively, this temporal 'manoeuvre' widens the spectrum for assessing present practices and, in so doing, displaces official understandings that equate service user involvement with a paternalistic devolution of centrally held power; instead, the emphasis is shifted to how service users might strategically *regain* agency previously lost through oppressive practices. This is a skilful discursive tactic that challenges the notion that powerless experienced in the present is rooted in individual deficiencies. Enabling service users to identify themselves as an oppressed group, it undermines the tacit notions of deficiency and reframes service user involvement in a discourse of social justice.

While service users may have a vested interest in the problematization of biomedical discourses, however, biomedical discourses are equally instrumental in sustaining power inequalities between different groups of professionals, thereby buttressing the dominant status enjoyed by the most powerful group (physicians) over *allied* professions (Mancini 2007, Powers 2007, Zeeman & Simons 2011). According to Zeeman & Simons (2011), who examined the introduction of the role of mental health worker (MHW) in Southern England, holistic forms of care that underpin this relatively new role have gone some way to challenging biomedical discourses through the promotion of psychological and person-centred discourses (Zeeman & Simons 2011). This, it is argued, has led to more holistic forms of practice that do not identify the service user merely as the object of the medical gaze. The tactical promotion of person-centred discourses can be applauded as an appropriate and overdue redistribution of professional power (that also benefits service users), but it raises a couple of points for consideration. First, the ground gained by person-centred discourses in clinical practice is likely to remain tenuous until it has become embedded in the academy where positivist methodologies continue to enjoy disproportionate levels of influence (Freshwater & Rolfe 2001; Rolfe 2002). Second, and related to this first point, ostensibly embracing multidisciplinary discourses could be interpreted as an adroit tactic by the proponents of biomedical discourse to protect their sphere of influence strategically rather than aggressively; in other words, by ceding some ground to competing discourses, they ensure that these remain subservient (Rolfe 2002, p. 4). Therefore, the

question arises as to whether multidisciplinary development is being deployed as a 'discourse of tolerance' that acts to neutralize challenges to the status quo. This is a factor that deserves some consideration in relation to the shifting discursive landscapes that shape professional status.

Even if the more hopeful view that discursive shifts are democratizing health care is accepted, Foucault (1977) reminds us that once a group of professionals have gained power through discursive shifts that reconfigure their roles, they are likely to create new 'regimes of truth' that in turn reinforce their position of power. Thus, the realignment of discourses of professionalism constitute yet another strategy among a group of professionals (in this case, MHWs) to seek the expansion of their power base through the development of a range of approaches and techniques that perpetuate the subordinate position of the recipients of mental health care in new ways. This is not to suggest that this is an explicit strategy but rather to acknowledge that all are inevitably bound up and implicated in circuits of power. As Bhaskar (1989, p. 80) puts it, '... people do not marry to reproduce the nuclear family, or work to reproduce the capitalist economy. But it is nevertheless the unintended consequence.'

From a post-structural perspective, an interest in eroding the hegemony of biomedical discourses does not equate to an interest in an ideologically neutral vista on mental illness. Indeed, from a post-structural perspective, this would not be possible. In Zeeman & Simons' (2011) study, the main focus on the quality of service user/professional interventions, it does not, however, acknowledge that Foucault viewed *all* clinical settings primarily first and foremost as sites in which subjects are constituted in order to comply with relations of power. This is not a criticism – a paper must necessarily limit its focus – but it should not be overlooked that the provision of care is not ideologically neutral. Relationships of power between professionals and service users need to be considered in relation to broader social relations that impact on how power is distributed in society. The exercise of power necessarily informs the relationship between service users and professionals, which are in turn embedded in broader social relations. One of the strengths of post-structural analyses is that they can direct attention to the sociological and political dimensions that shape how power is distributed in society. These are often obscured by a focus on individual pathology despite growing evidence that links psychosis with adverse life events and social disadvantage (Read *et al.* 2005). The reality remains, however, that the more socially disadvantaged an individual is, the more likely they are to experience psychosocial suffering (Skeggs 1997, Moglen 2005, Reay 2005, Freshwater 2006, Fisher

2007, 2012, Frost & Hoggett 2008). Furthermore, as psychology is grounded in Western discourses that define citizenship according to the norms applied to the white male bourgeois and people who do fall short of this standard are liable to be categorized as deviant. Women have historically been overrepresented in this category, which has, among other things, led to their incarceration of women for pregnancy, prostitution and witchcraft. Significant differences in the diagnosis, treatment and outcomes are also observable across different ethnic groups with the UK context, with African Caribbean people, in particular African Caribbean men, being most likely to be diagnosed as schizophrenic. There are two issues to consider here: first, the power of ethnocentric discourses, and second, the impact of disempowerment, disadvantage and exclusion, which are not equally distributed equally among ethnic communities (Freshwater 2006). The dominance of the medical model means that such complexities may be erased or overlooked, and actions are reinterpreted as symptoms. Behaviour, instead of being interpreted as one form of action among a range of possible actions, is reconfigured as representing the true essence of a person. Although MHWs may challenge biomedical interpretations, it needs to be considered the extent to which they may at the same time contribute to the construction of a differently transgressive subject.

A political voice

Our discussion has so far considered how post-structural analyses may be helpful in deconstructing discourses of power – as well as exposing nascent alternatives. Does this mean that we can claim that mental illness be regarded as another sociological category alongside class, gender, race and sexuality? Can those labelled with mental health diagnoses legitimately be seen as constituting yet another subaltern population disadvantaged through dominant discourses that perpetrate normative notions of citizenship? If these are reasonable questions to ask, it might follow that mental health is a political problem that legitimately falls within the framework of a politics of recognition or of identity. Certainly, the case for this merits deliberation when it is considered that mental health service users constitute a group who can be regularly labelled irrational, lacking in competence, deficient in agency and in some cases, even deficient in humanity (Radden 2012, p. 2). Whether or not the ultimate goal should be to valorize mental health diversity and differences (thereby locating mental health alongside gender, ethnicity, sexuality and increasingly disability) is beyond the scope of this paper, although this is an important concern that deserves to be debated far more widely. However, what we specifically

wish to highlight here is that similar to other socially disadvantaged groups (often those commonly labelled 'vulnerable'), people with mental health diagnoses continue to be denied what has been termed 'epistemic authority' (Fricker 2007 cited in Radden 2012, p. 2). As Radden (2012, p. 3) explains,

The mad have been excluded from the epistemic as well as the social community, their voices disregarded and dismissed as meaningless. Their struggle must include being believed as credible knowers, as well as being merely heard.

Some mental health activists, taking their lead from other civil rights movements, are challenging medical labels by symbolically redefining themselves as 'survivors', 'consumers', 'mad pride' and 'recovery' groups; however, such instances of resistance do not divert us from the oppressive impact of discourses of deficiency, which can lead people to experience the power that someone else has over them as natural and legitimate. Post-colonial literature has identified forms of psychic violence [Fanon 2004 (1961)] when a dominant cultural group or class invades a subject's discursive mindscape and shapes what they are able to feel or think. Similarly, in *A way of being free* (Okri 1997) focused on how imagination and creativity are often crushed by oppression. Colonization has been central to the success of modern medicine, with the sick person emerging as a recognizable social type. It required that the diversity of suffering be reduced to a more unified view that could be regarded through the lens of clinical medicine, which has had great successes but can be regarded as a form of colonialism (Herzlich & Pierret 1987).

To return to the specific focus on this paper, we suggest that post-structural analyses can expose the mechanisms of power that underlie expert authority – as well as point to emerging forms of resistance. People who challenge are often not the marginalized themselves but other groups of professionals and/or researchers pursuing emancipatory agendas (Freshwater 2007). Although they may disrupt the naturalness of discursive categories, researchers and professionals working within a social justice paradigm may not always apply the same standards to themselves in questioning the authority of their own analyses. Reified counterdiscourse can lead to the perpetuation of oppression by new means.

Marginalized people, including people diagnosed with mental health problems, must, despite their starting point of epistemic disadvantage, enact their own forms of resistance. A recurrent theme is that rebuilding a sense of self, as well as meaningful social roles and relationships, is central to recovery. We believe that narrative can offer a way forward by prompting a form of 'decolonization' through the telling and construction of stories, whereby people with

mental health represent themselves rather than being spoken for.

Narrative resistance?

Narrative methodologies may be underpinned by a range of theoretical and ontological perspectives, for example, realist, autobiographical, phenomenological and social constructionist; narrative research is an ongoing and often contested approach that cannot be easily defined (Smith & Sparkes 2008). In this paper, we focus on narrative associated with the social constructionist paradigm. We therefore understand identity as relationally achieved and constituted in the stories people tell. The subject comes into being in and through her concrete relationships with others while simultaneously constituting other subjects through 'an interactive process in which the self is constructed, deconstructed and reconstructed . . .' (Holloway & Freshwater 2007, p. 42). However, 'the end result is not a fixed identity; rather it is a new string point'. The positivist notion of reliability is not appropriate; getting the same answer to the same question is not the aim. Life is always in flux and so are life stories, with stories shaping life and life-shaping stories.

Reflecting similar concerns to those expressed in regard to post-structuralism (discussed earlier), narrative research within the social constructionist paradigm could be interpreted as privileging the social over the personal, thereby denying the active engagement of the individual in its account of the self (see Smith & Sparkes 2008). We would point out that while the construction of selfhood is a social act, it is equally a highly personal one in the sense that individuals look for meaning in very different ways. Our former distinction between stories and narratives is significant. Personal stories embrace the self as a reflexive construction, but one that takes place within complex webs of interaction extending beyond the intersubjective level to include narratives emerge within shared cultural understandings (Somers 1994). Somers (1994, p. 619) writes of ' . . . narratives attached to cultural and institutional formations larger than the single individual, to intersubjective networks or institutions, however local or grand'. Put differently, the materials that are used in the configuration of identities may share many commonalities, but the configurational acts themselves are highly personal. While narratives are constructed at the personal level, they are equally shaped by the effects of the social surrounds, material circumstances and broader social relations, including collective identities, for example, nationality, and cultural and subcultural identifications (Holloway & Freshwater 2007). McLeod (1997) suggests, 'Even when a teller is recounting a unique set of individual, personal events, he or she can

only do so by drawing up story structures and genres drawn from the narrative resources of a culture'.

To clarify our use of the term 'story' and how this compares with 'narrative', we refer to Harrington (2008, pp. 94–95) who defines stories as personal accounts that are 'living, local and specific', while narratives are cultural templates that provide us with tropes and plotlines to understand the significance of the stories we hear. Narratives are also resources that people draw on to develop their personal stories. In the context of illness, Frank has argued that the narrative of restitution, often told by those experiencing chronic illness, is one that is characterized by a passivity and surrender to medical interventions. Based principally on hope that health can be restored to a condition in the past, 'The story told by the physician becomes the one against which all others are ultimately judged true or false, useful or not' (Frank 1995, p. 5). While a narrative of restitution can be helpful when short-term recovery is feasible, in the context of long-term impairment, such as can be the case in serious mental illness, it may not be possible to envisage a future free of illness.

Individual stories of mental illness have traditionally not been conceptualized as a collective live body of work that offers legitimate insights into how experiences are shaped by the discourse and practices of mental health. As Kerry (2001, p. 269), whose work is influenced by Porter's *A Social History of Madness*, has asserted, it is time to 'restore the patient as a significant player'. In a study of mental patients' written and spoken testimonies from the 1950s to the beginning of the 21st century, Kerry (2001) argues that while patients have not been silent, their stories must be considered in the light of the narrative templates available to them. Patient testimonies dating back to the 1950s and 1960s are overwhelmingly based on a story of mental illness as loss, loss of life and loss of opportunities, always the story of what might have been. What the stories tell are of lives un-lived. At the same time, the hope for restitution is firmly placed in submitting oneself to the authority of nurses and doctors (Kerry 2001). Since the 1980s, recent service user stories (the semantic switch from patient to service user is applied advisedly) that have emerged within a widening discursive arena that incorporates the legal, political and cultural spheres tell stories of survival, often drawing simultaneously on discourses of survivors' rights, perceptions of the law and the language of consumerism. In this way, the 'narrative surrender' (Frank 1995, p. 16) of earlier accounts transmutes into an explicitly political story of survival and resistance, with the narrator newly cast as hero.

What we take from this is that if master narratives are powerful blueprints, something always escapes in their telling and retelling. As Deleuze & Guattari (1988, p. 216

cited in Tamboukou 2008, p. 2888) put it, 'something that flows or flees', which is often attributed to a 'change in values' by women, youth and the mad. Similarly, Frank (2005) writes of a breakthrough or moment of epiphany when people realize that there is more to their experience than can be accounted for by modernist medicine. This involves crossing the threshold into post-modern times – and reclaiming the capacity for expressing one's own voice. While this rarely prompts the evaporation of all hopes of medically achieved restitution, it can be equated with the beginnings of a post-colonial reconstruction of the self. For Frank, the post-colonial ill person sets out on a journey of quest that is no longer about restoring what has been lost but which involves creating something new.

The contemporary self has been described as 'a reflexive project', for which the individual is responsible (Giddens 1991). The post-modern quest that refuses reflexive surrender can be regarded in these terms. Through telling and retelling of personal stories new means of resistance are developed by widening the spectrum of cultural templates that can be subsequently drawn on in the construction of individual stories. In mental health, new heroic stories of survival and of human diversity arise, influencing how mental disorder is experienced. Hearing voices can, in some cases, now be regarded as a gift or sign of sensitivity rather than a distressing symptom. Taken together, mental health survivors provide the resources for the creation of new templates that question the inevitability of the restitution narrative.

Just as post-structuralist emphasizes positioning within discourse, for example, the discourse of medicine positions subjects as patients and physicians, and allocates power between them, people position themselves or are positioned in stories perhaps as victims or as heroes. This can offer exciting emancipatory potential, but a cautionary note is needed. As personal stories transform into shared cultural narratives that in turn constitute templates of meaning, the risk is that complexities, contradictions and inconsistencies may be erased through a perceived need to impose narrative order. Editorial decisions on the part of the narrator on what to include, what to exclude and how to assign meaning necessarily entail a certain responsibility. This is perhaps even more the case for researchers who present and interpret others' stories.

Hendry (2007) goes so far as to caution against the value of structural narrative analysis, which is the type of analysis that 'focusses on the way the story is put together' (Holloway & Freshwater 2007, p. 85); indeed, she questions whether narrative should be regarded as a methodology and argues in favour of moving away from analysis to a place of non-judgement where the relationship between the researcher and the researched is central, seeing this as

an encounter with no other purpose than attending to and being open to the other. The objective no longer concerns the production (of knowledge) but is about communion, and as such has a sacred dimension in its particular alertness to the other. There is much to be said for this; identification with the ill ultimately requires a commitment to research that does not foreclose people's identities by attempting to pronounce the last word; the horizon of possibilities and the unanticipated should remain open. Drawing on Bakhtin, Frank (2005) writes of people's 'unfinalizability', that is, their ability to change, to grow and to defy any definition that is placed upon them. Nevertheless, we question Hendry's plea that narrative should be experienced rather than analysed; we believe that the challenge lies in negotiating the tensions between both these positions. Identities are achieved relationally and through dialogue. There is no 'I' or self who decides to speak. Dialogue creates the possibility of becoming a person. Ideally, we see narrative research and analysis as an open and dialogical process, although we acknowledge the risk that it is likely to achieve this only imperfectly. While acts of symbolic violence are unlikely to be eradicated (Rabinov 1977), we suggest that telling, experiencing and analysing stories can make the personal, political, new narrative templates emerge and with them, alternatives for imagining and living with mental illness.

Conclusion

Drawing on post-structuralist analyses, we have considered how the labels that define people as mentally ill arguably

have no reality independent of the discourse of the society in which they occur but are in effect 'spoken into existence according to the values and beliefs that shape the discourse about what is "normal" and "abnormal" . . .' (Freshwater 2006, p. 56). While demonstrating how post-structuralism can be applied to deconstruct discourses that sustain unequal relations between professionals and service users, and between differing groups of professionals, we have also been alerted to the creative discursive strategies that people employ in order to generate more enabling discourses. Therefore, it would seem that the utility of post-structural analyses is not necessarily restricted to the deconstruction of dominant discourses but can additionally provide insights into how people subvert and reconfigure their own discursive subjugation.

Linking mental illness with social disadvantage and misrecognition, we were prompted to consider briefly the extent to which mental disorder should be reframed within a political paradigm of recognition that valorizes diversity. We argued that a first and vital step in this process requires people with mental health problems to gain epistemic authority in the public sphere through the telling of stories and the development of new narrative templates. With its promise of stories not yet told, we have suggested that narrative perhaps offers the most promising way to reimagine mental illness. This, however, is an ethical endeavour with far-reaching implications for how stories might be told and lived out in the future.

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