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Deterritorialising Mental Health: Unfolding Service User Experience

by

Ian Tucker

A Doctoral Thesis

Submitted in partial fulfilment of the
requirements for the award of

Doctor of Philosophy of Loughborough University

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Abstract

Mental health has a long history of proving to be a tough concept to define. Multiple forms of knowledge and representation seek to inform as to the nature of mental health, all contributing to the production of immense complexity as to the *experience* of living with mental health difficulties. This thesis sets out to explore this, by getting as close as possible to mental health service users' actual experiences. A range of forms of knowledge that pertain to inform as to service users' experiences are explored, prior to analysing a corpus of interviews with service users. These are analysed through the development of a *Deleuzian Discourse Analysis*.

Service users' experiences are analysed in terms of the relation between discursive and non-discursive factors, which include forms of mainstream psychiatric discursive practice, such as the application of diagnostic criteria and administration of treatments, along with how such practices are experienced in non-discursive dimensions of service user embodiment and space. The challenges facing service users are seen to operate around identity and control in relation to forms of psychiatric knowledge, along with presenting particular problems with regard to how user embodiment is *felt*, primarily in relation to psychiatric medication, and how these are driven into the production of service user *spaces*, i.e. day centres. Finally, a *politics of affectivity* is offered, as a way to unfold the complexity of service user experience, and to emphasise the existence and potential for change that can be gained through deterritorialising mental health.

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Chapter 1:

Mental Health: Introducing the Complexity

‘Mental-health problems are now so common that they affect all of us. One in four people will experience problems directly, which accounts for a quarter of all NHS prescriptions. By 2020 it is estimated that depression will be second only to heart disease as the leading cause of death and disability.’

Breaking the Silence, *The Observer*, (2001: 27)

‘MENTAL patients who pose a danger to society will be caged even if they have not committed a crime under new rules unveiled last night....The move is in a draft Mental Health Bill published last night. It comes in the wake of a string of murders and assaults by patients freed under the care in the community programme highlighted in *The Sun* this week. Home Office Minister Paul Goggins said: "We will not compromise public safety. If we are to protect the public we must ensure those with a mental disorder who are a risk to others receive the high quality treatment they need."'’

Maniacs to be Caged, *The Sun*, (2004: 6)

‘Looking after your feelings is as important as looking after your physical health. Of course, there are times when everyone feels upset, stressed, unhappy or anxious. This is part of life’s ups and downs. Positive mental health is about being able to enjoy life and cope with its ups and downs. People with positive mental health: feel good about themselves and others; have confidence; feel they have a sense of their own worth and of other people’s worth.’

Sandwell Public Information Network (2005)

1.1 Multiplex Mental Health

As seen in the opening extracts, experiences labelled as mental health difficulties are subject to many differing representations. This provides a sense of how complex the field of mental health is, in terms of the multiple forms of knowledge relating to mental health issues that exist. Of course, this is partly to do with mental health operating in the realm of the *psyche*, the fundamentally *human kind* (Hacking, 1995), which sets humans apart from the natural and animal worlds. Everything is rosy when this power of self-reflexive consciousness continues to work to make us the dominant *kind*, but what about when problems start occurring, e.g. when mental health difficulties act as a threat to reason, which in turn is the principle used to privilege the human¹?

There is much at stake in public debate about mental health. To some this may be out of curiosity, to others the matter of professional endeavours. Sure enough though, efforts to understand and produce knowledge regarding mental health difficulties are multiple and diverse; as are the knowledge claims made about them. To give some sense of this diversity, let us consider the extracts featured at the start of the chapter.

The first extract refers to a growing concern that mental health problems are proliferating across the population to the point of touching everyone's lives. The account then becomes more specific in detailing 'depression' as a major concern, one that will threaten the nation's health, secondary only to heart disease in the not too distant future. Here mental health problems are presented as a *medical* concern. Their understanding is produced as part of a process of discovery and medical progress. These problems, particularly depression, are becoming recognised as a threat to the nation's health, one that needs direct action. The threat is not solely one to health, but also to National Health Service (NHS) budgets, with depression forecast to account for one quarter of all prescriptions. Thus, mental health problems will potentially place a burden on tax payers' money in the form of NHS budgets. Mental problems are represented as an economic threat, as well as to health. Additionally, it seems to suggest that mood disorders are the prototype around which the general public should build their understandings of the broad range of mental health issues.

¹ It is recognised that not all literature presents experiences labelled as mental disorders by psychiatric definition as 'problems'. For instance, Romme & Escher's (1993) work on hearing voices reports on the non-pathological (hence non-problematic) nature of the experience for some people.

The second extract highlights a different concern associated with mental health. In this extract, from an article provocatively entitled *Maniacs to be Caged*, a different form of cultural knowledge is drawn upon, in which mental health disorders are referred to within a notion of risk. Firstly, mental disorders are allied with a health framework through the labelling of people experiencing mental disorders as ‘patients’. This is followed by describing the mentally distressed in terms of a supposed propensity to commit crimes, and violent crimes in particular. This renders it a legal issue, for which legislation is required so as to *control* this threat, which could be unleashed at any moment on an unsuspecting public. Unlike the first extract, no specification is provided regarding mental illness, rather the general overarching term of ‘mental patient’ is used. Thus, mental health problems as a whole are treated as a threat.

The third extract sets out to make general claims about what ‘positive mental health’ means. We see that to be mentally ‘healthy’ means that we can cope with the ‘ups and downs’ of everyday life. This rather idealised picture continues by suggesting that mental health allows us to feel confident and good about ourselves and others, and to have a sense of ours and other’s worth. This paints a rather existential picture of what ‘normal’ functioning mental health involves, and thus also indicates what it means if someone is mentally ‘unhealthy’. A surface level offering of mental health is provided, as referring to our ability to deal with the mundane minutia of everyday life experience. There is no talk of problems in mental health being associated with severe trauma in one’s life for instance, but rather as a dysfunction in everyday capacity to *deal with* life. Rather than the economic or legal issues indicated in the first two extracts, this one presents a humanised issue of what can occur if we start to struggle with working our way through the trivialities of day-to-day experience.

The scene set by these extracts is one of complexity. Mental health, whether good or poor, is portrayed in multiple ways. It is represented as impacting upon many aspects of life, from being a macro concern threatening to destabilise economies, and an issue of criminal potency, to being associated with people’s ability to work through the drudgery of everyday life. It is seen across physical and mental boundaries. It is everywhere.

What then is at the heart of this complexity? What are the underlying experiences to which these multiplex claims and representations refer? By way of an example let us consider an interview extract with a service user², Rob, in which he details an aspect of his experience (this is taken from the corpus of data analysed in this thesis):

Rob: (I: mm) (.) but er (1) you know things like that that I'd done certain things (2) er (1) telephone were bugged at one time (.) so I thought (I: mm) television had got a er (.) sensor in it (1) so I took the television back off (.) things like that that you know yeah (2) yeah.....(lines 206-209)

In Rob's extract a sense of what it means to experience mental health difficulties is felt. Beliefs that one's life is under surveillance by some unknown force manifested themselves in Rob's belief that his television had some form of surveillance sensor in it. This provides a different angle on mental distress than that provided by the opening extracts. A spatial understanding is illuminated in terms of what it can mean to experience mental health difficulties in everyday life, i.e. when sitting at home watching the television. Rob's delusions led him to undertake potentially dangerous activity, namely removing the back of the television to search for the sensor. His distress was manifest in directive action. Here, it is not some kind of action of a 'maniac', but rather an example of the lived concrete reality of delusional beliefs, which (in this instance) led Rob to undertake the potentially dangerous (but not to anyone bar himself) activity of removing the back of his television.

Utilising this extract is indicative of the approach I take in this thesis. Namely, that knowledge and understanding can emerge through focus on the experiences of people who are diagnosed with mental health difficulties, referred to throughout as 'service users'. None of the opening quotes really do justice to Rob's actual experience; they do not really get close to the actual experiences themselves. Namely, how his mental health difficulties are grounded in particular daily events, such as those of sitting watching television. As the opening extracts demonstrated, these experiences tend not

² There has been great change and debate surrounding how to most appropriately discuss people whose experiences have been labelled 'mentally ill'. There has been a move away from terms such as 'mad', 'mentally ill', 'insane', to terms such as 'psychiatric survivor', 'mental health service consumer', 'mental health service user' (Campbell, 1999). For the sake of clarity, the present thesis will use the term 'service user' and the shortened 'user' in the main, as an abbreviation of 'mental health service user'.

to be approached in and of themselves, but are rather always already represented by a range of different forms of knowledge. That is they are treated as ‘signs’ and ‘symptoms’ of something else, such as ‘illness’, ‘danger’ or ‘abnormality’. In this sense, service user experience is captured and framed according to a variety of different apparatus. Another short data extract demonstrates this point:

Frank: I spose it will always be there [I: mm] (.) but I don’t see myself as a sch..schizophrenic [I: mm] I don’t see myself as a me.. (.) um mental um (.) health (.) patient (.) I see myself as a person [I: mm] (1) er (2) and um (1) after all it is an illness [I: mm] and there is a person behind each illness [I: mm] um (1) and I think er (.) a lot of (.) people with mental health (.) see see the (.) illness (.) and not (.) their own qualities [I: mm] which everyone has (.) some qualities (.) um there’s a lot of creative people (.) within our centre [I: mm] really er (.) creative people [I: mm] (.) talented people [I: mm] (.) and anyone would be (.) proud (.) to have that talent [I: mm] it doesn’t mean er (.) because you’re a mental health you (.) develop a mental health problem you’re on the scrap heap [I: mm definitely definitely] (1) so er (1) and that’s what (.) trying to get across to the er (1) public [I: mm] and (.) we’re getting there but er (.) you’ll always have (.) stigma [I: yeah sure] (.) but um (.) it’s not as bad as it used to be [I: mm] but you’ll always get the er (1) the one (.) the people who will not move with (.) the times (1) they’ll always be stuck there with their own opinion [I: mm] (1) and the media don’t help.....(393-408)

In this extract with Frank, we see a range of different forms of representation that capture and code service user experience. This is of course a difficulty for users, in terms of attempting to make sense of their experiences in the face of such a variety of cultural representations. Firstly, the diagnostic category is present, ‘schizophrenia’, through which the biomedical psychiatric model of explanation is utilised. A diagnostic identity is resisted, through claim that the diagnosis signifies an illness, which does not act to entirely determine the person. It is something you *have*, rather than *are*. Here, an alliance with general health diagnoses is made, e.g. someone has cancer, rather than is cancer. Next, a link is made between creativity and mental health, something that has quite common cultural prevalence (Barrantes-Vidal, 2004; Bracken, 2003; Harlander, 1981; Prentky, 2000). This works to emphasise the positive aspects of service user

experience; used by Frank as a retort to the stigmatisation that exists in society (Knight, Wykes, & Hayward, 2006; Lee, Chiu, Tsang, Chui, & Kleinman, 2006; Pinfold, Huxley, Thornicroft, Farmer, Toulmin, & Graham, 2003; Schulze & Angermeyer, 2002). Commonly held lay representations are then alluded to through talk of the forms of stigma regarding service users that exist, before finally drawing out one of the main factors in producing and representing stigmatised views about mental health, the media (Foster, 2006; Stuart, 2006).

In Frank's extract, *some* of the different forms of cultural representations that capture service user experience are highlighted. A range of different forms of knowledge code service user experience in a variety of, sometimes conflicting, ways (Coppock & Hopton, 2000). In this thesis, it is argued that understanding the nature of this experience requires an approach that places the everyday experiences of service users at the forefront of research. This has become a well established approach (e.g. Coffey, 2006; Godfrey & Wistow, 1997; Krumm & Becker, 2006; Newnes, Holmes, & Dunn, 1999, 2001; Pinfold, 2000; Powell, Single, & Lloyd, 1996; Salvi, Jones, & Ruggeri, 2005; Spiers, Harney, & Chilvers, 2005; Trivedi & Wykes, 2002), although it remains dwarfed by the biomedical field in mental health. We have seen some of the forms of knowledge that produce cultural understandings of mental health issues, but what none of them fully illuminate is the actual grounded reality of service users' everyday experiences.

To date, questions regarding mental distress have predominantly been the job of the mainstay classification models of mental health to provide answers, through which understanding, definition and treatment are designed to be provided to those experiencing mental health difficulties. Given the range of different forms of knowledge that attempt to capture service user experience, actually getting to grips with what these experiences are is difficult. Let us start with addressing the predominant framework of representation of service user experience, and see if that can take us in a clearly definable way to service user experience.

1.2 Classifying Mental Disorders

Let us now consider the role of the most privileged knowledge producer applicable to mental health, mainstream psychiatry. For the past hundred years, the job of making

some sense of the complexity of mental health has been that of mainstream psychiatry. Its alliance with the general health field was forged in the late 19th Century, through the birth of psychiatry as a well-defined discipline, which has led it to approach mental health, and thus mental distress, in the same way as general health. Namely to formalise ways of categorising symptoms into disease-specific classifications, from which treatments and understanding can be applied. Let us consider how this operates.

We have seen above reference to mental health problems in both a general and specific sense. Specification in terms of illuminating understanding is a major driving force of much clinical practice. At the forefront of such efforts are the statistical manuals of the World Health Organisation and the American Psychiatric Association, the International Classification of Mental and Behavioural Disorders (ICD), and the Diagnostic and Statistical Manual (DSM) respectively. A glance through either of these will give a sense of the complexity of classifications through which mental health difficulties are clinically framed. Consider the categories assigned to the diagnosis of schizophrenia:

F20-F29

Schizophrenia, schizotypal and delusional disorders

F20 Schizophrenia

- F20.0 Paranoid schizophrenia
- F20.1 Hebephrenic schizophrenia
- F20.2 Catatonic schizophrenia
- F20.3 Undifferentiated schizophrenia
- F20.4 Post-schizophrenic depression
- F20.5 Residual schizophrenia
- F20.6 Simple schizophrenia
- F20.8 Other schizophrenia
- F20.9 Schizophrenia, unspecified

A fifth character may be used to classify course:

- .x0 Continuous
- .x1 Episodic
- .x2 Episodic with stable deficit

- .x3 Episodic remittent
- .x4 Incomplete remission
- .x5 Complete remission
- .x6 Other
- .x9 Course uncertain, period of observation too short

(World Health Organization, 1993: 28)

These multiplex categories and sub categories refer specifically to experiences labelled 'schizophrenic'. Other categories, with requisite sub categories, exist for related experiences labelled 'schizotypal disorder', 'persistent delusional disorders', and 'acute and transient psychotic disorders'. This highlights the immensity of the classification machine at work, with similar complex categories across the range of mental disorders. This discursive work of manuals formalizes an incredibly complex classificatory system to explain a range of mental health problems. It neatly categorises experience, from which appropriate treatment can be administered. However, it is not as straight forward as working to find the 'correct' category and sub category for any given individual. For multiple classifications can be applied to any individual case. So, not only is there complexity in the design of the system, but also in its administration.

Bowker and Star (1999) approach ICD with a view that its development and administration is a more complex contingent matter than that purported by its descriptive tag. They argue its aim of universal explanation is a futile one, given the amount of social, political and philosophical context that forms its categorical system. An early example is the design of ICD-1, in which a maximum of two hundred categories for causes of death (ICD was originally a classification system for causes of death solely) were included. Bowker & Star point out that rather than the figure of two hundred being the total amount of known causes of death, it was actually the total number of lines on Austrian census forms that were used at the time (1999: 64-65). An increase in categories would make it unworkable to record all causes of death. Thus, the choice was a pragmatic one, based upon the (limited) technologies of the time. Therefore, the practice of classification systems is more complex than a simple representative model of mental health disorders 'out there' in the world. It is not only technological contexts that impact upon manual design, social and political factors

impact as well. Bowker & Star highlight the case of childbirth and abortion, around which a great sensitivity was manifest through the differences in Protestant and Catholic views. This led to the design and introduction of separate categories for legal and illegal abortion, due to these non-reconcilable political positions.

Within formal psychiatric research, the design of classification manuals demonstrates that complexity is recognised within the medicalised psychiatric model of mental disorders. For instance, the myriad sets of categories and sub categories, each with the possibility of cross and co-morbidity with other categories. In this sense, complexity is almost welcomed in classification manuals, as it indicates that some of the diverse breadth of experience that occurs as mental health difficulties is being recognised, accounted for, and thus potentially treatable. Bowker & Star's analysis illuminates some of the pragmatic contingency at the heart of ICD. It should not be taken as a simple descriptive tool commenting on the world 'out there', but rather as a contingent tool operating across a variety of institutions (e.g. medical, insurance), whose design and implementation is fundamentally based within social, political and technological contexts.

Within this matrix of cultural information purporting to represent experiences labelled as mental health difficulties, lie people's experiences who actually live day-to-day with such problems. As we have seen, there is no one simple way to understand such factors. This has been one of the main catalysts for the development of service user research that focuses directly on users' experiences, emphasising the value of listening to their accounts and reports of their lives (e.g. Hopton, 2006; Speed, 2006). The operation of service users' lives is distinct from the multiple forms of knowledge that claim to represent them, as seen in Rob's extract earlier. It is on this basis that this thesis sets out to steer as closely as possible to the everyday life experiences of service users, through placing prime focus on allowing their experiences to be expressed, whilst recognising that it is not possible to simply gain unmediated access to their experiences. Clearly, relying on the dominance of mainstream psychiatry to inform as to the nature of service user experiences is not going to be a viable option, as Bowker and Star have highlighted the inherent complexity within the diagnostic model, and demonstrated how it is impacted upon by a variety of socio-political forces.

1.3 Service User Research

So far, we have seen how the area of mental health is a contested one, subject to many differing representations. Mental health has predominantly been captured through mainstream psychiatry, and its diagnostic-biomedical approach of viewing mental health difficulties as ‘illnesses’. In this sense, service users’ experiences are primarily captured through psychiatric theory and practice (i.e. the practice of diagnosis). Diagnostic classifications work to code people’s experiences, reifying them as diseases and illnesses, as things that can be identified, singled out, and treated. Critiques of this position have been long known (see Chapter Two for more detail of these), and although varied, have placed great emphasis on de-medicalising service users’ experiences, in terms of not purely seeing such experiences as symptoms of illness, but real-life experience, grounded in everyday life concerns that need to be listened to, addressed, and fed into research that informs policy decisions regarding mental health.

This move towards service user literature has demonstrated the value in placing analytic focus on service users’ experiences (Coppock & Hopton, 2000). This though, is not a straightforward task. Approaches that have opposed the biomedical model of mainstream psychiatry, from the position that it works to devalue service users’ actual experiences, through coding them solely as illness-bound, argue that the service user ‘voice’ needs to be heard. For example, Rogers, Pilgrim and Lacey (1993) published a volume analysing the views of service users across a range of topics including treatments, issues of consent and community services. This typifies a lot of the research conducted, in that it has focused on service users’ views on mental health, from the nature of their experiences that are labelled mental disorders, to the range of services they come in contact with through being service users (e.g. Burr & Chapman, 2004; Coffey, 2006; Godfrey & Wistow, 1997; Hostick & Newell, 2004). These approaches have illuminated the importance of undertaking service user research, by highlighting the benefits to service user experience that can be worked towards through analysing beyond the somewhat strict and narrow boundaries of the diagnostic model of mental health.

This is a valid and very important move. However, it has to be done with a recognition that it is not simply a case of re-coding service user experience through gaining ‘pure’ access to it. We have to recognise that service user experience is heavily mediated, by a

range of factors (e.g. discursive practices, bodies, objects, space). There is not *a* voice which can be simply accessed, as if it has been simply closed off and silenced in the past. Undertaking a service user approach requires recognition of the very complex, layered, nature of service user experience. Critiques of the capturing of mental health by mainstream psychiatry have worked to re-capture service user experience, and code it according to their own apparatus, e.g. arguing for increased choice over treatments. What is required is to build on this research, through placing analytic focus on unfolding some of the inherent complexity of service user experience, without claiming that their 'voice' can be simply accessed.

Critical social psychology (Brown, 2001; Brown & Lunt, 2002; Hepburn, 2002; Howarth & Hook, 2005; Nightingale & Cromby, 1999; Parker, 1992, 1998; Stainton Rogers, 1995; Stainton Rogers, 2003; Sullivan, 2002; Tuffin & Frewin, 2004; Willig, 1999) has proved a fruitful area in which to identify some of the mediating practices at work in mental health. For instance, Parker, Georgaca, Harper, McLaughlin and Stowell-Smith (1995) identify, through their version of 'deconstruction', how mental health has been captured and coded through psychiatric practice, along with the effects (often negative for users) of such practices. How critical social psychology places emphasis on the mediating factors of experience will be covered throughout the rest of the chapter.

In this thesis, analysis seeks to build upon critical social psychological research, in illuminating the multiple ways that mental health difficulties are experienced by those who receive diagnoses and treatments. In the first instance, this involves the ways that people become service users and how the process of operating as part of the relations of the service use system originate. This not only involves looking at the mechanisms in place to 'recognise' experiences in need of treatment (primarily the domain of mainstream psychiatric practice), but also utilising service users themselves as an analytic. This enables a way into the process of service use, utilising service user experience as the mode through which understanding is gained. Alternative approaches could have been undertaken, such as through alliance with clinical practices, but this would not have provided the grounded sense of experience that utilising service users as the 'way in' does. This is largely to do with the difficulties in *seeing* service use in community settings. In the days of institutionalisation one could enter asylums to see

how the experience of living with mental disorders operated – as we will see in the section on Erving Goffman in Chapter Two. In community settings this is far more difficult. The terrains of service use are vast, and as such the settings in which service users spend their time have the potential to be more diverse and spread out. Service users now occupy a wide range of locations, including multiple kinds of living arrangements, and attendance at a diverse set of day centres etc. This is precisely the catalyst for placing this thesis within the area of ‘service user research’, in which the experience of using mental health services, from the perspective of those who use them, is placed at the forefront of empirical efforts.

The complexity seen so far in regard to mental health poses a problem; namely to unpick some of the complexity of mental health, it is necessary to understand the ways that it is complicated. An area which has proved fruitful for this has been that labelled ‘constructionist’, which underpins the aforementioned critical social psychological work. However, this is a broad area (as is detailed in the following section), so it is necessary to set out the kind of constructionist thought that is developed in this thesis. For this, we draw on Ian Hacking.

1.4 Interactive Kinds

The notion of interactive kinds is, for Hacking (1999), one that allows for a non-deterministic conceptualisation of the relationship between social processes and individual experience. Critical social psychology has as its flag bearing goal the need to account for the role of social processes and practices in the constitution of human experience, rather than the individualised cognitive framework of mainstream experimental psychology (Burr, 1995; Gergen, 1985; Gergen & Davis, 1985; Hacking, 1999; Harré, 1986; Parker & Shotter, 1990; Potter & Wetherell, 1987; Shotter, 1993). In consideration of this movement we need to account for the role of social factors *on* experience, but of course, in such a way that does not err into any form of deterministic thought, i.e. that human experience is entirely produced by the social. This point would be, for Hacking, an example of a theory espousing a one-way movement of power, which works to produce a concept of individuals as devoid of the ability to *interact* with societal forces.

Hacking's interactive kinds have emerged from his work analysing the differences in relationships between constituents of the world that have no awareness of knowledge that exists about them, and those that do. These he refers to as 'natural' and 'human' kinds. He makes the split between human experience, which, uniquely involves the capacity to be self-reflective and conscious of knowledge, and the constituents of the world that do not share the same capacities. Natural kinds are the objects of the natural sciences, which can talk about generalised laws of physics, whose constituents have no awareness of the way they are classified, (e.g. quarks (Hacking, 1999)). These 'objects' may well be changed through the way they are classified, but crucially, this does not result from *self*-awareness. Hacking chose to re-name these *indifferent* kinds, in recognition of the sheer amount of philosophy that has been built around the notion of *natural kinds* (1999).

The distinction Hacking makes is founded on a fundamental belief that classifications used in the natural sciences are indifferent kinds, whilst those used in the social and human sciences are interactive kinds. The notion of interactive kinds is based upon the concept of humans as becoming consciously aware of the classifications applied to them. This awareness brings with it the propensity for experience to be altered through this awareness. People may well act differently in recognition of the way they are classified. This involves not just a base awareness, but one built through interacting with the world in a particular way *because* of classification. It is a spatial awareness, understanding classification through the ways that having a particular classification applied to oneself, means that one is located in a space or location organised according to classificatory knowledge. It is the interaction between the classified space and individual that Hacking is seeking in conceptualising interactive kinds.

By way of an example let us consider Hacking's own use of the classification 'schizophrenia'. Hacking utilises Boyle's (1990) argument that what is understood as schizophrenia is fundamentally a social construct. This claim is based upon Boyle's reported analysis of studies assessing levels of validity and reliability, criteria necessary for unequivocal acceptance as a valid scientific category, which, Boyle argues, mainstream psychiatry claim schizophrenia is. Hacking states that Boyle finds the 'idea' of schizophrenia necessary for the workings of many parties, whether

psychiatrists, patients or families. Boyle's underlying position is neatly set out in the title of her book *Schizophrenia: A Scientific Delusion?*

Boyle's argument is used as an example of claims as to the social construction of X, in this case schizophrenia. Hacking makes the claim though, that the classification is in fact an interactive kind. So, he develops Boyle's argument in theorising the ways that people react and alter behaviour in awareness of being classified. He articulates this through a historical analysis of the role of hallucinations in the schizophrenia classification. Hacking dates the introduction of the category as occurring through the work of Eugen Bleuler³ (1950), and uses Bleuler's classification as a contrast to Kurt Schneider's (1959) that emerged three decades later. For Bleuler, hallucinations were not a key part of the schizophrenia classification, and as such were not concentrated upon in the labelling of people as schizophrenic. For Hacking, this meant that people were not wary of expressing hallucinations, as doing so, did not have a stigmatising effect. Schneider, on the other hand, made hallucinations the first of his 'First Rank Symptoms', which meant they became a dominant part of the classification. Hacking argues that this was due to the way that people diagnosed schizophrenic had previously acted. Their willingness to express hallucinations led Schneider to believe they were a key part of the classification, and should play a dominant role. In this way, the classification is very much an interactive kind. It has been molded through the interaction of those people classified as such, whose awareness of the organisation of the classification altered their actions, which then fed back into later formations of schizophrenia.

Hacking's interactive kind provides a move away from the one-way relational process of social processes, arguing they do not just act upon individuals in a one-way directional manner, but are taken up and re-worked through the ways individuals understand and alter their behaviour in awareness of the classifications placed upon them. Hacking's concept though does not inform beyond a social-individual framework. Despite his early focus on the spatial production of classificatory knowledge, in which individual experience is conceptualised as spatially located

³ Bleuler was indeed the first to use the term 'schizophrenia', although it was very much the work of Kraepelin before him that developed the foundational ideas about the concept.

according to the way settings are organised by classificatory knowledge, Hacking does not include spatiality as an analytic. He remains focused on his central point concerning the ways that changes in classificatory knowledge are brought about through altered behaviour due to awareness of classification.

The diagnostic model of mainstream psychiatry seeks to frame service users' experiences as natural kinds, that is, reifying them as diseases and illnesses. Hacking's interactive kinds allows a way of thinking about experiences that recognises how our knowledge of how we are classified impacts upon our subsequent behaviour. In a generalised sense, service user research is aiming to do just that, to identify the effects on people, i.e. how their lives and actions are altered, once they enter into service use. A wariness is required here though, as we must recognise that service user experience is not easily accessed, due to its mediated nature. This kind of constructionist thought provides a way of 'thinking' complexity, and it is the medium of language that it has argued is the prime force of construction.

1.5 The Role of the Discursive

The analysis that is worked throughout this thesis is one indebted to the 'turn to language' of much social theory in the last thirty years (see Burr, 1995; Harré & Gillett, 1994; Parker & Shotter, 1990). This cross-disciplinary endeavour has ceaselessly worked to place the role of the discursive at the heart of social scientific enquiry. In doing this, language, discourse, text have emerged as *active* constituents of the production of social experience. It is argued that language use needs to be understood as a key activity in the everyday make up of social life.

1.5.1 Historical Context

This turn to language, and we should note that this section is very much about *language* per se, came about as a result of a number of factors, primarily related to moves in the social sciences to ally more closely to the natural sciences. According to Winch (1958), the social sciences had become increasingly frustrated with the reliance on philosophy in thinking about the nature of the social sciences, and instead saw great attraction in drawing on the natural sciences in reformulating ideas about how social science should operate. The magnetism of the natural sciences came from the belief that greater progress could be made in social scientific theory if ideas were introduced

from natural science, rather than the “dead hand of philosophy” (Winch, 1958: 1). Winch sums up the attraction of the natural sciences in stating its ethos as “[G]enuine new knowledge is acquired by scientists by experimental and observational methods” (1958: 5).

Winch argues that philosophy focused on language in a different way than that of natural science. The natural sciences approach language in a way that emphasises its representative, reporting role. Here, there is no concern with concepts, but rather how findings about the world are reported *through* language. Its role is passive. Philosophical thought at the time began developing alternative, more active conceptualisations of the role of language, and at the heart of such a move was Wittgenstein.

In *Tractatus-Logico-Philosophicus* (1933) Wittgenstein set out to illuminate the ways that language worked to represent aspects of the world. His concern was with problems such as thinking about the accuracy of our representations of our worlds. Part of this involves thinking about how to go about conceptualising human experience. Shotter (1993), drawing on Wittgenstein, argues that to do this, analysing how language represents everyday life is inadequate, as there is no way of assessing the ‘correctness’ of such representations. Rather, one should study the role that language plays *in* everyday experience, that is, as an active constituent part of such experiences. Shotter reports that this realisation in Wittgenstein’s theory led him to debunk his earlier claims to language as solely representative, and instead, in *Philosophical Investigations* (1953), to set about thinking about the nature of language use in practice.

In *Philosophical Investigations* (1953) Wittgenstein’s philosophy emphasised that language be conceptualised as a *practice*, which incorporates the social context within which it is said (or written). In considering language use, Wittgenstein argues that social context provides ‘rules’ by which future language use is understood. This means that for language use to be socially comprehensible it needs to abide by the rules that produce forms of social understanding. This is not to say that all language use is *dependent* on prior experience, but that in the first instance language use needs to accord with rules, which Wittgenstein conceptualises as *language games*. For instance, a family is a language game in which the set of roles (e.g. mother, father) are

understood according to their context (living together, raising children, financially tied). Thus, when we talk of families, we are drawing on these language games, so as to be understood as referring to what is socially understood to be a family. Wittgenstein argued that language use operates as part of existing 'forms of life', which refer to current existing ways of being. Forms of life are in part constituted by previous language use, and crucially are contextualised by social fields. It should be noted that in considering Wittgenstein's contribution to discursive theory, it has been more influential in the area of Discursive Psychology, and has been criticised from other quarters for its failings to adequately account for notions of power and its effects (Parker, 1996).

Another key contributing factor in reformulating theories of language was Austin's (1962) Speech Act Theory, in which he argued that language needs to be understood as an active force in its own right. Austin thought of language sentences in different forms. He argued that a group of sentences exist that are functional in terms of what they *do*, rather than what they describe. These he named *performatives*. An example would be a judge handing out a sentence "I sentence you to a ten year custodial sentence". Austin believed that some sentences had the primary function of description, he termed these *constatives*, but placed greater emphasis on the workings of performative sentences. Whereas prior philosophical thought had been concerned with the descriptive nature of language, and thus questions as to truth and falsity, Austin's theory to a certain extent negated the requirement to assess questions of truth. If language is performative, performing actions in its own right, then it cannot be true or false in the same way as descriptive language. However, Austin came to realise that actions and description could not be separated in the ways he had originally thought. Instead, he argued that all sentences have both performative and constative parts, and that issues of truth and falsity can exist for performative sentences, just as meeting felicity conditions is a requirement of constative sentences; primarily due to the mixture of doing and describing that Austin stipulated. Austin also highlighted the importance of analysing language at a micro level, namely sentence use in interactions, rather than some of the more macro focused theory that follows in the next section.

The early movers in the turn to language therefore very much focused on language use, which as we will see through this thesis, is not the only focus of analysis when it comes

to service users' experiences. As we work through the rest of this chapter, we will cover some other pivotal theories involved in developing discursive theory, but also ones that moved on from the aforementioned early writings in accounting for non-discursive aspects of experience, within the same critical social psychological field. I should note that I will utilise the vocabulary of *non-discursive* and *discursive* throughout the thesis when discussing factors that have been referred to as *discursive* and *material* (e.g. Yardley, 1997). This is because discourse is entirely material in the first place (Brown, 2001), and to use a vocabulary of 'materiality and discourse' as separate essences, is to potentially suggest a false dichotomy. To use non-discursive though, as opposed to *material* and *non-material*, is not to bow to an idea that the discursive has a primacy as such, but to be aware that the critical social psychological tradition, within which this thesis operates, is one that has placed so much emphasis on discursive theory. So, in recognition of this, I will draw on the common vocabulary of *discursive*, and use the terminology of non-discursive and discursive, but based upon the implicit understanding that I am not placing a primacy on either.

1.6 Archives of Discourse

The work of Michel Foucault has been a major influence upon discursive theory. Through his early writings, Foucault sought to articulate the historical contingency upon which certain forms of knowledge were based. In *History of Madness* (2005) it was the concept of mental illness, whilst in *Birth of the Clinic* (1975) Foucault approached the area of medicine more broadly. This led to the development of Foucault's thought that at the heart of the production of such forms of knowledge were discursive practices. Similarly to Wittgenstein and Austin, Foucault did not suggest that discursive practices operate in some form of representational way, but that they were the key mechanisms through which knowledge is formed. As such, discourse is held to construct the objects of which it speaks, whether or not such objects 'really' exist. As can be seen by the kinds of knowledge he studied, there was a greater focus on macro forms of knowledge, and discursive use, than that seen with Wittgenstein, and particularly Austin. Additionally, in some respects, Foucault went much further in his theorising regarding the operation of discursive practices.

It is in the concepts of the *statement* and *archive* that Foucault beds down his claim to the operation of discursive practices (2002). The *statement* is what Foucault came to

see as the heart of his discursive theory. Foucault's primary concern was to illuminate the conditions by which a statement was produced. He was not interested in questions as to the truth or falsity of statements, or indeed, to a certain extent, in the meaning of statements. Whereas Wittgenstein assigned meaning in terms of language being understood within a context of inter-related shared practices (Dreyfus & Rabinow, 1983), Foucault (at this stage) placed the conditions by which the possibilities arose which led to the development of statements at the forefront of his analytic endeavours.

Statements are not simply made up of words or propositions, nor do they merely refer to sentences. In this way statements do not solely refer to linguistic functions. This differentiates them from the language games of Wittgenstein or the speech acts of Austin, which remained in the domain of linguistics to a large extent. Foucault was not concerned with providing meaning to discursive practices, or indeed imbuing them with particular subjects or objects. Rather, his drive was to draw attention to the ways that statements inter-relate with objects to create a space in which multiple forms of subjectivity and objectivity can be formed. Foucault demonstrated this way of thinking through historical analysis (or archaeology) of forms of knowledge such as madness (*The History of Madness*, 2005) and penal law (*Discipline and Punish*, 1995). The example Foucault provides is that of A Z E R T, which refers to the first five letters used on French typewriters. In itself, these letters are not a statement, just a series of letters. But, when related to their existence on keyboards, they become a statement of the alphabetical order utilised by French typewriters.

The crux of Foucault's theory is the notion of regularity. It is only through a regularity of connections through inter-relations that discursive formations are produced. No singular set of conditions act in a causal manner to *create* formations, rather it is through this regularity that they come to be recognised as a practice. In talking about the 'object' of psychiatric discourse in the nineteenth century, Foucault analyses the inter-relating events and practices that, in regularity, made it possible for the discourse of psychiatry to emerge, and be recognised so as to 'say something' about it. The conditions necessary are based upon a complex set of inter-connecting relations between a variety of heterogeneous factors, which Foucault sums up as "institutions, economic and social processes, behavioural patterns, techniques, classification types, modes of characterisation" (2002: 49).

The concept of *archive* works to elucidate the practice that leads to multiple statements inter-relating to form patterns of regularity that facilitate particular happenings and events, that in turn open up spaces in which knowledge and practices can mold and reform (Foucault, 2002). Foucault sums up the archive as the “*general system of the formation and transformation of statements*” (2002: 146 emphasis in original). It is in archives that statements inter-relate so as to make regular patterns of knowledge, but these are not determinate, as archives always operate in a space where statements can be re-worked and/or new ones formed.

It is exactly the discursive formation, the sets of relations that make something recognisable, that have been the focus of much of empirical efforts in discursive theory (e.g. Hollway, 1989; Walkerdine, 1990). As we see from Foucault’s own example of psychiatric practice, his focus was often on more macro operations of language; something which has threaded itself through the work of those whom draw upon his theory, and which has been valuable in terms of highlighting how certain discourses (e.g. surrounding psychopathology in Parker et al., 1995) position people through making them the subject of particular forms of representation.

1.7 Making Visible

Foucault’s theory then was a key catalyst in the turn to language, but one that was interested in *practices* in a broader sense than as solely constituted by discursive practices (Brown, Pujol, & Curt, 1999). He was interested in the historical production of knowledge, which operated in the realm of discourse. In analysing the conditions of possibility developed in the discursive formation of psychiatry, Foucault was concentrated on the practices that co-produced the knowledge that existed in discourse. Foucault’s theory was more explicitly incorporative of non-discursive factors than other language-oriented theorists.

Foucault talked, for example, in terms of the spaces in which relations produced knowledge practices. In terms of mental health, this is some of what Foucault went after in writing *The History of Madness*. He illuminated the practices of dividing, within spaces, which were at work in the 19th Century that made 'madness' visible. These practices involved the production of difference that split normality and abnormality. The 'mad' were then viewed as abnormal, and through the discursive

practices of Penal Law and the notion of delinquency that defined the category 'abnormal', people who came under its gaze were sent to asylums, which in turn became the 'bricks and mortar' marker of 'madness'. At the time, to understand what madness meant, one would go and visit an asylum (a common socially acceptable activity), and *see* madness at work in the structure and embodied souls of the institution. This provides a sense of the ways that through the connection of heterogeneous sets of events, knowledge practices are produced that make these events *visible*, through the combination of both descriptions (primarily *discursive* work) and the laying out of space in a way with boundaries that work to mark out the territory of particular experiences. In Foucault's terms the asylums became the *marked out* space of 'madness'.

This *dividing* work is very much the domain of discourse for Foucault. Throughout his early writings (*The History of Madness* (2005), *Order of Things* (2001), *Archaeology of Knowledge* (2002)), Foucault developed an epistemology based on discursive practices, through which knowledge was constructed and produced. This was his answer to a problem of realism. For Foucault phenomena, e.g. madness, did not exist in realist terms, but rather were the subject of the organising powers of discourses. These refer to institutionalised macro discourses, such as those of psychiatry, law etc, rather than the micro speech acts of everyday interactions. By 'discourse' Foucault meant the totality of the signifying work that expressed any particular given, e.g. madness. At this stage, we see the links between some of the debates in discursive theory regarding at what level the operation and production of social experience exists in discourse (see Parker, 1998). Many argue that an over-reliance on all things discursive has developed, to the analytic detriment of the non-discursive world (e.g. Coupland & Gwyn, 2003; Parker, 1999a, 1999b). Foucault, along with those drawing on his writings in furthering these debates, provides us with fertile ground from which to develop ideas that neither fall into a representational epistemology, or indeed the trap of blinkering ourselves into a relative analytic blindness with respect to non-discursivity.

This distinction is in need of further exploration, in that one needs to consider the existence, and the problems facing theories that seek to avoid adopting a positivist or one-sided approach to theorising language and non-discursivity. It is the relation

between the two that is of interest, if we accept that for some ‘thing’ to become recognisable, namely visible as a knowledge practice, it depends upon the successful inter-relating of both non-discursive and discursive practices. As we will see in the following section, it is the Deleuze-Guattarian concepts of *content* and *expression* that can be of aid here.

1.8 Non-Discursivity

Deleuze and Guattari (1983; 1987) place the non-discursive at the heart of their analytic endeavours. For them, everything is in a state of flux, ever changeable. This flux becomes ordered, rendered stable, ‘molarised’, through various operations (e.g. psychiatry). This ordering though does not cease the eternal ubiquitous *flow*. Their work is about how flow is captured, bifurcated and ordered, and how we can relate to both change and stability at once. This is what I use the term ‘code’ to define. Namely, the capturing of experience into particular forms of socio-linguistic meanings. Deleuze and Guattari are continually focused on developing systems of thought and concepts that illuminate how experience and knowledge can *become*. That is, they are interested in considering what the present can become in the future. They are not concerned with the past as a causal effect on the present and future, nor do they believe in definitive essences, such as the psychoanalytic concepts of ego, id, superego, that act as determining factors that produce experience. Rather, theirs is a much more fluid philosophy, less interested in highlighting stable patterns of behaviour that exist over time, but actually to always emphasise the potential for experience to spin off in new directions. To think, act, feel, in new ways. This is the concept of becoming; placing the potential to become in new directions at the forefront of thought.

A useful concept here, to articulate how this formation of knowledge relations operates at an individual level, is Heidegger’s (1962) notion of *thrownness*, which is used to frame the way that we find ourselves thrown into a world already made up from pre-existing sets of knowledge relations. Thus it is not possible to start anew, but once immersed in prior relations one becomes part of their continual (re)production.

Although the present is always linked to the past, it is constantly made anew, which led Deleuze and Guattari to feel that any notion as to the causality of the past was unsatisfactory. At the heart of the relations of knowledge is the relationship between

discursive and non-discursive practices that Deleuze (1988) articulated in the concept of strata, drawing on Foucault:

‘Strata are historical formations, positivities or empiricities. As ‘sedimentary beds’ they are made from things and words, from seeing and speaking, from the visible and the sayable, from bands of visibility and fields of readability, from contents and expression.’ (Deleuze, 1988: 47)

This provides us with a workable ‘solution’ to the problem of the relation between the discursive and non-discursive. For Deleuze, neither is the determining component, but rather each mutually form – through co-function and interweaving practice – sets of relations through which particular kinds of actions and activities are produced. In this way, we can gauge how relations are required to be constantly reproduced to continue to exist, which forms the essence of *action*.

1.8.1 A Theory of Strata

For Deleuze (1988) it was in the *Archaeology of Knowledge* (2002) that Foucault first drew out this distinction between the discursive and non-discursive, which built upon ideas from the earlier *The History of Madness* (2005), although with emphasis placed on the discursive. In *Discipline and Punish* (1995), a positive light was thrown on non-discursivity, as through his work on prisons Foucault's emphasis shifted to a more balanced view of the inter-dependency of discursive and non-discursive practices. This position emerged through analysis of the Panopticon, the prison design of a central tower, from which all prison cells are visible, but which cannot itself be seen. The notion of light, illuminating the lives of prisoners led Foucault to recognise the inter-dependent, but crucially distinct nature of discursive and non-discursive practices. He believed that it was a fundamentally *different* form of knowledge produced in the visibilities of prisons, i.e. the buildings and prisoners themselves, than that produced by the discursive practices bound up with prison life and societal discipline, i.e. Penal Law and the notion of delinquency that led to the prisoners entering and remaining in prison. For Deleuze, this is a crucial part of Foucault's thesis; the emphasis on the interdependent, but entirely non-reductive nature of practices of discourses and visibilities. The crux being that what is *seen* is different to what is *said*; although neither exists without the other. In the Panopticon, a set of practices make the

inhabitants *visible* as prisoners; the layout of the prison itself, the prisoners' bodies, their actions - restricted as they are by the Panoptic design. How they *feel*, is in part produced by the physical organisation of the space in which they exist. Foucault's point is that these practices are distinct from the discursive ones at work in Penal Law and the notion of delinquency. What is said about delinquency is dependent upon, but distinct from, what is seen of delinquency in the prison.

1.9 Visible Non-Discursivity in Mental Health

If we consider the notions of mental health set out in classification manuals, diagnostic categories tell us a lot about different forms of mental disorder. For example, that someone diagnosed paranoid schizophrenic would have experienced a lengthy (six month or more) episode of falsely believing they were being persecuted. These forms of knowledge frame experiences for which they act as describers in terms of irrationality, which itself is presented as referring to issues of mental cognitions. Symptoms such as paranoia are constructed as existing as false and exaggerated beliefs. Here we see a traditional system of thought focusing on the 'mind', where concepts of rationality and consciousness constitute the knowledge produced. What is lacking here, is knowledge of the socio-non-discursive matrix of the actual experiences that classification manuals are designed to represent. For example, to see the spatial orienting of this person diagnosed as paranoid engaging in everyday practices of locking themselves in their homes, only going out under the cover of darkness etc, forms a different kind of *visible* (i.e. non-discursive) knowledge, than that of the discursive practice of classifying. We would see how people's bodies are used, and how they inter-relate with the non-discursive parts of their daily lives, as seen in the earlier extract of Rob thinking his television had been installed with surveillance devices to monitor his every move. Forms of discursive and non-discursive practices are multiple. In mental health, discursive practices involve classification manuals, media reports, doctor-patient consultation, amongst others. Each a different form of discursive practice, saying something different, and thus distinct about mental health. Classification manuals, given such an important role to play, only operate as a form of discursive practice, distinct from forms of visibility and other discursive practices in the assemblage of mental health. But what of other claims to mental health knowledge?

1.9.1 Electro-Convulsive Therapy

Electro-Convulsive Therapy (ECT) was first introduced in the 1930s on the basis that induced fits lead to an improvement in the lives of people diagnosed with schizophrenia (Gelder, Mayou, & Cowen, 2001). This led to the mass administration of ECT to patients with diagnoses of schizophrenia. Over time however, beliefs regarding the efficacy of ECT altered, and through administration to patients with a range of mental disorders, it was observed that the most marked changes involved people suffering with depressive disorders (Gelder et al., 2001).

ECT as a whole is a rather ambiguous treatment, as although it has been used for over seventy years, it is still unknown as to what exactly it does to brain activity, in terms of how it is supposed to improve certain mental disorders. The Shorter Oxford Textbook of Psychiatry (2001) reports a range of factors involved in the process of ECT treatment. This ranges from the actual process of administration, to the range of previously observed after-effects of ECT. These cover physiological changes, unwanted effects, memory disorder and general cognitive impairment post-shock. This is designed to *say* something informative about the process of undergoing ECT treatment. What this does not do though, is give any sense of how ECT is *seen* in practice.

In *Asylums* Goffman (1968a) undertook a detailed exploration of the role of institutional life, part of which focused on living in mental hospitals in the 1960s. During his ethnographic study he witnessed much of the operation of patient life, including the administering and receiving of ECT. Goffman was able to see how the process of ECT acted as an event in daily life, and thus some of how it was made visible:

‘This knowledge [of shock therapy] is based on the fact that some of the patients in Ward 30 have assisted the shock team in the administration of therapy to patients, holding them down, and helping to strap them in bed, or watching them after they have quieted. The administration of shock on the ward is often carried out in full sights of a group of interested onlookers. The patient’s convulsions often resemble those of an accident victim in death agony and are accompanied by choking gasps and at times by a foaming overflow of

saliva from the mouth. The patient slowly recovers without memory of the occurrence, but he has served the others as a frightful spectacle of what may be done to them.’

(1968a: 39)

The process of ECT administration and reception works as a more socially expansive event than that portrayed by the individually focused description in the Textbook of Psychiatry. In Goffman’s observation ECT operates as part of a social event involving not only the team of staff giving the shock, but also a number of other patients. A space is created in which not only a patient is treated, but also an audience can partake in the event. The effect of this observation is marked. Other patients see the throws of agony of the convulsive patient under treatment, the gasps and saliva escaping from the mouth. After shock, the audience witness the amnesia experienced by the treated patient, who can express no recollection of the shock. This, in turn, produces an effect far removed from the individualised focus of the textual descriptions. The treatment becomes a show by which to incite fear and thus adherence in the other patients. The effect of *seeing* the event of shock treatment leaves a telling mark on the audience, who are now very visually aware of what the process of ECT involves. Indeed the experience of *seeing* is one that allows the audience to be able to embody what it means to experience ECT in a way not afforded by discursive reports of treatments. Here we see the distinction between the forms of knowledge (in this case regarding ECT) produced by discursive practices and those produced by non-discursive practices. The physical layout of the institution provides a space within which knowledge and understanding of mental health disorders is produced that is different and distinct from that produced in psychiatric textbooks and classification manuals. It allows for and enacts a different form of conscious *feel* than that produced by discursive practices of description, as found in classification manuals. Neither can exist as they do without the other, but equally neither form is reducible to the other. Goffman’s ethnography provided an insight into this distinction in terms of institutional life, which in current practice does not play such a prominent role, given the move to community care.

1.10 The Visible and the Discursive

What we have then is a way of thinking about human life as made up of distinct sets of practices based upon the totality of discursive practices, and the integration of these

with the totality of practices of visibility. Here a representational understanding of the relation is cast out, as the distinction between what is said and seen operates between the relations of two semi-autonomous sets of practices. This is to move constructionist accounts (such as the discursive theories discussed earlier) into the realm of ontology. This disengages with ideas of singular subjects and objects, to notions of the fluid multiple, something that Mol (2002) refers to as *ontological politics*. So where does this leave us? Firstly, there is a need to deal with exactly how to work this distinction.

1.10.1 Content and Expression

Deleuze & Guattari (1987) focused on this distinction between discursive and non-discursive practices. The concepts they developed to think about this distinction were *content* and *expression*. The realm of non-discursive practices are forms of *content*, whereas discursive practices are forms of *expression*. Expression works by means of signs, but not in a representative way. Crucially, to quote Deleuze & Guattari, “one cannot posit a primacy of expression over content, or content over expression” (1988: 97). They refer to distinct, yet inter-dependent, multiplicities. Multiplicity does not refer to a multiple as opposed to a singular. It is not framed in terms of there being a definite ‘one’ (i.e. subject or object). Rather, it refers to a space in which different forms of subject and object are formed, re-worked, and interact in a fluid manner. It is a way of referring to differences that do not sum up to produce a coherent whole, but which nevertheless are held together.

It is in his writings on Foucault that Deleuze (1988) introduces the concepts of content and expression, when discussing the concept of *strata*. Forms of expression and content both have a form and a substance, which Deleuze (1988) lays out using Foucault’s writings on prison life in *Discipline and Punish* (1995). Deleuze (1988) demonstrated the forms of content of the disciplinary practice of punishment through incarceration were the prison itself, along with its inhabitants. We saw earlier how the spatial organisation and design of the Panopticon allowed for and produced particular consciousnesses of being a prisoner. The forms of expression at work in this assemblage were Penal Law, which acted as the mechanism through which people were imprisoned, and the notions of delinquency, on which Penal Law based its action. The prison is nothing without the prisoners, whilst Penal law is devoid of meaning without the notion of delinquency. Yet, each of these parts all operate at different

levels, contributing different forces of production. The discursive formation of delinquency and Penal Law provided forms of knowledge that were distinct from the forms of visibility of prison life produced by the inmates in the Panopticon. Its design producing a self-regulating embodied consciousness due to the fear of constant surveillance from the central tower. Deleuze and Guattari (1987) summed this up in stating:

‘Precisely because content, like expression, has a form of its own, one can never assign the form of expression the function of simply representing, describing or averring a correspondent content.’ (1987: 95)

These discursive practices, designed to *say* something about criminality at the time, produced distinct forms of knowledge than those of the spatial organisation of the prison and inmates themselves. The concepts of *content* and *expression* refer to the way that the discursive and non-discursive operate as *distinct multiplicities*. Distinct because they operate in a semi-autonomous fashion, neither being entirely reducible to the other. Multiple, because each is formed through the regularity of the inter-relating of (either discursive or non-discursive respectively) heterogeneous practices in a space in which they become recognisable as such. Deleuze describes the concept of multiplicity as follows:

‘...multiplicity must not designate a combination of the many and the one, but rather an organisation belonging to the many as such, which has no need whatsoever of unity in order to form a system.’ (1994: 230)

Discursive and non-discursive practices are dependent on each other; discourse does not exist in some ethereal space completely without contact with any non-discursive substance, nor can forms of non-discursivity stand alone without the productive input of the discursive. They require each other’s presence, but are productive of *different parts* of relations of knowledge. They produce distinct forms of knowledge, which themselves inter-relate in the production of wider knowledge practices. They come together in the *production* of knowledge and experience.

We saw earlier the example taken from Goffman's observations of the workings of administration of ECT in mental institutions, in which forms of expression as set out in psychiatric texts on treatments produce knowledge that is distinct from the socio-embodied matrix of knowledge produced in the space of ECT administration in a hospital. Its visibility is very different to what is written about it, particularly as its content exists in a wider social space (e.g. with medical staff and audience) than the individual focus provided by texts.

1.11 Territorialisation

In considering how people become service users in the first place, it is necessary to think about the varied ways in which they become subject to forms of knowledge that mark them out as service users. The concept of *territorialisation* is a useful one here; as it refers to the ways that people become subject to particular forms of knowledge, and subsequently their experiences are modified accordingly. It bears similarities to Hacking's (1999) notion of *interactive kinds* we saw earlier in terms of the ways it recognises that people's experiences and actions are affected by the forms of knowledge that they are exposed to. But, like interactive kinds, territorialisation accounts for the subsequent ways that people actively re-work the kinds of knowledge forms applied to them. They are not just passive recipients, or docile bodies. Experiences are coded, for example, when experiences such as Rob's in the earlier extract become captured, coded, and thus territorialized through the diagnostic practice of psychiatry. Diagnostic terms, e.g. paranoid psychosis, become the forms of expression that relate to the contents of experience. They become the psychiatric apparatus that codes experience. With this comes a whole raft of territorializing factors. For instance, media representations of people who experience mental health difficulties (i.e. as 'risks' to the rest of society) (Philo, 1996); medication treatments (with the negative side effects they can bring) (Rettenbacher, Hofer, Eder, Hummer, Kemmler, Weiss, & Fleischhacker, 2004; Smith, O'Keane, & Murray, 2002); cultural stigmatisation leading to problems maintaining employment (Midgley & Milne, 1995; Pevalin & Goldberg, 2003). All these operate as territorializing forces, that link together forms of content to modes of expression so as to make experiences understood according to apparent stable forms (e.g. diagnostic categories), despite the natural flux and fluid nature of flows of experience.

So far we have seen some of the multiple ways that service user experience is captured and coded in socio-linguistic forms of meaning. What these have done is to offer alternative reifications of mental health, as we saw in some of the critiques of biomedical psychiatry. This though can be problematic. In wanting to steer as close to the actual experiences of service users, devising a way of thinking that offers an alternative reification is not desirable. Rather, what is required is a way of thinking that instead of focusing on the capturing and coding of experience, incorporates a concept of process and change. This is where I will draw on the concept of *affect* (Massumi, 2002), which places movement and change at the heart of its thought. This will not be elaborated on now, as there are other aspects that need be covered before a full exploration of the concept will be possible.

When analysing how experience is continually impacted upon and molded by territorializing forces, Deleuze and Guattari were mostly interested in the moments of change, of continual becoming in different ways from before. That is why we see more of the sister concepts of territorialisation in their writing, namely *deterritorialisation* and *reterritorialisation*. Deterritorialisation is used to consider the ways that experience is changed, or, to use a term more familiar in constructionist theory, *deconstructed*, from previous ways of being. Whereas reterritorialisation refers to how the deterritorialised state is territorialized in an alternative, new, way.

In this way forms of content and expression are indelibly linked to forms of deterritorialisation, as how they are continually re-worked and *become* is dependant on the deterritorialising forces at work in any given context. Deleuze and Guattari sum this up:

‘Both forms of content and forms of expression are inseparable from a movement of deterritorialisation that carries them away’ (1987: 97)

Deterritorialisation is really at the heart of Deleuze and Guattari’s philosophy, as it emphasises the constantly changing fluid nature of life. New ways of thinking and being continually emerging. In this way, it is really an inherent feature of the concepts that they produce. In service use people become deterritorialised by the practices of psychiatry through which they are recruited as patients. For instance, the application of

diagnostic categories, or the exposure to media representations of the ‘mentally ill’. These are forms of knowledge that deterritorialise people’s pre-service use lives. In this thesis it is the processes of reterritorialisation users engage with in re-working their experiences that are of interest.

1.12 The Way Forward

The discursive practices at work in service use cannot in themselves illuminate the contents of service use. A key analytic in this thesis is to analyse service users’ actual grounded everyday experiences, to get a sense of how service users engage in practices that allow them to manage on a day-to-day level. Focusing on forms of content allows for a purchase on the multi-sensual *feel* of service use, which analysing forms of expression alone cannot provide. This is the drive behind utilising theories developed by Deleuze and Guattari, who, as we have seen, provide ways of thinking that allow for consideration of both forms of content and expression, thus including both discursive and non-discursive realms. What this is getting at is that the embodied experience of living with mental health difficulties is distinct from the forms of understanding elucidated by forms of expression alone. For example, the experience of taking medication (as will be focused on in Chapter Six) is felt and made visible in a way that differs from that detailed in textbook descriptions of drug treatments. Analysing service user experience requires accounting for the relation between forms of content and forms of expression. This includes relations between service users’ bodies, objects, and the places that constitute the landscape of service.

As we will see in the following chapters, daily experiences of service users often involve dealing with medication, which can provide a series of challenges in terms of bodily functionality due to the side effects some medications can bring. These challenges feed into people’s ability to engage in activities, such as attending day centres etc, so the relations between bodies, medication and space is an important one. It is then an approach to mental health service use that focuses on the experience of living with mental health difficulties when *not* using services. That is, the vast swathes of time in which service users are not at their local day centre, support group etc; when they do not have a visit from their Community Psychiatric Nurse (CPN). Life in community care involves a great deal of self-managed time, and it is a sense of how this time operates that is at the heart of this thesis. Advances can then be made in how

we go about thinking about human experience in the social and human sciences as a theoretical aim of the thesis. And, through a thorough empirical grounding in service use, new possibilities for thinking and dealing with mental health difficulties can be developed on the basis of a greater understanding of the non-discursive workings of service use, as opposed to the individualised approach of mainstream psychiatric practice.

Chapter 2:

Community Care and Service User Literature

'I have intimated to the hospital authorities who will be producing the constituent elements of the national hospital plan that in 15 years time there may well be needed not more than half as many places in hospitals for mental illness as there are today. Expressed in numerical terms, this would represent a redundancy of no fewer than 75,000 hospital beds.....so if we are to have the courage of our ambitions, we ought to pitch the estimate lower still, as low as we dare, perhaps lower.'

Enoch Powell (1961) Report of the Annual Conference of the National Association for Mental Health

'I will go so far as to say that a hospital plan makes no sense unless the medical profession outside the hospital service will be able progressively to accept responsibility for more and more of that care of patients which today is given inside the hospitals. It makes no sense therefore unless the medical profession outside the hospital service can be supported in this task by a whole new development of the local authority services for the old, for the sick and for the mentally ill and mentally subnormal.'

Enoch Powell (1961) Report of the Annual Conference of the National Association for Mental Health

2.1 Formal Politics of Power

The quotes that start this chapter are taken from the infamous 'Water Tower' speech given by the then Secretary of State for Health, Enoch Powell, at the Annual Conference of the National Association for Mental Health (now known as MIND) in 1961. This was the genesis for the 'care in the community' policy of treating people

with mental health difficulties in community settings, rather than the mental hospitals that had stood as the bedrock of mental health care since the nineteenth century. Powell vehemently states his position that numbers of beds in mental hospitals be massively reduced, and care of patients be undertaken through the development of community services. As we shall see further on in the chapter, this is not the only instance in which radical libertarianism and radical socialism share some uneasy ground, as both sought the same outcome, namely, de-institutionalisation. Although it was some three decades on from this speech until major closures of mental hospitals took place, its execution very much operated as a catalyst for change.

Following this speech there were several Government policy reforms, with numerous Green and White Papers introduced, including the Hospital Plan for England and Wales (1962); Better Services for the Mentally Handicapped White Paper (1971); Better Services for the Mentally Ill White Paper (1975); and the Care in the Community Green Paper (1981). These demonstrate the legislative moves that resulted in a mass reduction in mental hospital populations between the 1960s and 1990s. Support for these changes was not unequivocal, although it did come from many different angles, both implicit and explicit. A key factor here was the introduction of psychotropic drugs for the treatment of diagnosed mental disorders in the 1950s. The first drug (Chlorpromazine) had been found to be 'effective' in the treatment of psychotic symptoms, in that behaviours associated with psychosis were greatly reduced when taking this medication. It was argued that mental patients were now in less need of large specialised institutions, given that medication provided them with a more controlled behavioural existence, one more suited to community care and (re)integration in society (Coppock & Hopton, 2000). The right wing conservatives of the time argued that given the development of psychotropic drugs it was now no longer necessary to maintain and keep hospitals. Left wing politically oriented campaigners - spurred on by the writings of Goffman (1968a; 1968b) and Foucault (2001) - argued that to house people in these institutions was tantamount to political oppression, and as such they should be closed (Jones, 1993). Thus, support was widespread, irrespective of political allegiance, although ideas about how community care should operate were diverse and much divided.

In the days of institutional care, people's mental health difficulties were viewed as long-term, which contributed to the idea that it was *care* that was the main focus, rather than treatment (Rose, 2001). Throughout the 19th Century numerous institutions were built on Greenfield out of town sites, which provided a range of activities and facilities, all set in a countryside environment. With the increasing numbers of people admitted throughout the first half of the 20th Century, overcrowding started to become a problem. This was a time that coincided with the introduction of physical treatments, such as Electro-Convulsive Therapy and Insulin Coma Therapy. These led to the belief that people's lives could be sufficiently improved and that managing them in institutional care was an easier task.

The push to close institutions and discharge patients into community care schemes continued, and by the mid 1990s the number of hospital beds for mental patients had been reduced from around 140000 to 18000 (Coppock & Hopton, 2000). However, the number of people diagnosed and recognised as being in need of treatment due to experiencing mental health difficulties has not changed dramatically (Warner, 1994). This has resulted in the current climate of mental health care in which a large number of mental health service users are treated in community settings. The potential geography of mental health changed quite dramatically, from the localised spatial layouts of mental hospitals and their grounds, to the expansive landscapes of towns and cities. It is the purpose of this chapter to address this operation and draw out some of the key issues involved with living with mental health difficulties in the community.

2.2 From Sites of Confinement to Control Societies?

In this opening section we have seen how the terrain of service use has changed substantially with the move from hospitals to communities as the primary care setting. This is the current framework of service provision that the services users included in this thesis exist within. Mental institutions previously acted as the 'sites of confinement' (Deleuze, 1990) for people with mental distress (Foucault's (2005) 'History of Madness' provides a valuable, although not uncontroversial (see Andrews, 2003; Porter, 1990), account of this). Once entered, 'patients' would remain for many years, often for the remainder of their lives (Scull, 1977). In this way, such institutions acted as the sites in which mental health was captured, and then, subject to the coding of the dominant form of expression at the time (e.g. psychiatry). With the move to

community care came the hope that such confinement was firmly in the past, and service users would be presented with far greater opportunities to (re)integrate into society (Bennett, 1991; Ekeland & Bergem, 2006; Pinfold, 2000; Rossler, 1992). Deleuze (1990) argued that this freedom of current technological modern societies is a myth. Rather, control exists, as it always has. All that differs is how it exists:

‘With the breakdown of the hospital as a site of confinement, for instance, community psychiatry, day hospitals, and home care initially presented new freedoms, while at the same time contributing to mechanisms of control as rigorous as the harshest confinement.’ (Deleuze, 1999: 178)

This is the picture of modern society that Deleuze painted. Gone are the days that control existed through the sites of confinement of the 18th and 19th Centuries, e.g. factories, prisons, mental institutions. At that time, these sites, provided quite stable locations where control was visible (as Foucault (1995) demonstrated). Deleuze argued modern society has become more fragmented, with the advancements in technology facilitating and producing more distributed forms of control. It is a mistake to consider modern society more ‘free’; rather the modes of control have become dispersed and technologised. In a sense then, the mechanisms of control and influence of mainstream psychiatric practice extend beyond the closed sites of mental institutions that existed in such abundance prior to the move to care in the community.

At a surface level, it may appear that service users have more scope to integrate with society in a way that is not so evidently restricted by the limited spaces and closed off locations of mental institutions. As Deleuze argued however, this is not really the case, as what has happened is that forms of control have shifted from the institutions to more dispersed modes that function as care in the community. Let us now consider one of the pivotal mechanisms through which control remains through psychiatric practice, despite the change from institutionalisation to care-in-the-community.

2.3 Pharmacological Revolution

Despite the debates that exist regarding the move to psychiatric medication as the dominant treatment, its development has been a major factor in service use.

Psychopharmacology allowed for a very different system of practices to be introduced that previously would not have been possible.

The discovery that drug therapy could be useful in treating mental health disorders was not a result of research directly focused on mental health. It occurred through an accidental finding that drugs used as anti-histamines could have a sedating effect on people experiencing psychosis. This came about after a French naval surgeon, Henri Laborit, had been experimenting with different forms of anaesthesia with a focus on treating patients in shock (Le Fanu, 1999). His working hypothesis held that a pre-shock trauma may result in the release from red blood cells of chemicals known as histamines. If he could identify a workable anti-histamine (drugs now well known in the treatment of allergies), post-trauma shock could potentially be reduced. With this aim, he administered patients with anti-histamines, which he noticed had a sedating, almost euphoria-inducing effect. With an idea that these kinds of drugs may have a similar outcome in psychiatric patients, he invited the French pharmaceutical company Rhone-Polenc to work with the drug to reduce its anti-histaminic nature, and increase its sedative nature (Jones, 1993).

In 1950 Rhone-Polenc initiated a considerable research programme to investigate the potential of this class of drug, known as phenothiazines, with one of the leading chemists observing many of the same sedative effects in rats, using one phenothiazine, Chlorpromazine. It was not long before these considerable efforts led two French psychiatrists, Jean Delay and Pierre Deniker to be the first to administer Chlorpromazine to a patient diagnosed schizophrenic.

Their patient was known as Giovanni A, a fifty-seven year old male labourer. He had been admitted to hospital due to a series of events, which included “making improvised speeches in cafes, becoming involved in fights with strangers, and walking around the street with a pot of flowers on his head proclaiming his love of liberty” (Le Fanu, 1999: 68). Within two weeks of first administration of Chlorpromazine, Giovanni was able to hold coherent conversation, and so great was his observed improvement that within three weeks he was discharged. This experiment was soon joined by others in the UK and United States (e.g. Elkes & Elkes, 1954; Lehmann & Hanrahan, 1954). Within a few years other drugs were designed and found to be effective in other forms of mental

distress, such as affective disorders. The road towards drug therapy becoming the dominant treatment for mental disorders was well on the way.

These observations as to the effects on psychotic symptoms of Chlorpromazine fitted in well with the previous alliance struck between the treatment of general and mental health. Ideas around the nature of mental disorders as operating organically could be supported, allowing for further investigation into the nature of the biological basis of disorders. In this way, mainstream psychiatric practice could draw on theories of medical science, which had a greater history and cultural value in being prescriptive systems of thought about treating problems in health. In addition to this, drug therapy could be drawn upon by the debates regarding the most appropriate location for mental health treatment (Rogers & Pilgrim, 2005). If symptoms could be lessened, it made the necessity to house the 'mentally ill' under one roof less apparent. Previous symptoms, including active hallucinations, catatonic behaviour, and persecutory delusions, amongst others, were suddenly far less overt. According to these knowledge practices, institutional care had been necessary to manage the symptoms of these neurological abnormalities, as very close observation and a controlled environment was required. However, when medication was found to be effective in reducing symptoms, re-integration into society was argued to be possible (Rogers & Pilgrim, 2005).

These moves were premised on the idea that mental disorders were, in some form, operational in neurological terms. This activity could be impacted upon by the effects of the new drugs, and illnesses could be controlled (it soon became apparent that symptoms were lessened rather than cured by the drugs (Jones, 1993)). Critiques of this approach though were quick to highlight the continued lack of aetiological evidence to support biological claims as to the *causality* of mental disorders. Drugs had been found to be effective in reducing the overt expression of symptoms, but did not eradicate them completely, as patients still reported occasional symptoms (Le Fanu, 1999). Additionally, aetiological evidence remained absent regarding underlying causality, and as such the whole paradigm shift towards drug therapy was based upon an accidental finding, rather than any linear progression of hypothesis-based empiricism. In Jones's (1993) history, these findings became utilised in government policy to further strengthen the case for a shift in emphasis from hospital to community. In this

way, bodies were represented as now controllable by medication, which had previously required the controlled and limited spaces of institutions.

Rogers and Pilgrim (2000) offer an alternative account to the ‘pharmacological revolution’ narrative about the key facilitators of the development of community care. For them the evidence that the introduction of neuroleptic medication was the dominant factor is not clear cut, with some European countries reporting increases in in-patient numbers after widespread use of medication. Rogers and Pilgrim prefer to lay the causal flag at the feet of several different factors, with emphasis placed on economical and ideological issues. Following on from Scull’s (1977) argument that in the early 1950s, the Government sought to radically reduce the financial cost of mental health care, and envisaged a care framework based in communities, rather than asylums, as a cheaper, and thus more desirable, financial option. This was seen to combine with ideologies that segregating people, rather than integrating them, was the way forward; a line of thought combined with the perceived negative views of asylum care that had become widespread in the first half of 20th Century (Rogers and Pilgrim, 2000).

Despite the debate over the role of the advent of medication as the dominant treatment in the move from in-patient to community care, its existence and operation in current psychiatric practice is a central part through which the model of service use operates as a control society, and it is the technological machinery that facilitates control to be maintained. The move from hospital care as the prime location for service provision to community settings was a prime goal of critiques of hospital-based care. Let us now consider some of the key figures in the critical literature, prior to moving into the area of ‘anti-psychiatry’ that they came to embody, and its role in the development of the area of ‘critical psychiatry’ that now operates.

2.4 Institutional Critique

In addition to the emergence of medication, histories of community care also highlight the role of anti-institutional knowledge (e.g. Coppock & Hopton, 2000). A key proponent of anti-institutional views was the American sociologist Erving Goffman, who had spent around eighteen months undertaking an in-depth ethnographic study of institutional life in a Californian hospital, prior to writing his influential book ‘Asylums’ (1968a).

2.4.1 Goffman

For Jones (1993), Goffman's strength was in his ability to draw out common threads in institutional life, which readers took as professing general patterns in institutional care. Goffman's critique was eloquent and wide ranging. From the moment patients enter institutions the 'mortification of the self' (Goffman, 1968a) began. He argued people were stripped of their identities, through the removal of all aspects of personal identification. They wore standardised clothes and personal belongings were removed. Goffman reported that conditions for patients in institutional life could be quite horrific. Although, his book focused on what he referred to as 'total institutions', he was, in part, talking about mental institutions. Goffman argued that life was harsh for mental patients, indeed, that it was in essence abnormal, with a two-tier social world, with the staff and their social activity (numerous games, groups and other events) on one hand, and the patients' limited existence of menial work, exclusion from staff activity and very limited space, on the other. Goffman was scathing about physical treatments, such as Insulin Coma Treatment, Electro-Convulsive Therapy and Psychosurgery. He observed administration of treatments (one of which detailed in Chapter One) and argued that they constituted a form of abuse. The social world of patients also came under Goffman's wrath, as he stated that group activities such as games, art lessons, dances etc, formed another attack on patient privacy as they contributed to the controlled nature of patients' time and space.

According to Goffman's argument mental disorders are vulnerable to the effects of individuals' immediate environments. If conditions are poor, patients are exposed to practices producing negative experiences, resulting in exacerbation, rather than improvement, in mental health. Individual bodies are presented as susceptible to the workings of social practices, meaning mental distress operates as impacted upon by external forces. This was a move away from the mainstay prescription of individual neurology as the basis of distress. Goffman's work, amongst other anti-institutional research, introduced the notion of social practices as contributing to mental distress, which was no longer within the sole remit of neurological activity. Biological psychiatry drawing support from drug therapy was not the sole determinant in the continued move into community care. Despite differences in concepts of mental distress, these contrasting approaches became part of the same relational forces to move mental health care from institutions to community settings.

2.4.2 Laing

Laing (1969), himself a trained psychiatrist, argued that the focus should not be on the practices associated with 'schizophrenia', but on individuals' experience of their own world. This is drawn from existentialism, and involves understanding people's own individual subjective experiences; the ways people consciously encounter the outside world. The medical approach that constructs people as machine-like, in terms of their susceptibility to their own physiological make-up, fails to adequately account for their overall 'illness' experience (Laing, 1969). From this, Laing did not attempt his own theory of schizophrenia, but believed that an insight into individuals' perception of their *world* (Laing defines this as the space and time from which a person experiences and acts) could help understand their so-called abnormal behaviour. The focus of much of Laing's work was individuals' perceptions of their own family environment. This had led to childhood, and particularly the relationship with parents or caregivers, to be seen as a key factor in the development of mental disorders. Laing and Esterson (1964) sought to gain insight into how individuals who had been diagnosed and consequently treated as 'schizophrenic' perceived their own *worlds*, both as an individual, and as a part of the 'family *nexus*' (p.21), in which the person may be a brother, sister, or father etc. From this perspective, Laing provided therapy to individuals and published certain case studies of his work. He believed that the realms of psychiatry and psychopathology were not the correct places to attempt an understanding of the meaning and significance of mental disorders contained under the umbrella of 'schizophrenia' (Laing, 1969).

The move Laing is making is summed up well in the following extract:

'No one has schizophrenia, like having a cold. The patient has not 'got' schizophrenia. He is schizophrenic.' (1969: 34)

Laing sought to re-conceptualise schizophrenia as a way of being, an existential state that people *are*. Although he was careful to state he was not coming up with a new theory of schizophrenia as a whole, he clearly was to an extent, in terms of offering a new system of thought regarding people's experiences labelled as schizophrenic. Namely, that it is not something that people *have*, but a way people live. He did not believe that schizophrenia was an illness as such, in the same way that people may

have a virus. Rather the schizophrenic experience was a way of living, of being, that is predominantly constituted in the network of relations that form people's family environment.

2.4.3 Szasz

Another key anti-psychiatry proponent was Szasz, who argued from a very different position than Laing. For Szasz (1974), mental illness as defined by psychiatry is very much influenced by social, cultural, and particularly political factors. He believed that mental illness is an invention of psychiatry, akin to the invention of 'witches' in medieval times, which can then account for certain social and moral difficulties. Rather than admit that particular problems exist, the people who are involved can be diagnosed mentally ill, through no fault of their own, and then 'treated' through psychiatric intervention. In addition to this, mental illness can also camouflage and blur the borders surrounding certain socially outcast subgroups. Bowers (1998), in drawing on the writings of Szasz, describes how certain societal issues, such as poverty, domestic violence, low employment, can become medicalised through diagnosing those within such situations as mentally ill, thus covering up the real difficulties members of such groups suffer. Bowers (1998) critiques the work of Szasz by stating that it is too generalistic, as social and morality factors associated with illnesses are always ignored or glossed over. Additionally, the crux of Szasz's argument really concerns a *category error*, namely that he disagrees that experiences labelled as *mental* illnesses are any different to those labelled *physical* illnesses. With this he offers his definition that for an illness to exist a physical lesion should be present. He uses this to suggest that diagnoses for which no aetiological nature has been identified (e.g. schizophrenia), should not be treated as illnesses, with subsequent pressure to engage in current dominant treatment practices (e.g. taking medication). Rather people should be free to choose what kind of treatment they desire, if, that is, they make the decision to seek treatment. In this way Szasz adopts a liberalist humanist position, a very different one to a lot of the other so called 'anti-psychiatrists'. This is another example of an ambiguity regarding political viewpoints, in that radical libertarianism (that of Szasz) end up desiring the same thing as left-wing socialists (such as Laing and Cooper), namely, a move away from an 'illness' model of mental health.

2.4.4 Basaglia

Approaches critical of psychiatry that had an impact on ‘anti-psychiatry’ also emerged from work taking place in Italian psychiatry, primarily under the helm of Franco Basaglia (1981; Basaglia, Scheper-Hughes, & Lovell, 1987). The political thrust that drove Basaglia was an anti-psychiatric one, but with a distinct flavour from that of Szasz and Laing. Basaglia had been very influenced by phenomenological writings in his early years as a psychiatrist, and believed that to develop an understanding of mental illness one had to directly address the subjective experiences of those who suffered with such disorders. His beliefs though began to change when he became psychiatrist in chief at the Gorizia psychiatric hospital, where he came to realise that his commitment to a phenomenological philosophy failed to account for the range of social and political factors that constructed cultural understandings, and the actual experiences, of living with mental health difficulties in mental hospitals. This is the stage at which Basaglia became more overtly political in his approach. He sought to strip away the layers of social and political forces, and concentrate directly on what people had to say about their experiences. This involved moving away from the vocabulary and material infrastructure of psychiatry, such as diagnostic classifications and psychiatric treatments. He was accused in some corners of denying that mental illness existed (Basaglia et al., 1987), but this was not an accurate representation of what he was trying to do. He actually believed that one could only know the reality of mental illness if one stripped away all the political and social factors that construct it to such an extent. He believed in it, but not in the ‘reality’ created by the psychiatric vocabulary that was the dominant knowledge framework through which mental health was understood.

Basaglia’s was a practical philosophy in a sense. He sought to translate his beliefs into a material existence through transforming the psychiatric hospital at Gorizia. He was not solely interested in developing a new theory of mental health, but was driven by a desire to practically improve the lives of those treated by psychiatry. He fully believed that they had mental illnesses, but did not agree that institutional psychiatry was a beneficial, or appropriate, treatment and care paradigm. While Basaglia was the driving force behind reform at Gorizia, it was the move from a hierarchical power structure, with psychiatric power (i.e. Basaglia) at the top, to a collective shared form of power and responsibility. The creation of a weekly forum (*assemblea*) occurred, in which no

formal power structures were present. It had no set directive, aside from being a space in which patient and staff concerns could be raised and discussed. This often led to disagreements and fierce debates, but this was welcomed, as there were no right and wrong answers, in a psychiatric sense, to be produced by the assemblea. Rather it was a forum for all voices making up the institution to be heard. Chaired variously by staff and patients, it helped create a shared responsibility. If decisions made turned out to be incorrect or not appropriate, it was not the staff that were held responsible, but all members. This shared responsibility was galvanised when one particular decision did turn out to be incorrect. This was the case in which a patient was released back to his family but proceeded to murder his wife (Basaglia et al., 1987). Despite the authority's attempts to lay the blame for this firmly at Basaglia's feet, all members of the assemblea protested, on the basis of it being the result of an incorrect decision made collectively.

A range of factors meant that Basaglia was not able to truly experiment with his own version of anti-psychiatry until the early 1970s when he became asylum director of the Trieste Institution. Basaglia set up a pioneering centre for the treatment of people with mental health difficulties in the town of Trieste in Northern Italy. The premise behind the centre was a move away from large asylum based care, to smaller (e.g. 15 bed) centres, something he performed through persuading people (e.g. left wing groups) that 'patients' should be released from mental institutions in the name of liberty and freedom (Jones & Poletti, 1985). Basaglia was clearly influenced by Marxist ideas, in that he focused on the social forces at work in the cultural ways of thinking about mental illness. The large institutions were taken as the physical workings of institutional power designating what should be seen as mentally ill. In this way, Basaglia believed that radical changes were needed, as the lives and experiences of those housed in asylums were the product of political forces. Lives could be re-claimed through integration into smaller, community-based programmes of mental health care. Basaglia argued people would benefit from a more socially integrative framework, with small units set up in general hospitals for those in need of in-patient care.

2.5 The Emergence of Critical Psychiatry

The anti-psychiatric writings of the likes of Szasz, Laing and Basaglia helped to produce a cultural consciousness of debate and controversy around the issue of mental

health. In themselves though, none of the critiques made by the aforementioned writers led to a sea change in psychiatric practice. Psychiatry remains the dominant apparatus of capture for service users' experiences, and the use of psychiatric medication is still the treatment of choice.

In recent times, the field of anti-psychiatry has morphed into the area of *critical psychiatry* (Hopton, 2006). As with anti-psychiatry it is necessary to point out that critical psychiatry is a heterogeneous field, with differences in beliefs and arguments existing within it. What is shared, as inherited from anti-psychiatry, is the desire to question the workings of mainstream psychiatry. A dissatisfaction has continued to exist with regard to mainstream psychiatric practice, despite the move from institutionalisation to community care. Criticisms of the workings of community care have been widespread in the same way they were in regard to institutionalisation (e.g. Campell, 2001; Coppock & Hopton, 2000; Muijen, 1996; Newnes & Holmes, 1999). These have been based on the belief that service users have not been integrated back into society in such a way that has led them to have improved lives than those that were treated as in-patients. Rather, critiques argue that mainstream psychiatric practice still faces many challenges in appropriately caring for service users (Silvestri & Hallwright, 2001).

The field of critical psychiatry has worked on many levels across a range of areas in questioning and constantly evaluating the many facets of mainstream psychiatry. This has included the validity of diagnostic classifications (Boyle, 2002); applicability and amount of community services (Silvestri & Hallwright, 2001); social inequalities (Williams, 1999); racism (Patel & Fatimilehin, 1999); gender inequalities (Emslie, Fuhrer, Hunt, Macintyre, Shipley, & Stansfeld, 2002); and abuse in care (Lucas & Stevenson, 2006). Developing new and improved services has been a pivotal aim, through greater inclusion of service users in planning of services; more choice over treatments; and working to reduce forms of discrimination that can exist (e.g. those that provide obstacles for service users seeking employment). Intervention remains a pivotal area of debate and disagreement. Since the pharmacological revolution, psychiatric medication remains the dominant form of treatment for service users (Moncrieff, 1999). It remains though, a very contested area. The negative aspects of medication have been widely reported, such as the range and severe nature of some of

the physical side effects that can occur (see Crepaz-Keay, 1999). Additionally, more politically-focused critics have felt very uneasy about the role of pharmaceutical companies in the marketing of medication (e.g. Breggin, 1994; Moncrieff, 2006). One point on which both advocates and critics can share some agreement is regarding the level of choice over treatments available, which is often very limited. Crepaz-Keay (1999) is one of many voices to argue that more choice over treatment should be made available.

Whilst the diagnostic biomedical paradigm remains dominant, critical psychiatry has proved pivotal in implementing changes. Issues around compulsory treatment for service users deemed a danger to themselves or others remain, and reforms of these policies may not go as far as some would like, but there is no doubt that efforts in the critical psychiatry field have ensured that the debates continue longer than they would otherwise. Let us work through some of the theoretical and empirical contributions of areas operating within a critical psychiatric field.

2.5.1 Deconstructing Mental Health

A central part of critical psychiatry has been an attempt to deconstruct the whole of psychopathology as a practice and dominant paradigm for thinking about mental distress. It has been argued that due to the questionable nature of much of mainstream psychiatry, such as the debates surrounding some diagnostic classifications (e.g. schizophrenia), a radical overhaul is necessary to assess whether psychiatric doxa is the most appropriate way of thinking and treating mental distress. A large part of this endeavour has been to delicately unpick many aspects of psychiatric practice to evaluate its effectiveness. To this end, in the social sciences, it has been the concept of *deconstruction* that has been drawn upon, a driving force of much social constructionist thought and writing in the last thirty years.

Parker et al.'s *Deconstructing Psychopathology* (1995) is a valuable contribution to the deconstructive efforts focused on psychopathology. The notion of *deconstruction* is developed from the work of Derrida and Foucault and the desire to challenge and unpick the mainstay forms of knowledge that exist regarding psychopathology. It is not possible to provide a simple definition of deconstruction as Derrida himself stated that

it cannot be simply labelled as one particular concept or method (1983). Indeed some critics would go so far as to say that deconstruction is simply a label for Derrida's own highly particular philosophical style (Reynolds & Roffe, 2004). Broadly speaking, the concept is based on trying to think beyond current traditions of thought. This of course is a common problem in Western continental philosophy, namely, how is it possible to think beyond current traditions of thought, when by definition, our thought is structured by current ways of thinking? Thus, it is not adequate to just use deconstruction as 'critique', in terms of questioning and criticising how mainstay forms of thought have developed and function. Rather, deconstruction involves a far more complex problematic, where deconstruction can itself be deconstructed. Our whole way of talking about, and the language used in attempting to define deconstruction is part of current ways of thinking, which are deconstructable themselves, and in turn form a circular problem. One 'answer' to this, and it should be said that Derrida himself stressed the very ambiguous nature of the concept, is to argue that deconstruction fundamentally denies 'reason' as it is formed in current thinking (1983). It attempts, in no formal coherent way though, to turn everything on its head, not just forms of knowledge that make up cultural understanding, but the whole underlying framework of how 'reasoned' thought is possible.

Due to its ambiguous nature it is necessary to ascertain how deconstruction is used when it is addressed, such as in the work of Parker et al. discussed here. They state that their deconstructive endeavours are based on a notion of deconstruction that "identifies conceptual oppositions, recovers notions that have been excluded, and shows how the ideas that have been privileged are dependent on those they dominate" (1995: 3). Parker et al. state that they are using deconstruction in "a less pure way" (1995: 3), as they are focused on analysing the dominant power discourses of psychiatry, and critiquing them. They term this "practical deconstruction" (1995: 3). Thus, with the dominance of psychiatry in the field, the brunt of the deconstructive work concentrates on unravelling psychiatric literature, thought and practice.

The productive role of language is of fundamental importance to the deconstructive effort. Drawing on the theoretical work in the 'turn to language', language is not seen

as a mere form of communication used to represent forms of factual knowledge, but rather aids in constructing the factual claims that are socially perceived as ‘taken for granted’ truths. Parker et al. (1995) argue that in the case of psychopathology the veridical discourses of diagnostic classifications, such as schizophrenia, are taken as scientific truths, and thus given a strong currency within society. This is viewed as, at the very least, potentially risky, as it may be that particular claims are incorrectly given credence, but beyond this it can be potentially damaging. For instance, in psychopathology the classifications given to people can have profound effects on their lives, such as stigmatisation into roles that can have adverse effects on, amongst other things, employment, social relationships and physical health. This is not to say that psychiatry and its medicalised position is wholly to blame for the way classifications have come to be socially represented and perceived, such as in the media, just that with this in mind it is doubly important to be aware of the effects of psychiatric knowledge, given its privileged position. Thus for Parker et al. it is of paramount importance to question and understand how psychiatric classifications have been formed, and whether they are valid constructions. In order to do this, the constructive nature of language has to be addressed and analysed.

The deconstructive effort is very much focused on the mainstay forms of knowledge surrounding psychiatry, and how these operate and function on the people they are applied to. For instance, the role of medication (of which people’s experiences are very much embodied) is discussed in terms of how it has developed and been used within psychiatry. It is argued that this has occurred due to the accidental finding that drugs may help people classified mentally ill. Parker et al. (1995) draw on Breggin’s (1994) work in arguing that the role of the capitalist desires of the companies that manufacture psychiatric medication has led to drugs becoming the treatment of choice. The growing size of pharmaceutical companies, both in terms of manufacturing capabilities and profitability, has led to them becoming incredibly powerful. This is a key function of power in psychiatry. Medication use has flourished through the power of pharmaceutical companies, with their ability to fund research (and well resourced marketing campaigns), forming strong lasting alliances with psychiatry. To a certain degree, people prescribed medication then become recipients of this form of power, and its subsequent dogmatic adherence to the role of medication in psychopathology.

The relationship between pharmaceutical companies and psychiatry is becoming increasingly one of concern, both in mainstream and critical psychiatry (Moncrieff, 2006; Read, 2005).

Parker et al. (1995) have laid the foundation for valuable critique of all aspects of mainstream psychiatric practice and thought, raising important questions regarding aspects of practice. For instance, the need to investigate why a higher proportion of women, people of lower socio-economic status, and ethnic minorities receive mental health diagnoses than the white Caucasian population. Studies have drawn on this foundation to analyse the experiences of people through interview to study psychotic discourse (Georgaca, 1996), paranoia (Harper, 1999), and personality disorder (Stowell-Smith, 1996). In addition to the conceptual deconstruction of psychiatric theory, this work has empirically focused on the people affected by psychiatric theory and practice. This has allowed for, amongst other things, a comparison between psychiatric and service user thought, which in turn brings first hand experience of how mainstream psychiatry actually functions on the people it is directed towards. This valuable work has formed, supported and helped to further the empirical push towards moving the people who have experiences labelled 'mentally ill' from the bottom of the empirical focus (due to the mainstream view that they are the victims of biological abnormalities), to the forefront of research. There is still a very long way to go for research based upon service users, as biological research still forms the brunt of psychiatric empiricism. However, it is important to keep empirically focused on service users, and to draw on research performed so far.

What these works have done, is to prise open mental health research in such a way that makes the development of new research avenues both possible and necessary. By questioning the perceived wisdom of mainstream psychiatry, and demonstrating its weaknesses, the demand for continued research from a variety of angles is emphasised. An important strand of this has been work focused around offering a re-conceptualisation of certain experiences labelled as 'mental disorders'.

2.5.2 New Concepts Attending to the Meaning of Voices

Part of the drive pushing those developing their own version of critical psychiatry has been to put forward new concepts of experience that are deemed as symptoms of mental illness under the psychiatric paradigm. A prominent strand of this work has been undertaken with the group known as The Hearing Voices Network (HVN). This group has its origins in pioneering work performed in the 1980s with people who reported hearing voices by Dutch psychiatrists Marius Romme and Sandra Escher (1994). They studied a large proportion of voice hearers, and invited them to talk about their experiences. What came out of the research was that a significant proportion of voice hearers reported the emergence of their voice hearing as coming after some form of trauma. Whilst this in itself was not ground-breaking, the way that Romme and Escher set about treating people was different to that of mainstream psychiatry. Hearing voices is taken as a symptom of illness in the diagnostic model, and as such, the aim of treatment is to eradicate voices, not to attend to them, and certainly not to imbue their content with any meaning. Romme and Escher argued that treatment should be a therapeutic journey, in which the content of voices is listened to, and given meaning in terms of the underlying trauma that may have been the catalyst in the first instance. In fact, they argued that it could only be through deciphering and analysing the meaning of voices that coping strategies could be developed.

This way of thinking also meant that the goal should not be, by default, to eradicate voices. For some people, voices could be very distressing and they may wish to stop hearing them. Others though, found that voice hearing itself could be a coping strategy, that voices could be benevolent rather than malevolent, and would adamantly guard against anything (i.e. medication) that may eradicate voices. Romme and Escher's model then sought to re-conceptualise voice hearing as a *normal* response to traumatic experiences, rather than be seen as symptomatic of an underlying illness. Their way of thinking has been important for people who sought to deconstruct mainstream psychiatric practice, as it provides strong evidence that psychiatry may not offer the only way of thinking about experiences labelled as mental illness, and that beneficial alternatives existed. This view has been continued in more recent work with the HVN (Blackman, 2000; McLaughlin, 1996).

2.6 Communities of Care

The combined efforts of an emerging biological psychiatry propelled by the growing use of medication, and the critiques of institutional care, led to a decline in the numbers of people treated in mental hospital beds throughout the second half of the century. Community care therefore became the bedrock of mental health service provision. Evaluation of its operation though, soon came under the same force of critiquing effort as had been directed towards institutional care.

2.6.1 Social/Community Psychiatric Research

Much research focusing on community care operates through the field of social (or community) psychiatry. Its emphasis on social factors makes it a key player in community research, where social factors are more overtly prevalent than in the days of institutionalisation. According to the Oxford Textbook of Community Psychiatry (2001) research concentrates around several key areas, two of which will be considered here.

Socio-economic status has for some time been reported as a major factor in determining prevalence of mental health, with people from lower socio-economic status reported to be more at risk of developing mental disorders (Neugebauer, Dohrenwend, & Dohrenwend, 1980). This research clearly marks out social and economical practices as active constituents of the operation of mental distress. Claims like this have not just existed in terms of community care, but also right through the history of mental health. These claims are evidenced when looking at diagnosis rates, as people from lower socio-economic status are over represented in diagnostic populations (Williams, 1999). An oft used argument to attempt to explain this is the social drift hypothesis, which claims that an effect of suffering with mental distress is a gradual decline through socio-economic status, created in part by factors such as losing employment, becoming increasingly isolated (Fox, 1990). Of course, this places the cause for decline on the notion of mental distress, rather than looking at the socio-economic status first, and questioning whether people of lower status tend to be diagnosed more commonly, and thus whether wider cultural factors are at play (e.g. class prejudice). Similar data can be found for gender and race, with women and ethnic minorities more likely to receive diagnoses of mental disorder than white middle class populations (Bayne Smith, 1996; Loring & Powell, 1988).

Recently, the question as to the prevalence of abuse (physical and/or sexual) has been the focus of research (Janssen, Krabbendam, Bak, Hanssen, Vollebergh, de Graaf, & van Os, 2004; Read, 1997). The link between abuse as a causal factor in the development of mental distress (particularly experiences labelled psychotic) has been highlighted in the critiques of medicalised views of mental health put forward in the pioneering work of Dutch psychiatrists Romme and Escher, and the formation of the HVN (as seen in the previous section). The focus on abuse as a catalysing factor is also reported in a wider set of literature, as summarised by Read, van Os, Morrison and Ross (2005), in which a review of literature revealed prevalence of abuse in the past of people experiencing psychosis to be at minimum 51% and maximum 97%; providing some very strong evidence.

Mechanic (2001) claims that the most important unifying framework in community psychiatry is the 'stress, coping and social support process'. This refers to the relationship between individual and group, and is used in identifying prevalence of mental disorders along with attempting to guide systems of intervention (Mechanic, 2001). Its basic concept is that the functioning of the relationship between individual and groups depends on the 'fit' between individuals' ability to successfully deal with the challenges presented by social factors. Individuals' ability is framed in cognitive terms, with people claimed to develop a variety of cognitive-based coping strategies for successfully (or not) managing everyday life in the face of environmental challenges. It is argued that when people struggle to meet the challenges facing them, an increased risk of mental distress exists.

This kind of research involves a different set of concepts. Social practices are framed as influential, but not in a determinant fashion, as 'resistance' is incorporated in terms of individuals' coping strategies. These may not always be successful, but if operating effectively, have the propensity to repel social difficulties. So, mental distress is held as dependent upon the relationship between external and internal factors. Whether individuals have any potential control over the internal cognitive factors is absent as a question of inquiry.

Research into community care generally revolves around the impact of social factors on instances of mental distress, concentrating on efficacy of service provision, in

addition to continued efforts to illuminate the practices of treatment (e.g. an der Heiden, 2001; Tyrer, 2001). Reading the Oxford Textbook of Community Psychiatry allows a thorough overview of current research into community care. A large portion of the textbook is devoted to evaluating the *process* of research and community care, rather than analysing aspects of it. Aspects are focused on at a macro level; analysed in terms of their impact on mental health in the community. In this way, they are conceptualising the role of social practices with regard to the impact *on* service users. In addition to this, one needs to consider how these kinds of social forces impact on people's lives in terms of how they are taken on and re-worked. This involves taking into account people's own agentic actions, in addition to focusing on the one-way direction of social forces upon people.

2.7 For an Integrated Mental Health

What we have seen is a mixture of approaches studying mental distress in community settings. From an initial neurological basis, whereupon the efficacy of medication is seen as controlling most symptoms of mental distress that previously required institutional care, to the focus on social factors impacting on mental distress. What remains absent in all these approaches is relevant analysis of the actual experiences of service users, the *content*, that these forms of *expression* attempt to speak. It is this need that the service user centred literature has set out to serve.

2.8 Service User Movement

The 'service user' movement has developed due to increased concern at the apparent lack of direct inclusion of service user experience in mental health research (Bowl, 1996; Bracken, 2003; Brandon, 1990). Approaches held under the term are far from homogeneous however. What they have at their heart though is a shared belief that directly focusing on the experience of people who use services provides a form of knowledge that cannot be achieved by other means. That is, service user literature illuminates aspects of experience that are distinct to that position.

2.8.1 Historical Overview of Service User Movement

To be able to position the underlying drive of this thesis, it is necessary to provide a story of the history of the circumstances that led to the development of approaches that became visible as the 'service user movement'. Whilst this has predominantly been a

development of the past twenty years, reports of people who use services speaking up about their experiences has a much greater history. Indeed, in 1620 'The Petition of the Poor Distracted People in the House of Bedlam' was undertaken (Campbell, 1996). In the Nineteenth Century, with the growth of asylum care for the mentally distressed, came the setting up of groups such as the 'Alleged Lunatics' Friend Society' and the 'Lunacy Law Reform Association' (Campbell, 1996). Both of these had the expressed desire to provide a space within which the experiences of those living in asylums could be made visible.

Campbell (1996) provides a number of key events that catalysed the greater emphasis placed upon service user experience in the last twenty years. He argues that in the mid-1980s two conferences in the United Kingdom stand out for the place they gave to the input of service users. These were closely followed by the birth of what would turn out to be two key players in the service user movement; Nottingham Advocacy Group and Survivors Speak Out. People involved in their development were very much drawing on and inspired by action groups that existed as part of 'anti-psychiatry'.

Internationally, activities with the service user in mind had been underway prior to the sustained efforts that emerged in the UK. By 1977 in the Netherlands there were already around thirty-five user groups (Rogers & Pilgrim, 1991), that along with the United States, achieved national recognition. Rogers and Pilgrim (1991) argue that it was the political climate at the time, one so concerned with civil rights, that provided the drive for the marginalized to be 'heard'. Along with Gay and Black civil rights, the mentally ill pushed against social and political pressures to attempt a less marginalized position. As we can see, these moves operated largely in the form of being 'anti' the dominant position at the time. A lot of these user groups disagreed with how they had been treated by psychiatric services, and set out to make this known, in an attempt to improve service provision. This kind of 'anti' impetus has continued in the work of many of the proliferation of user groups currently working. It is felt that psychiatric services do not sufficiently take account of service users' views in the everyday running and policy changes regarding mental health.

Taking a stance 'against' psychiatric services though is not a straightforward exercise. Firstly, a lot of user groups do not necessarily seek to implement change by dealing

with psychiatric services themselves, but identify the political policies which have a key role in the design of service provision, as the place where change is needed (this can be seen in the current fervent debates surrounding reforms to the Mental Health Act – which will be discussed further in Chapter Eight). When considering what is meant by ‘service user literature’ it needs to be recognised that approaches focusing on direct use of psychiatric services come from a range of political and ideological starting points.

2.9 Service User Literature in Clinical Psychiatry

For the current purposes, what is meant by ‘service user literature’ is that which has focused directly on people who have had first-hand experience of using mental health services, and how addressing experience in this way can inform as to aspects of living with mental health difficulties in a way not possible from any other perspective. What we are after, is a sense of what kinds of knowledge service user literature has brought, and indeed, what possibilities remain untapped. Let us begin with what literature has introduced so far within clinical psychiatry.

2.9.1 Assessing Services

Including service users’ perspective in mental health research has been a key objective of Government policies in recent years (Department of Health, 1999). Driven by a desire to be more consumer oriented, the focus has broadened to consider users’ perspectives as an integral avenue through which to assess services. It is very much in the forum of assessment that users’ perspectives have been sought. Research has highlighted views on day and accommodation services (Bryant, Craik, & McKay, 2005); Electro-Convulsive Therapy (Philpot, Collins, Trivedi, Treloar, Gallacher, & Rose, 2004); the functioning of user contact with clinical appointments (Hostick & Newell, 2004). This kind of push led to the Institute of Psychiatry implementing the development of a service user oriented research group (Service User Research Enterprise - SURE), with the prime directive of incorporating service users themselves in the planning and undertaking of research projects. Their projects have included assessing users’ views on ECT, and user involvement in change management amongst others. This area of empirical research provides an alternative perspective on the effectiveness of services, a valuable contribution as it comes from the viewpoint of those who use the services. It should be said that this field of user research has largely

operated in terms of mainstream approaches to mental health care, namely the diagnostic model seen in Chapter One, and assessing services within this model.

The assessment and evaluation of how service user research is carried out and the implication of how it is used by particular research areas (e.g. mainstream psychiatry) has been focused on (Diamond, Parkin, Morris, Bettinis, & Bettsworth, 2003; Roe & Davidson, 2005; Telford & Faulkner, 2004). It is very much a new area of research, and one in which a variety of approaches are being undertaken across a number of varied terrains of research. One of the key debates here, and the impetus for the aforementioned evaluative research are questions as to whether research is being undertaken ‘correctly’, with single inverted quotes used here to allude to the tricky nature of the concept of correctness. Much of the catalyst for service user literature has been one of emancipation, in that there has been a desire to give service users a ‘voice’, to attempt to re-balance research so that users’ ‘expert view’ can become an important contributor. These factors present challenges themselves, such as the role of research itself (i.e. it is not a passive vessel through which findings can be unearthed and presented to a wider field). These issues will be taken up in more detail in the final chapter (Eight). For now it is sufficient to have pointed to a pivotal factor in service user research, that of an overarching concern as to whether the service user voice is valued appropriately.

2.10 Theoretical Approaches to Service User Experience

Service user literature has additionally emerged from across disciplines interested in the area of mental health, e.g. social psychology, sociology, anthropology. Many of these have not positioned themselves explicitly for or against mainstream services as such, but rather have identified areas in which they believe, research can be contributed to. Often it has been a broadening of knowledge as to how specific mental categories are experienced by users that has been of interest. By way of an example let us consider Burr & Chapman’s (2004) analysis of experiences of depression in women from South Asian communities.

Burr and Chapman set out to conceptualise depression from a particular perspective, believing that experience needs to be contextualised beyond definitions in classification manuals. Their argument centres around the specific context of the social practices at

work in the lives of depressed South Asian women in North East England. By placing an emphasis on social practices, Burr & Chapman focus on the role of discourse as productive of the social practices at work. Discourse, they argue, provides stable patterns of societal meaning, which themselves set up and make available ‘subject positions’ that individuals occupy. This, heavily Foucauldian influenced theory, marks out the positions available to South Asian women in the study, e.g. as women, South Asians, depressed patients. By approaching the discourse utilised by women in focus groups and interviews, Burr & Chapman argue they can highlight the practices at work in those contexts, and how they act as constituting of individual experience.

In Burr and Chapman’s analysis, we see an alliance with the position of theoretically incorporating an embodied sense of experience, in this case depression. They home in on the problem documented in literature that South Asian women often report their depression in physical (embodied) terms, due to a difficulty in expressing mental health difficulties in psychological terms. Burr and Chapman incorporate the body as part of the *discursive* construction of women’s experiences, that is how discourse works to position our non-discursive selves. This is the way that theories of this kind claim to account for non-discursivity. For example, discourses that position minority groups in stigmatised ways often do so because of their embodied state, e.g. as someone of racial minority. However, the theoretical focus and efforts are still on analysing the *discursive* practices utilised and drawn upon through the possibilities made available to South Asian women by the subject positions they occupy. This conceptualises discursive practices as dominant, and suggests that non-discursive aspects, e.g. bodies, are experienced as they are due to the forces of discourse. Whilst this provides valuable insight into the ways South Asian women created meaning about their experiences, and how these relate to wider social practices, it does not theorise non-discursivity beyond its constructed meaning in discourse, and positioning *by* discourse.

2.11 Towards New Models of Mental Health

Critiquing the diagnostic model of mental health has been a common practice since the days of anti-psychiatry, and one that has fed through into service user literature. Problems with treating people according to an assigned category, such as schizophrenia, has been argued to be an invalid conceptualisation of mental health disorders (Boyle, 2002). One way of developing alternative avenues of thinking has

been to approach mental distress not in terms of overall categories, such as schizophrenia or manic depression, but rather as singular ‘types’, which are associated with classifications. For example, the ‘symptoms’ of delusions and hallucinations.

Geekie (2004) undertook this kind of approach in reporting on user perspectives of their psychotic experiences, with a focus on explanatory models. He identified the differences in models of users to those of practitioners, leading him to advocate a broader space in which multiple viewpoints can be aired, rather than what he claims to be the current system of professional viewpoints being forced upon users. Geekie did not argue that service users’ views on their experiences were in some way ‘better’ than professional opinion. Rather, that in continually developing knowledge in the area of psychoses, first hand experiences should be included as part of the kinds of knowledge built.

2.11.1 Phenomenological Approaches

Sharing the view that the diagnostic model of mental health is an inadequate explanatory model, approaches have set out to develop different theories of mental health. Unlike the work of Geekie (for example) though, it has not always been the prime concern to utilise first hand experience to facilitate understanding of ‘hallucinations’ rather than ‘schizophrenia’, but to utilise service users’ accounts to postulate alternative theories of mental distress. It is argued that empirically focusing on direct experience of hallucinations can contribute to overall understanding of mental distress. Thomas and Bracken (2004) draw on the phenomenological writings of the French philosopher Merleau-Ponty to posit a new theory as to the meaning of voice hearing. They argue that it is only in understanding the embodied *situatedness* of the experience that insight can be gained. By accounting for the context in which voices develop (in Thomas and Bracken’s example it is a fractious marriage), the *meaning* of voices can be identified. So, they set out to analyse in depth the context of the development of the voice hearing, something that leads them to root onset in the marriage difficulties facing the individual at the time. They go on to posit that teasing out meaning is a clinical tool that subsequently allows for improvements for people experiencing hallucinations. In this case, developing new theories as to the onset and treatment of hallucinations provides a positive clinical outcome.

2.11.2 Discursive Therapeutic Theory

The notion of therapeutic value has been an important one within mental health. Davies, Thomas and Leudar (1999) argue that a discursive approach to accounts of voice hearing can provide both a theoretical frame for considering the relation between individual experience and social practice as existing in discursive practices, and that personal discursive constructions of narrating one's experiences can be a therapeutic tool in itself. This involved a dialogical approach, in that producing a narrative allowed for voice hearers to enter into dialogue with the voices, which led to a greater understanding of their meaning. In this way, voices were not understood as symptoms of an illness, whose content was meaningless to an extent (it was the *presence* of voices, rather than what they said that was of interest), but rather as meaningfully relating to voice hearers' life experiences. The emphasis on language is on its production of a narrative that allows for users to make sense of their experiences, which subsequently forms a key therapeutic tool. This differs from other discursive theories that have been reviewed, those which concentrate on the role of discourse as constituting of social practices that impact on individual experience.

2.12 Summary

This chapter has identified the broad ranging terrain of service user literature. Approaches have operated within different models of mental health, from mainstream psychiatric practice to critical approaches arguing against the diagnostic model. The focus on service users' perspectives has been well researched, as well as the utility of analysing first hand accounts for developing alternate theories as to the nature of mental health difficulties. Let us consider what the literature covered brings to the field.

Service user research in mainstream clinical psychiatry invites the service user into research, both as the subject of it, along with becoming part of the research team as well, which is a valuable move within the dominant knowledge producer of mental health understanding. It is very much within a mainstream diagnostic framework that this operates however, and its empirical concerns are largely about assessing user views on current services. Research such as that of Burr and Chapman adopts a more critical approach, in arguing that considering mental health difficulties (in their case depression) in diagnostic terms, is inadequate. Rather, much greater focus is needed on

the social factors at work in positioning people as service users, and the consequences for them of that kind of positioning. Adopting a discursive approach emphasises the pivotal role that discourses play in the positioning of people. Burr and Chapman's work with South Asian women with depression has proved valuable as it draws in and highlights the social context of mental health, something often broadly overlooked in the diagnostic model. The other approaches covered take a different empirical route, in terms of placing importance on the need to address the content of mental health distress, specifically, experiences such as hearing voices, which in a traditional medical model have been viewed as symptomatic of illness with the main aim to eradicate them, predominantly through the use of medication. Therapeutically, these avenues are promising, as they potentially offer alternative (not solely medication based) ways of dealing with mental distress, and working towards improvement.

To sum up the first two chapters, we have seen how mental health is initially captured by the diagnostic framework of mainstream psychiatry, which sets up service users' experiences as due to underlying natural kinds. Moves to offer alternative frameworks were important in a sea change in terms of location of service use, through the development of community care. This though, did not itself provide a 'freedom' for service users, but acted as a more distributed form of control, a control society hinged on the administration of psychiatric medication. Alternative frameworks have provided new systems of thought, such as those seeking to give voice to the experience of service use, as if it can be easily accessed. This can be problematic, as it does not illuminate the heavily mediated nature of service user experience. Critical social psychological work has fruitfully emerged as an area in which ways of deconstructing mental health, avoiding alternative reifications, have been developed. Approaching discourse as the analytic point through which to approach service user experience has been demonstrated as a valuable method. This thesis seeks to build on this, through developing a form of Deleuzian Discourse Analysis, which draws on resources across the discourse analytic field, along with specific Deleuzian theories to offer an analytic means through which to unpick the multi-layered, spatio-non-discursive nature of service user experience. In doing this, we can develop a micropolitics of service use, in which we see how such forms of complex analysis are needed to illuminate how the practices of psychiatry impact upon service users on a day-to-day level.

Chapter 3:

Methodological and Analytic Concerns

3.1 What it Means to do Service User Research

In this chapter I will illuminate some of the methodological issues associated with this thesis. This will enable an underpinning practical account to be narrated, which serves to mark the problems faced when undertaking research of this kind. Given the primary emphasis placed upon direct empirical efforts towards first hand experience of service users, I will start by discussing the viability and utility of such an approach.

3.1.1 What is Service User Research?

As seen in the review of literature in Chapter Two, service user research refers to placing the experiences of using mental health services at the forefront of research. By directly focusing on those experiences it is argued knowledge can be gained from the ‘experts’ of what it means to live with mental health difficulties in the community care paradigm. This is not to suggest they have more superior knowledge about clinical features of mental health diagnoses than mental health clinicians, but that if one seeks to unpick some of the mediated and layered operation of service user experience, directly addressing their accounts is the most appropriate means of access. In this sense, an approach is required that can analyse and unfold some of the complex nature of service user experience. As seen in the previous chapter, many different strategies have been used for placing service user experience at the forefront of empirical efforts. Each strategy though, faces a similar set of factors to address.

3.1.2 The Challenges Faced

By means of a way to discuss some of the challenges facing service user research I would like to work comments around a data extract. Some of the data of the overall corpus collected for this project involved the reporting of ‘abnormal’ beliefs (or ‘delusions’ according to a psychiatric vocabulary) as part of accounts of people’s experiences, including those in relation to diagnosis. Despite the psychiatric status of delusions as beliefs not grounded in reality, their inclusion in this project is no different to that of the non-delusional narratives. That is, they are analysed for their functionality

as part of the discursive work of accounting for one's experiences, and in this case, in relation to diagnosis. Consider the following extract:

Chris: how powerful this man is I speak to across the phone (.) this planet is one dimensional, one (.) planet one time (I: mm) imagine suffering (actual death) (.) as million and millions and millions of planets (.) in space, the universe (.) in SIX EARTH DAYS (.) that's how powerful this man is I speak to across the phone in heaven, Uncle Imbed (.) and what he's going to do to these people for what happened to me and this particular person I mentioned earlier (I: mm) and we were both hurt by lots of evil people (.) and the doctors want to get on the right side of (her) (.) cos my actual father (.) is staying in a little room at my mum's for the last ten years (I: mm) and (INAUDIBLE) in that book called The Wild Geese by Daniel Carney (.) chapters three four five and six (.) it's talking about a little boy who gets his own way ..hh a rich powerful Dallas family ..hh and the Devil's son (.) the own person in the universe more powerful than this man, the only person he's afraid of (.) and very soon he's going to get dealt with (.) how powerful this man is I speak to across the phone (.) million and millions of planets in space, the universe (.) in six earth DAYS.....(lines 261-276)

In the first instance this extract appears to be one whose contents do not correspond to actual life events happening in Chris's life. He talks about talking on the phone to an all powerful being, who is able to seek revenge on Chris's behalf for the failings he reported earlier in the interview regarding the psychiatric care he received during a spell in hospital. Let us consider some of the difficulties in analysis that this kind of extract typifies.

Perhaps one of the most common claims made about problems with addressing service users' experiences is that they are, by the nature of the fact they are suffering from mental health difficulties, not a valid source of data (Coleman, 1999). This view has some historical precedence, based upon the premise that mental health difficulties involve some form of abnormal mental functioning, and as such, experiences and accounts cannot be taken as an accurate or veridical description of lives. For instance, if we are listening to a service user talking about their daily lives, how do we know

they are not merely hallucinating?⁴ This is a claim that one could expect to be heard when faced with an extract like Chris's. It is not a big step from this to recognise the potential effects of such ideas in terms of bracketing off the accounts of people experiencing mental health difficulties as an unrecognisable source of data, which have played a significant part in the absence of a service user 'voice' in mental health research until relatively recently.

At some level this kind of argument makes sense. If we take some mental disorders, e.g. hallucinations, as featuring experiences that involve losing touch with reality of everyday occurrences, then does it not necessitate that such experiences be accepted as 'not real?' If they are not grounded in actual life experience, then what use are they to the researcher? This idea is based on the notion of such experiences being problematic, and as such, needing treatment to attempt to limit or eradicate them. Such a notion forms a line of argument that is an underpinning force in the armoury of drug medication, in terms of being conceptualised as needing to be controlled, and it is the use of medication treatments that have developed to facilitate this. This kind of position negates any importance placed upon, and attending to, the content of voices.

There is a counter position to this though, which places primary importance on the content of people's mental health experiences, which forms an approach that centres around psychotic experience, predominantly in the area of auditory hallucinations. Rather than take voice hearing as indicative of illness, with concern only that voices exist, other approaches have taken an alternate tack. These kinds of approaches have argued that knowledge can be gained through analysing the content of people's psychosis, as we saw in Romme & Escher's (1994) work covered in the previous chapter. They analysed voices heard by voice hearers, and formulated a therapeutic process based upon building knowledge as to the meaning of voices heard, and how their content relates back to potentially mentally damaging past experience that catalysed the development of people's mental health difficulties originally. In this way, the content of people's psychotic experiences can be linked to actual life experiences, i.e. possible abuse. This forms one approach in which attending to service users' experiences provides a valuable contribution to knowledge.

⁴ This is a question I have faced more than once whilst presenting data drawn from this project.

3.2 The Ethics of Mental Health Research

Ethical issues need to be faced in several forms by adopting a service user perspective. In an academic sense this involves research gaining the required ethical approval from the relevant bodies prior to it being undertaken. For this thesis, an application was submitted to the Ethics Committee at Loughborough University, which was subsequently approved.

In a wider sense though there was an ethical issue that became ingrained in the project itself. This referred to directly approaching service users as experts of their own experiences. When concerned with gaining insight into the practices involved in living in community mental health settings, the primary source of information (or data) is that of service users who have those experiences. An ethical position is formulated that places considerable emphasis and value on service user accounts (Mental Health Foundation, 1999; Geekie, 2004). The position is arguing that service users can actually account for their own experiences. Whilst the dominant areas of research still revolve around biomedical investigations, service user experiences are slowly being recognised as beneficial and highly informative to continued building of mental health knowledge. In psychology the value of listening to service users and adopting service user perspectives in research has been set out as a 'live issue' in mental health research (British Psychological Society, 2000).

In a theoretical sense, this draws on Shotter's (1993) notion of *authoring*, in which he argues that to emphasise people's ability to author their own experience is to respect the 'space' in which such experience occurs. And, to do so, is to develop an ethical position stating that people are the best authors of their experiences, as they are the ones who actually live their experiences. I would argue that Shotter's principle applies as much to a 'pathological' population as a 'non-pathological' one. The crux of the argument developed here is that whether someone is experiencing/has experienced mental health difficulties does not mean they cannot reliably report on their experiences. As researchers we have a duty to respect this authoring. Indeed there is a growing trend in service user research to not only respect the space of authoring, but to also include users as researchers themselves (Davis, 2005). The researcher's job should be to facilitate the implementation of a research process that enables the participants to author their own experience. As mentioned earlier, this is not to suggest that the

researcher role has no impact, as of course it will, but it remains important to ensure as much as possible that participants are able to represent their experiences as they wish.

3.3 Methodological Orientation

Having laid out the argument justifying the approach of directly addressing service user experience, it is necessary to detail the procedure of recruitment for the project. This, in itself, raised a number of issues. Although used as a singular term, 'service user' refers to a rather heterogeneous set of people. For instance, many people who have experienced mental health problems as would be defined by psychiatric practice, do not actually see their experiences as problematic or in need of treatment. We saw examples of this in Romme & Escher's work, and there is a growing number of 'Hearing Voices' groups whose philosophy of non-pathologising voice hearing is based on the pioneering work that formed the set up of the Hearing Voices Network (Romme & Escher, 1993, 2000).

3.3.1 Which Service Users?

The definition of service users incorporated in this thesis is based upon the notion of being in contact with psychiatric services of some kind. That is, people who are being treated for having experienced and been diagnosed with mental health difficulties. Of course, this represents a diverse set of people itself. A further procedure was to include people currently living in community care, which meant that anyone hospitalised was not included in the sample used. The nature of approaching potential participants proved an issue requiring a particular strategy. As part of their incorporation and treatment by psychiatric services many people would come into contact with clinical psychologists. A perception of psychology as a part of treatment may well be formed through this, and as such I was aware of the need to not be viewed in alliance with, or part of, any kind of psychiatric or clinical service.

This strategy meant identifying alternate means through which to access service users. Care in the community means that service users only become visible when in contact with services, or other kinds of centres. Given the requirement to distance myself from psychiatric services I decided to approach people through other avenues that they access due to being service users. This meant identifying and approaching a number of non-psychiatric settings, which involved day centres, support groups, and charity run

places for people with mental health difficulties to attend. Given the non-clinical status, it is possible that people using such centres may not actively be using psychiatric services themselves, and as such present a problem as to their status as service users. This was flagged up as a potential issue, but did not present a problem as all the participants were in contact and being treated by services. The nature of this contact was varied, with some in more regular contact than others.

Seven groups in the East Midlands area of the United Kingdom were approached, with myself providing an introduction to the research to staff, whom felt it most appropriate to inform members as to a time when I would be present so they could come and talk to me about the research. On meeting, I introduced the project and members expressed whether they were willing to be involved.

3.3.2 Participant Information

In total 38 interviews were conducted, with 9 female and 29 male service users. All participants were over 18, and thus issues of adolescence and mental health were not involved. Given the variability in both nature of mental health difficulties experienced, and course and outcome of distress, there were decisions to be made regarding assessing service users' mental state at point of interview. This was something discussed between service user, centre staff, and myself. All service users, upon reading the Participant Information Sheet, and Informed Consent Form (which can be seen in Appendix Three and Four respectively), provided written consent, and were happy to proceed with interview. Only three service users approached were not prepared to take part in the study.

Clinical information was not gathered on participants prior to interviews taking place. This was because it would have involved approaching people through formal psychiatric services, as detailed clinical information was developed and utilised as part of formal practice. Additionally, it was not considered of prime importance. A detailed clinical history could inform as to a psychiatric understanding of people's past mental health difficulties, but it does not enable insight into how service users' own knowledge practices, or indeed how they manage their treatments and surrounding environment. Having said that, in the course of interviews almost invariably service users' mental health difficulties arose as a topic, and as such insight was gained into the

user's own understanding of their experiences. The predominant reported experiences involved factors associated with a diagnosis of schizophrenia, e.g. reports of voice hearing, 'abnormal' beliefs. In addition, a widespread complaint was depression, with a number of service users suffering from, often quite severe, depression. Other difficulties were reported, such as experiences associated with diagnoses of Obsessive Compulsive Disorder. The common link between all participants was contact with service providers, along with continued treatment, primarily psychiatric medication treatment. All participants were recognised by services and themselves as 'service users'. Variability existed in regard to the prevalence of mental distress at time of interview. Those who had received a diagnosis of schizophrenia were generally 'in recovery' of some sort, i.e. they were not actively experiencing an episode of distress at the time. The mental states of those whose experiences were depressive in nature were sufficient to require continued treatment. All participants received treatment due to the continued mental distress or to prevent any relapse.

3.3.3 Interview Technique

In-depth semi-structured interviews were used; the schedule can be seen in Appendix Two. This approach allowed the participants to elaborate and introduce new aspects of experience, whilst still covering a set number of key areas. The decision to utilise interviews was further guided by consideration of the nature of the space provided. Given the understanding of service users that I was not allied in any way to clinical services, allowed them to engage in the interview space as a confidential one, not forming part of their engagement with service provision. This enabled topics to be explored that may have not been so if interviews occurred as part of their service use. Possible evidence of this is covered in Chapter Six, in which users discuss aspects of medication practices that they claim would not be discussed with service providers. Issues such as this, or detailed discussion of their past life experiences may not have arisen if they were part of a wider focus group either. One issue was that an implicit assumption may have been formed that the interview was a kind of counselling session. Certainly, service users, at times, discussed some issues, such as physical and sexual abuse in earlier life. To this end, it was made clear prior to interview, that it was not a form of counselling, and that if any issues arose that users found distressing members of staff were available after interview if any users wanted to talk to them. Interviews were then transcribed using a technique based upon that designed by Jefferson (1985),

but to a less detailed degree (e.g. Potter & Wetherell, 1987). This can be seen in Appendix One.

3.3.4 The Role of the Researcher

It is worth considering my role as researcher in this project. As we saw in Chapter Two, many different approaches have emerged in the service user research area. The one utilised here was for myself to act as researcher, with service user experience directly focused upon. Therefore, there were not issues such as providing research training for service users, as can be the case when users act as researchers themselves (Clark, Davis, Fisher, Glynn, & Jefferies, 2006; Davis, 2005).

Given the theoretical approaches of considering knowledge production as contextualised, dependent on the re-worked nature of social practices, it is necessary to consider the practices at work in the interview interaction itself. What the context of interview brings, is myself as social psychological researcher, and the impact of that role on the production of interview. This issue refer to the process of being reflexively aware of one's role throughout the research.

Assessing my own role is an important, although not straightforward task, although I will address it in the following ways. Two strands of interest need to be highlighted. Firstly my impact on interview interaction in terms of service users' perception of me and my profession. This has been covered in the earlier section relating to theorising the position and location of the interviews in this thesis. It was mentioned that users understood that the research did not constitute any form of counselling, nor was it allied to any form of clinical practice. Rather, what was of interest was users' own knowledge of their experiences as service users, along with gaining insight into the ways they manage their lives on a day-to-day basis. Users understood that interviews provided a safe, confidential space in which they were free to elucidate on any aspect of their experiences, framed around a semi-structured set of questions.

These issues can be thematised through recognition that analysing pure experience is always going to be an unachievable goal. Thus, it is simply not possible to gain unmediated access to service user experience, as there is a whole series of mediating factors (as have been detailed in the previous two chapters). What I, as interviewer

bring to user experience in the interview context is yet another layer of complexity. This additional layer does not render the whole project redundant. But, of course, it needs to be taken into account. Whichever methodological approach undertaken, an extra layer of complexity will always be added. And, the challenge has to be to seek to analyse how all the different layers are interacting, which is the analytic goal of this thesis.

3.4 Analytic Issues

As seen in the first two chapters, this thesis has a number of theoretical issues that feed into the methodological issues under focus here. Primarily these revolve around forms of discursive analysis, and what claims can be made about experience through analysing language. These kinds of debates have proliferated theories of discursive analysis (e.g. Coupland & Gwyn, 2003; Parker, 2002). For the purposes of this thesis, analysis needed to form two key threads. Firstly, insight into the social practices impacting upon, and through which service users re-work their experiences and understandings. Secondly, illuminating some of the non-discursive production of experience (i.e. the forms of *content* introduced in Chapter One). Whilst a vast set of literature has set out the value in attending to the discursive work of those under the empirical focus for informing as to the kinds of social practices that form and rework their lives (e.g. Henriques, Hollway, Urwin, Venn & Walkerdine, 1984; Parker, 1992; Potter, 1996; Potter & Wetherell, 1987), less literature has focused on the non-discursive constituents, i.e. the *content* of such experiences (Brown, 2001).

One strategy for making the practices of service user visible would be to do in-depth ethnographic or participant observation studies. This though presents ethical and methodological problems. Firstly, is it ethically viable to follow people around continually to observe the myriad practices that make up their everyday lives? Parr (1997; 1998; 2000) conducted covert ethnographic research in cultural geography, analysing the spatio-embodied experiences of service users in semi-institutional places (Parr's work will be covered in more detail in Chapter Seven). Whilst providing some valuable analytic insights, her research was limited in the number of service users included in the study. Additionally, such an approach would not allow for the inclusion of service user awareness that they were part of a research project, and would, in a sense, not provide them with the space of authoring previously mentioned. In purely

pragmatic terms such an approach would also be unlikely to access a large number of participants; nor gain appropriate ethical approval. What was needed instead was an approach that allowed insight into service users' everyday life patterns; one that facilitated a large data set to be attained, and one which acknowledged proper ethical standards. To this end interviews provided the greatest scope for analytic insight, by allowing an approach sensitive to the relation of both forms of content and expression (that is the non-discursive and discursive dimensions of experience).

3.5 Developing a Deleuzian Discourse Analysis

A pivotal thread running through this thesis refers to the ways that service users manage and evaluate meaning of their lives. This is not strictly focused on the actual periods of active mental distress or experiences that led to a diagnosis of mental disorder being given. Rather, it is a sense of the ongoing living as someone who is treated for and recognised as a service user that was a significant drive through the thesis. Gauging how service users' experience everyday life as part of the many social practices at work was an early analytic goal.

3.5.1 Foucauldian Discourse Analysis

Undertaking this kind of analysis required drawing on forms of discursive analysis that have developed with great influence from the work of Foucault (see Willig, 2001 for a description). As was seen in Chapter One, Foucault placed immense emphasis on the role of discursive practices in the operation and production of social practices. Much discursive literature has drawn upon these influences, in theorising discursive practices as the predominant force of knowledge-making through constituting experience (e.g. Heaton, 1999). In doing this, it is argued that discursive practices make available particular *subject positions* (e.g. Harré, 1998; Hollway, 1989; Stenner, 1993), which impact upon experience, e.g. a discursive practice of medicine produces subject positions of 'patient', 'illness sufferer', for people who experience ill health. Discursive practices refer to cultural understandings, and through analysis of people's discursive activity, it can be seen how they make sense of, manage and attribute meaning to their experiences in relation to social practices.

Theories of this type were a move away from dominant ideas that knowledge operated in singular forms, and that the objects of which knowledge spoke existed as static

forms. Discursive theories formed part of the approaches labelled social constructionist (e.g. Berger & Luckmann, 1967; Burr, 1995; Gergen, 1985; Gergen & Davis, 1985). This field has done most in moving away from a natural scientific paradigm of understanding human life in terms of *matters of fact*. That is, they have worked to illuminate the expanse of practices through which constituents of the human world are inherently and indelibly socio-historically contingent. Not only this, but contingencies are based upon practices that are predominantly *discursive*. More bluntly, they state what is understood as *reality* does not actually exist as some form of pre-given essence that the social sciences then set about attempting to describe. Rather, what we take as reality is in fact constructed, and that the main producer of this constructing is language. Language works to construct *all* aspects of experience. To date, we have seen conceptualisations of the constructions of facts (Latour & Woolgar, 1979); emotions (Harré, 1986); gender (Lorber & Farrell, 1990); quarks (Pickering, 1984); serial homicide (Jenkins, 1994); organisational change paradoxes (Luscher, Lewis, & Ingram, 2006); digital danger (Kuipers, 2006); international politics (Ziegler, 2005); the image of Girona (Espelt & Benito, 2005); beliefs about cancer (Petersen, Soucar, Sherman-Slate, & Luna, 2004); market value (Zajac & Westphal, 2004); the ocean (Gunter, 2004); Europe (Christiansen, Jorgensen, & Wiener, 1999); Indian forests (Sharma, 2000); tourist places (Young, 1999); and Zulu nationalism (Golan, 1994), amongst others.

This movement of heterogeneous ideas shared a view that knowledge and experience were produced in socio-historically contingent ways. They contextualised experience, where prior theories had referred to knowledge and experience primarily without significant reference to the social contexts within which such claims operated. With constructionist ideas came the notion of multiple versions; it was no longer the case that objects of enquiry existed in stable forms across cultural boundaries, but rather that different cultures and societies produced knowledge practices dependent on their specific contexts. It was on the foundations of these ideas that Foucault worked up his theories as to the productive and constructive nature of discourse. Particularly, through developing ideas about ‘discursive formations’, which Foucault took as the overall term to define institutionalised entities, e.g. law, medicine, psychiatry. Within formations, ‘discourse’ exists as the “group of statements that belong to a single system of formation” (Foucault, 2002: 121). Hence, he talked about ‘psychiatric discourse’.

These terms are the concepts imbued with the productive force of constructing knowledge, which is always formed in socio-historical contexts.

3.5.2 Analysing Power

Theories influenced by the macro concerns of Foucault's writings have made a valuable contribution to the analysis of power relations in society. Drawing on the emphasis Foucault placed on power in his work, these kinds of analysis have been pivotally concerned to incorporate power as an analytic. Understanding the socio-historical nature of experience, involves recognition of the power relations at work in society, as we have seen in Chapters One and Two regarding the operation of mainstream psychiatry. Within Parker et al.'s (1995) deconstruction of psychiatric thought and practice was a concern with power; providing valid and insightful analysis. With this comes the need to *situate* analysis. We are a long way from the laboratories of mainstream experimental psychology that only account for context through concepts such as experimenter bias, in which the fear is that participants may *discover* what the individualised intentions are of the experimenter. Context needs to be accounted for beyond the actual interaction occurring in the research field (i.e. interview). One needs to understand the social practices at work in constructing the research process, and those taking part in it (i.e. researcher and participant/s) (Parker, 2005). This involves an understanding of the particular discipline at work in the operation of research (i.e. psychology) and the power relations involved in its production (i.e. as a culturally privileged domain for producing knowledge about human experience). With this, the researcher is imbued with a power, in terms of allegedly being the 'expert' in the research setting. These factors have to be accounted for in research. However, it is not enough to perform such a task only to stop at that stage. We also need to analyse how such factors are worked through at an interactional level in the research itself; the implications of such realities on how the research operates. To this end, we need an approach sensitised to both micro and macro concerns.

By way of an example let us consider Harper's (1996; 1999) deconstruction of 'paranoia'. Harper seeks to systematically unpick a range of factors that combine to produce social understandings and practices concerning experiences that are labelled as 'paranoia'. By doing this, Harper argues we can gain a broader understanding of the concept of paranoia, and the social effects that mainstream psychiatric versions of the

concept can have on service users' lives. Harper performs this through analysing a series of binary constructs through which paranoia is constructed, which include rationality-irrationality, form-content, and lay-professional views. In analysing accounts from both mental health professionals (e.g. psychiatrists and clinical psychologists) along with service users, Harper demonstrated how dominant discourses of paranoia offer and enforce particular positions for service users and professionals to occupy. Subsequently, their experiences are defined in the main by those allowed and facilitated by the position they occupy. Within the ways that service users and professionals discuss experiences labelled paranoia exists a great deal of variability, as would be expected in a discourse analytic approach. What Harper highlights, is the range of political interests that such variability serves.

It is the use of a discourse analytic approach informed by the understanding of social practice as formalised through discourses that the aforementioned contradictory and variable nature of talk of paranoia is illuminated. And, Harper argues, it is only through unearthing the multiple versions of paranoia that are constructed that the range of political implications for such talk can be demonstrated. For instance, the identification of an empiricist and contingent discourse in professionals' discussion of paranoia demonstrates the ways that the concept is represented as something whose existence requires the involvement and expertise of professional help (Harper, 1994). In doing this, the political interests of psychiatry are served, as to emphasise the necessity of psychiatric expertise is to draw such experiences into mainstream psychiatry, which has such a privileged cultural position as the domain in which experiences labelled 'mentally ill' should be treated. In turn, this results in such experiences becoming framed as mental 'illnesses', and as such, requiring treatment. Service users are then subject to forms of treatment (e.g. medication) and socially positioned as someone with a mental disorder (which can itself operate as a stigmatising label). Harper argues, that by deconstructing paranoia, we can demonstrate the political interests served by current dominant discourses, assess their impact on people to whom they are applied, and then explore alternative conceptualisation which may provide an improved way of being for those who have such experiences.

Theories that have become known as Foucauldian Discourse Analysis (Willig, 2001) have in placed a great focus on the role of discursive practices *on* people in the

production of subject positions. Foucault himself began to think that, in addition to this, greater analysis should be undertaken of the production of subjectivity and agency at a micro level, rather than, solely, the operation of macro social forces *on* people's lives (Foucault, 1986). Discursive Psychology can be of aid here, with its greater utility of the more micro-concerns within interactions at the discursive work accomplished by people in accounting for their experiences and knowledge. To solely rely on tools provided by Discursive Psychology can be to underplay the role of wider discursive practices in producing experience, but to use it alongside more Foucauldian theory allows for a more integral analysis to be developed.

3.5.3 Discursive Psychology

Discursive Psychology is the term commonly used to describe one strand of discourse analysis that focuses on discursive activities in interactions (Edwards, 1997; Edwards & Potter, 1992; Potter, 1996). Discursive psychology operates at the side of discourse analysis which holds close links with conversation analysis and ethnomethodology.

The focus here has been to approach key ideas and concepts in psychology (e.g. emotion, cognition) not as distinct generalised patterns of individual states, but as linguistic entities, to be studied in terms of their operation in language. To consider an example of emotion (Edwards, 1997), Edwards seeks to address the use in everyday conversation language (interactional) of the term; to consider how ideas of emotion are put forward, utilised and put to work in individual accounts. An example would be to analyse the ways that the emotion jealousy is drawn upon in accounts of a marital break up. In this area, it could be used in multiple ways in managing the 'stake and accountability' (Potter, 1996) of the individual. One may want to apportion blame for a break up, and thus manage one's stake in a more positive light, by blaming a partner's infidelity as a cause for jealous reactions. Here, jealousy is not conceptualised as a distinct cognitive entity, but rather as a rhetorical 'tool'; part of the production of a particular version of events that works to articulate subjectivities through language.

This has provided a taster of what discursive psychology can do. By way of a more detailed illustration, with relevance to mental health, let us consider Antaki's (2004) use of a Discursive Psychological approach. The focus of analysis for Antaki is a critique of the 'Theory of Mind' (ToM), a major player in cognitive psychology, that

conceptualises social activity as based upon individuals' (cognitive) ability to understand their own feelings, thoughts, beliefs (as internalised states), and the fact that other people have *different*, feelings, thoughts, beliefs (Astington, Harris, & Olson, 1989). Theory of Mind suggests that this ability is a fundamental human ability, one necessary for normal functioning. However, it is argued that not everyone has this ability, namely children below the age of about three or four, along with autistic children (Baron-Cohen, 1989), and people diagnosed schizophrenic (Frith & Corcoran, 1996).

Antaki's critique then focuses on consultant-service user interaction, and sets about to highlight how taking the discursive work of such interactions as representative of a ToM deficit is misguided, as it misses (and fails to conceptualise) the discursive work as *active* within a social context. In this way, psychological phenomena, such as beliefs, thoughts, attitudes, are not taken as internalised cognitive functions, but rather as actions, performing interactive 'jobs'. Antaki demonstrates that by taking the discursive practices at work in the interaction as forming the social context of the setting itself, rather than indicating whether the person diagnosed schizophrenic can accurately understand that others have different thoughts and beliefs than themselves, actually tells us much more about how these kind of social experiences operate. More so, the forms of discursive practice at work, for example Antaki works through the service users' seeming tentativeness in response to consultant's questions, form common socially understood practices, in this case the practice of tentativeness. With this, one then sets out to analyse what this work is doing in the interaction in question. Interactive language is taken as conforming, contradicting, misrepresenting social understandings, which fundamentally means drawing upon such cultural practices. The work of the discursive psychologist is to identify these practices, and then illuminate how they function at the micro level of individual interactions.

The value of this approach is in the formulation of analytic strategies for getting at some of the complexities of interaction, which can inform as to how people work up and account for their experiences, in interactional settings. For example, a defendant in a court case may have a considerable amount of concerns to be accounted for in the courtroom setting, in terms of managing the truth or falsity of the claims made against them. These are very much interactional concerns, operating between prosecuting and

defining barristers, the judge, jury members etc. Discursive Psychology would argue that to understand courtroom activity one needs to attend to the interactional ‘business’ that occurs within.

3.5.4 Discursive Analysis Moving Forward

Despite the demarcation often made between Discursive Psychology and Foucauldian Discourse Analysis, it is an over simplification to define the variety in discourse analytic approaches in only two areas. The area of discourse analysis is a fertile one, in which some strands have become more sedimented, such as Foucauldian Discourse Analysis and Discursive Psychology, but many other strands exist that draw on influences across different approaches. Indeed, in order for forms of discourse analysis to avoid becoming another *method* in the way that experimental approaches are; that is, as something to be applied to human experience as *the* method to analyse it with a whole set of pre-figured assumptions; fertility, fluidity and continued exploration and experimentation (meant in its most literal sense), are necessary.

Following on from arguments made by Wetherell (1998), it is argued that discursive analysis can be strengthened by pulling threads from approaches operating with a heavily macro concern, along with those concentrating on micro interactional activity. Wetherell (1998) argues that tools such as *subject positions* enable insight into what social practices are productive in placing someone in a particular space in which they are of analytic interest. Additionally, notions such as ‘stake and accountability’ and ‘footing’ provide utility in extracting the discursive actions at work in managing interests in conversation. To this end Wetherell delineates a more fluid analytic framework, which allows cross-boundary movement between different approaches.

With this in mind we need a form of discourse analysis that can take the strengths borne from the variability in the field. Such variability should not be seen as a weakness, but rather as the necessary manifestation of what has been an experimental (in the literal, not mainstream psychological, sense) field, formed and developed through the multiple analytic avenues followed. This helps build an analytic approach for this thesis that can operate as a hybrid discourse analysis, able to utilise the micro-analytic points taken from discursive psychology without losing sight of the discourses that position people in the spaces from which they undertake interactions. For instance,

in the analysis in this thesis there is a need to address the discourses at work in positioning people as service users. Clearly, there are effects on service users' experiences that result from their position as service users. Additionally, these need to be analysed in terms of how they operate, impact upon, and are taken on and re-worked on an everyday basis. This is not to reify discourses as pre-existing in the abstract (Potter, Wetherell, Gill, & Edwards, 2002), and then analyse how they impact *upon* service users. Rather it is to analyse how service users' lives are produced through the matrix of relations at work, and in turn, how discourses both position people, but are additionally used and re-framed through service user talk and action. It is to this end, that a Deleuzian Discourse Analysis, and its micropolitical approach, is utilised.

3.6 Analysing Non-Discursivity

Here, it is forms of content that are the prime focus, rather than those of expression covered in Chapters Four and Five. Leading on from theoretical arguments in Chapter One, it is argued that not *all* experience is formed and constituted through discursive practices, but that understanding and highlighting factors such as embodiment, and how embodiment and spatiality inter-relate, requires slightly different theoretical tools. An obstacle though is evaluating the appropriateness of and viability of analysing the embodied spatiality of experience *through* the discursive ways that people talk about their experiences.

In claiming, as was seen in Chapter One, that discursive and non-discursive practices operate inter-dependently, but crucially as distinct factors, the relational way through which knowledge and experience are produced was highlighted. This makes possible the strategy of analysing non-discursive practices through the ways they are related to in discursive work. When utilising discursive theory to analyse sense making in relation to wider social (and discursive) practices, one is not arguing that discursive work can only be analysed in that way. The potential remains to illuminate some of the inter-dependent non-discursive practices that both feed into, and feed off discursive practices. What I am seeking to reveal is the relationship between forms of content and expression, through the ways that service users talk about their experiences. To do this, certain theoretical tools are required that can be used to analyse the relational, yet distinct, non-discursive practices. These will be elaborated upon in Chapters Six and Seven. In this way the utility of theory is illustrated through the role it plays in making

sense of those aspects of service users' experience. However, this is not a straightforward process as such, as Deleuzian Discourse Analysis must necessarily use theory to 'invent' concepts that can assist in deducing change and flow from the 'stability' of the data extracts. Forms of expression capture experience, and as such, interview transcripts in this thesis are made up of *captured experience*. They provide a stability. In terms of forms of content, what is required is an approach that can get close to the ever-changing nature of non-discursive experiences. In itself, this necessitates a slightly different take on empiricism, as by its nature of seeking to build knowledge of life, empiricism necessarily has to capture experience and provide stability (Massumi, 2000). A different sense of the empirical is utilised in this thesis, namely, one which opens up the possibility of getting close to *change* (more will be said about this with regard to the concept of *affect* in Chapter Six).

3.6.1 Non-Dualistic Relations

To talk of non-discursive and discursive practices is not to dichotomise them in a dualistic fashion. The argument developed is that they are both parts of the nexus of relations that form experience, and indeed distinct parts. That is, they have different roles to play, as they produce different aspects of experience and knowledge. In every sense though, discursive practices are materially based, in that they are spoken by embodied people, or written on material products, e.g. newspapers. The argument made by discursive theories borne from social constructionist ideas is that once spoken/written they have a productive role, and work in a distinct fashion to the non-discursive from which they emerge.

3.6.2 What is Non-Discursivity?

A further concern here is what constitutes non-discursivity. To refer to anything non-discursive is to attempt to account for an inordinately large amount of the world. Primarily what is taken here as non-discursivity are the objects (in the broadest sense) that form our everyday environments, and things that make knowledge and experience visible. This draws on the work of Foucault and Deleuze covered in Chapter One, in providing distinct producing roles for non-discursivity (forms of content) and discourse (forms of expression). Of course, in itself, non-discursivity involves an incredible amount of variation. A crucial part being the relation between human and non-human. Bodies are in every sense non-discursive, but differ in many ways from inanimate

objects, which, as work such as Actor Network Theory has shown (e.g. Law & Hassard, 1999), can take on pivotal active parts in knowledge production but, crucially, do so without the self-reflexive knowledge of humans. So, to talk of non-discursivity is not to homogenise it, but rather to distinguish it from forms of expression of discourse.

3.6.3 Material-Discursive Approaches

In the area of health and illness much has been written regarding the problems of biomedical approaches, in terms of understanding some of the individual meaning of experiencing ill health (Paris Spink, 1999; Radley, 1999). This has led to a keen interest in social theoretical approaches emphasising the contextual nature of experience, and the role of discursive practices in its construction and maintenance. Whilst providing greater focus of the social aspect of health and illness experience, concern has been expressed that a move to a socio-linguistic approach can go too far, creating a similar problem as caused by biomedical approaches; the difference being a claim that experience is *solely* located in the socio-linguistic realm rather than within individual bodies. This problem has led to much thought regarding the inter-relation of embodied experience, thus grounding the illness experience, and the discursive practices forming the social context within which health and illness gain common meanings and are made visible.

Yardley's (1997) 'material discursive' approaches have set about considering how best to go about developing theories that allow for a materially-grounded discursive understanding to be developed without reduction to either in entirety (I will briefly return to a vocabulary of material-discursive, as opposed to non-discursive-discursive, due to Yardley's use of the terms). Yardley provides the introductory ground from which chapters in her edited collection pose a variety of ways of working materiality and discourse. In doing this, she sets the scene, highlighting a number of ways in which the inter-relation between constructionist and embodied approaches has often been recognised. For example, Foucault, so often paraded as an originating force of discursive practices, clearly considered discourse to be fundamentally based upon material foundations. It is against theories that are often presented as being overly-focused on the operation of discursive factors that Yardley's approaches are positioned. For example, Discursive Psychology with its concern with language in interaction leads some to believe that this is in detriment to other material aspects of

experience (McLennan, 2001). Whilst elegantly laying out the terrain on which to work, Yardley does not take this further in developing a detailed theoretical position of her own, choosing rather, to sow the seeds and provide the tools (e.g. Foucault) for others to utilise.

In an analysis of dizziness Yardley (1999) seeks to demonstrate how it is produced and experienced as part of a set of interlinking factors, which are social and individual. For sure, biological factors are present, in terms of neurological activity that controls our ability to balance, but also environmental factors play a key role, as it is only in times when social inputs fail to provide the 'correct' information (e.g. on a swaying ship), that dizziness can happen.

Material-discursive approaches of this kind have as their central concern a desire to move beyond dualistic thought, of the kind found in mind-body dualism, when analysing health-related experiences. The body is recognised, quite rightly, as something that needs to be appropriately taken into analytic and theoretical account. The problem with these approaches is that they take the body as a static entity, that is *given* to analysis, as if it sits awaiting interpretation. In this sense, the fluid and contextual nature of embodiment as part of wider forms of content is not accounted for. Experience is taken as a stable presence, rather than analysed for the different ways knowledge is formed and experienced of it according to the context in which it is analysed. Mol (2002) provides a valuable analytic insight into the variety in the context-dependent ways illnesses are experienced in analysis of atherosclerosis (see Tucker, 2006).

3.7 Analytic Issues associated with the Body and Space

Analysing bodies in social psychology has presented a number of issues that have catalysed a vast amount of literature (see the special edition of *Theory and Psychology*, 1996; Burkitt, 1999). Amongst discursive theorists, embodiment has proved an analytic obstacle requiring particular attention. For many this has been dealt with by theorising the 'discursive body', that is to go after the multiple ways bodies are constructed and produced in discursive activity. Interactional approaches focus on the body as a rhetorical tool in conversation, part of people's accounts of managing their interests in particular settings (e.g. Wiggins, Potter, & Wildsmith, 2001). Approaches concerned

with discursive use as and in social practices have articulated the variable forms of positioning of bodies by discursive formations. For instance, producing a subject position of someone of ethnic minority, is very much to do so on the basis of their bodily make up.

Within social theory efforts have been made to incorporate the body conceptually, and these efforts continue to date. Work such as that of Shilling (2003) and Burkitt (1991; 1999) have attempted to address the analytic challenges presented by human embodiment. The pivotal concern of the field has been to find a way to move away from certain dualisms that have acted as 'problems' of theorising the body in sociology. Firstly, the tradition in sociological thought to theorise the body based upon the Cartesian split between mind and body (similar concerns have existed in psychology). The work of Merleau-Ponty (1996) has been drawn upon, due to his arguments that the mind and body are fundamentally the same substance, and are not separate essences (Turner, 1984). Beyond this, the concern has been to develop theory that allows on the one hand to thoroughly address the role of social processes and structures in the constitution of embodiment (this has traditionally been the main focus of sociological thought), and to account for the body as a site for active agentic actions, but without negating the social (Howson & Inglis, 2001).

Let us briefly consider some of the offerings from the area. The body, for Burkitt (1999), is not a purely biological entity, but exists also as a social and natural construction which is open to "re-formation through its location within networks of historically variable social relations" (1999: 7). Foucault's notion of *bio-history* is drawn on to illuminate the role of evolution and biology that has shaped the body. This does not relate to some kind of biological determinism though, as the processes of *bio-history* have always been working in dialogue with socio-historical processes. Thus we cannot reduce the body to any one factor, and indeed cannot define the body as a coherent stable entity that can be bracketed off from socio-historical factors. The body functions as an intersectionary being, operating in a nexus of a whole set of interrelating and ever changing relations. This makes the job of empirically attempting to analyse the body a difficult one, due to the necessity of gaining an understanding of the different sets of relations that form knowledge of, and the position of, the embodied individual in psychopathology.

Shilling (2003; 2005) attempts to move beyond dualistic theory in embodiment through addressing the role of the three prominent areas he sees as heavily influential in the sociology of the body, namely structuration theory, social constructionism and phenomenological approaches. His own theoretical aim is formed around a three-pronged conceptual tool to demonstrate the ways the body is constructed by social processes; the originator of social processes; and constructing agent of social processes. In this way, Shilling can address the previously explicated weaknesses of constructionist, phenomenological, and structuration theories. The three-stage model is based around the notions of the 'body as location' of social processes – where effects of society are made visible; 'body as source' of social processes – where bodily actions are constitutive of social forms; and the 'body as the means of positioning' individuals within societal practices – where the interaction of body as agentic and constructed operates. This forms Shilling's central argument of the "body as a multi-dimensional medium for the constitution of society" (2005: 28).

The body, for Crossley (2001), is not to be thought of in dualistic terms, be it 'mind-body', 'body-society', but rather as "at once both embodied and mindful" (2001: 20). This self that we recognise is one that is fundamentally constructed through action, as it is embodied activity that others see. Thus, Crossley argues that our sense of self is a centrally embodied self, and that we learn the significance of our body through socially derived meanings. Actual objective differences exist between us, such as male and female physiological differences, but the meaning of these is entirely socially constructed. These differences then become manifested in our habitual nexus, which is learnt through socialisation throughout life.

Building on the contributions from sociological theories of embodiment, one can move forward to consider gaining a theoretical and empirical hook into how the body operates in spatial and non-discursive contexts. Bodies exist in social settings, in concert with any number of other factors, be it other bodies, objects, language. Embodied experience is always socially bound, and as such emphasis needs to be placed on the ways that it operates in relational ways with the other occupants of our everyday environments. Bodies are no doubt subject to societal pressures, but key to this is that society and bodies do not exist as *distinct entities*. They are part of the same constitutive practices; society does not exist outside of the embodied non-discursive

practices through which it is formed. With this comes the notion of the multiple body. Often the body is referred to as a *singular* subject or object, reified, but this initiates questions as to what constitutes this singular being? Is it flesh and blood, or cultural understandings, however they are constituted? It is a generalised body that is represented, rather than gauging how bodies exist in multiple ways and forms.

Analysis of bodies through empirical data has not been of prime concern in this field, meaning methodological advances remain, in the most part, absent (Tucker, 2006). Most of the literature converges around the same theoretical goal of considering how best to conceptualise the body in modern society. In this way, theoretical insights can be taken, but in terms of analytic tools, offerings remain limited (Radley, 2003 is an exception, as detailed in the following section). The issue for this thesis is about analysing the body, as part of the non-discursive set up of experience, *through* discursive work, but crucially, not solely *as* discursive work. This requires a set of theoretical tools, along with a pragmatic approach to the study of transcripts of interviews with service users.

Analysing how human experience is constituted and produced spatially has traditionally been the concern of human and cultural geography (e.g. Bonta, 2005; Saldanha, 2005). This kind of analysis is new to psychology, although a growing body of it is developing (e.g. Brown, 2001), influenced in part by the studies concerned with the interaction of humans and non-human objects in the production of experience, in the social sciences (e.g. Actor Network Theory (Law & Hassard, 1999)). Marrying discursive analysis and spatial analysis has not been a common task. It is with this in mind that a Deleuzian Discourse Analysis was developed for the analytic goals of this thesis; a method that allows for the complexity of the multiple relations between forms of content and forms of expression to be unfolded.

3.8 Does Discourse Know All?

Identifying the discursive work of constructing versions of the body, e.g. the gendered body (Burkitt, 1999; Butler, 1990) is valuable in terms of identifying inter-relational forces at play, in particular the active nature of discursive practices *on* bodies. This is valid and informative analysis, but the claims made are ones about knowledge produced through the constitutive effect of discursive practices on the body. Following

Radley's (2003) argument, I contend that whilst analysing the ways discursive practices position bodies is valuable, it is not the only means through which to analyse embodiment. Different analytic needs require different approaches. Radley (2003) articulates this through analysis of flirting, which he performs through textual descriptions of interactions in which flirting occurs. His specific focus is on the gestural work at play in such interactions, and how flirting can be analysed as partly formed through gestural interplay, in terms of the ways people use and manipulate their bodily comportment and actions to enact flirting activity. Radley rightly points out that different analytic approaches could go after alternate ways of knowing the body in the interactions described, such as bodily activity as constructed through discourses of sexuality and gender. This though, informs as to some forms of interest and experience, but not in all-encompassing fashion. Radley's approach is guided by his analytic concerns at the time, and these are gestural, and non-reductive to discursive practices in totality. Here we see some of the inter-relational work in respect to non-discursive and discursive practices, with the emphasis upon the input of non-discursive practices, although emphasis is not placed on the fluid, constantly re-working, *flow* of experience.

Discursive activity in interviews is argued to be both relational to social practices existing in discursive form, as well as productive and active as a fluid and dynamic form for creating accounts in conversations. It is akin to a putty that can be molded and kneaded into different shapes dependent on the contextualised concerns at any given time. Additionally, it is grounded in relations with factors, aspects of which are not reducible to discursive activity in entirety. Through analysing the ways non-discursive factors are talked about (e.g. bodies), we can illuminate some of the experiences that relate to discursive work, and indeed are co-dependent upon it, i.e. the relation between forms of content and expression. Additionally, concepts can be drawn upon that offer an approach that recognises the *captured* nature of empiricism, and offers ways of thinking *change, process and flow*.

Chapter 4:

Diagnosing Lives

'To classify is human. Not all classifications take human shape or are standardized in commercial and bureaucratic products. We all spend large parts of our days doing classification work, often tacitly, and we make up and use a range of ad hoc classifications to do so'

Geoffrey Bowker and Susan Leigh Star, *Sorting Things Out: Classification and its Consequences, 1999: 1-2*

4.1 Introduction

This chapter is concerned with illuminating the ways that service users relate to the procedure of receiving a diagnosis. The process of becoming a service user involves coming into contact with mental health care services, during which the administration of a diagnosis will be given so as to identify that person as someone 'in need' of particular services. This in turn enables psychiatric service providers to describe a set of experiences in such a way that allows for a process of treatment and care to be implemented and to identify the appropriate course for each diagnosis. It is thus at the heart of psychiatric practice that diagnosis operates.

Following on the tradition of analysing how people are made into 'patients' and service users, which has its origins in the work of Goffman (1968a, 1968b), this chapter is concerned to explore the issue of diagnosis, with a particular interest in how categorisation operates. Goffman (1968a; 1968b) highlighted the ways that people were positioned as mental health patients by social forces, with a particular focus on the role of identity in relation to stigmatisation. His analysis was an in-depth one, articulating how social understandings of 'normality' and 'abnormality' work to subject people, and make them visible, as members of some form of deviant group. This chapter follows this line of thought, but with a focus on the process and practice of diagnosis, which forms the primary force that recruits people into psychiatric categories, and thus identities. The concern with categorisation illuminates how people

cope with the problem of requiring a diagnostic identity so as to become a service user and receive help for their difficulties, whilst facing the challenges to their identity that membership of such categories can bring.

Diagnostic terms become the means through which people are categorised, the forms of expression that capture service user experience, and as such have important consequences for social identities (Sadler, 2005). A diagnosis of schizophrenia acts to identify that person as a 'schizophrenic'. This identity has a particular societal currency, in that those diagnosed become recipients of the effects thereof (Bhugra, 2006; Davidson, 2003; Dinos, Lyons, & Finlay, 2005). To be exposed to a particular identity (e.g. a 'schizophrenic'), comes through being a member of a specific category. To be identified with a category brings with it exposure to a series of implications and entitlements. Having received a diagnosis as part of their becoming service users, this chapter is focused on analysing how service users relate to their diagnostic identity. It is of concern how such a prominent form of expression impacts on their everyday experiences, taken from service user perspective, rather than, say, looking at the practice of diagnosis from service providers' (e.g. psychiatrists) point of view. In doing this, a sense of the ways service users relate to their diagnostic identities over time is gained, as many would have received diagnoses some time in the past. Sacks (1995) demonstrated the kinds of 'membership categorization devices' that people utilise when discursively attending to membership of categories; feeding into the kinds of entitlement and implications that subsequently open up.

4.2 Category Entitlement

Sacks (1995) exemplified this process in his analysis of a conversation between a witness to a fatal car accident, and a friend. Sacks was interested in the different ways that narrative 'rights' work for each member of the interaction. Between the witness and the friend, it was demonstrated that the friend did not have the 'right' to express the same feelings of distress. A different form of ownership occurs, in that the friend cannot construct the same level of ownership, as they did not actually witness the event:

'The question is, is the recipient of this story entitled to feel as you do? I think the facts are plainly, no. That is to say, if you call up a friend of yours who is

unaffiliated with the event you're reporting, i.e. someone who doesn't turn out to be the cousin of, the aunt of, the person who was killed in the accident, but just a somebody you call up and tell about an awful experience, then if they become as disturbed as you, or more, something peculiar is going on, and you might even feel wronged – though that might seem an odd thing to feel.' (1995: 243-244)

The point Sacks makes is that the non-witness cannot 'own' the story in the same way as the witness, and as such, it is the on-looker that has the entitlement, through their membership of the category 'witness' in this case. For service users, recruitment into diagnostic categories results in exposure to a set of entitlements and implications, that they are then faced with dealing with. It is of interest how this operates in an interactional sense in this chapter, but additionally in regard to the social forces at work in positioning people as particular categories, i.e. as a 'schizophrenic'. How they negotiate these is the focus.

In considering the experiences of service users, it is important to flag up and analyse the dominant form of knowledge that focuses upon their lives. Psychiatric classification systems (e.g. ICD) produce the predominant form of expression that positions people as service users. Their initial recruitment as users of psychiatric services comes about through the administration of a diagnosis, and subsequent category entitlement. Diagnostic systems are then the most privileged producers of knowledge about service users' experiences. In Deleuze and Guattari's (1987) terms, diagnostic systems are the dominant *signifying regime* of mental health. Service users are obliged to pass through this regime, as it is the prime capturing apparatus of mental health, in accounting for their experiences, and it is the challenges users face in doing that, along with their attempts to overcome such challenges, that are of interest. The problem facing users in this context is that of wanting to be visible as someone in need of psychiatric assistance, but recognising the problem of being visible, i.e. the challenges to identity that entering diagnostic categories can bring.

4.3 Prototype and Aristotelian Systems

Theories of classification have emerged from the fields of cognitive science and the social sciences (Rosch & Lloyd, 1978; Varela, Thompson, & Rosch, 1991). The

contribution of the social sciences has been that of offering an alternative conceptualisation of classification, which has involved illuminating how classification operates as a social practice, rather than as a cognitive process (Bowker and Star, 1999). These have worked to conceptualise the ways that classification systems are produced and operate. Bowker and Star (1999), as we saw in Chapter One, discuss some of these theories, arguing that classification does not tend to work in a straightforward manner, but tends to be more complex, with boundaries not as clearly demarcated in practice as they are in theory. For instance, they use the example of a chair, where it is possible to have two objects classified as a chair that do not share two common characteristics. In doing this the theories of *Prototype* classifications and *Aristotelian* classifications are highlighted as two central modes of classification theory. Prototype theory is drawn from cognitive science, and works on the basis of each of us having a ‘best example’ of whatever it is we are classifying, which is then used to judge the category assigning of any other object. So, it may be that a robin is used as a best example of a bird, and then any other bird (if it is furry, flies, and generally resembles our best example) will be classified accordingly (Rosch & Lloyd, 1978). Aristotelian classification is more strictly ordered, with objects defined according to binary factors that are exclusive to each branch of the classification system. There is less room for fuzzy boundaries in this system; either an object possesses relevant binary characteristics or not. The system also works on different levels, according to the number of features it has to display to characterise its nature. So, at a level incorporating telephone, cup and photograph; then cup can have the feature of being something to drink from. However, on a level with telephone, cup, photograph and bottle, other features would need to be adduced.

The notion of *practice* is central to the classification process. Bowker and Star argue that in *practice* classification operates neither in a Prototypical or Aristotelian sense exclusively. Rather practices of classification tend to be more nuanced, fuzzy and murky. Boundaries subside; moving and stabilising in different places at different times:

‘This distinction between two main types of classification is a very useful one. There are a number of reasons, however, for saying that it is not an absolute distinction. Indeed, one could say that we all probably have our own prototype

of the ideal Aristotelian classification system, but that no one system fully meets a single set of Aristotelian requirements.’ (1999: 63)

The problem Bowker and Star address is that centred on the category work performed in the ICD manual. This classification system is one that faces a particular problem of managing and categorising the natural and the social; of attempting to segment the inherently complex and fluid social world according to objective criteria. This is a complex problematic centred around attempting to make fuzzy fluid factors *look* like objective neatly demarcated definitions. For Bowker & Star classification systems (particularly the ICD) work by making Prototypical classifications appear Aristotelian, which it needs to do to perform its health-related role of providing a system by which neatly ordered categories can be applied to instances of mortality and morbidity.

Bowker & Star discuss how temporal factors necessitate the constant re-working of categories to incorporate new information, along with other factors related to the social existence of disease (e.g. changing political landscapes), rather than the objective definition of something existing as a ‘natural’ form. An example used is that of the declassification of homosexuality as a form of morbidity in the 1960s due to the social and political pressure to de-pathologise it (Rubenstein, 1995). Here there is the constant friction to classify something as a ‘natural kind’ that has a social existence.

This struggle to manage the role of making fuzzy prototypical classifications appear Aristotelian has been a major one in the area of mental illness classifications. Complex experiences such as those labelled schizophrenic have necessitated constant re-workings of the classification of schizophrenic-type disorders. The medical need of the ICD and the American equivalent DSM to provide scientific explanations for what are very difficult factors to explain and define, especially in the case of schizophrenia where no aetiological cause has ever been found, forces these kinds of classification to provide diagnostic guidelines. This process as we will see has not always been an easy or unquestioned endeavour.

4.3.1 Practical Kinds

Zacher (2001) takes this debate on further by making the link between the classical Aristotelian and Prototypical systems and psychiatric disorders. His argument is

worked around the idea that to be a member of a classical system requires a distinct set of necessary and specific conditions, which operate in an essentialist manner. Zacher (2001) argues that psychiatric disorders do not fit a classification system that defines its constituents into neatly ordered categories, for which a set of necessary and specified internal conditions exist. In this sense, psychiatric disorders are not natural kinds, in that they are not “internally consistent from one instance to the next” (Zacher 2001: 167). If we take the category ‘schizophrenia’, a number of factors can lead to a diagnosis. For instance, hearing voices, or ‘delusional’ thought. There is no *one* criteria whose existence is necessary for every case of ‘schizophrenia’. Given this, Zacher argues that it is a misconception to theorise psychiatric disorders as classical systems, as Bowker & Star illuminated, due to the lack of distinct criteria within which all instances of mental health difficulties fit. Rather, it needs to be accepted that mental classifications operate with fuzzy boundaries, often manifested in instances of co-morbidity, such as people diagnosed with schizophrenia suffering with depression. As Bowker & Star pointed out, psychiatric classification, in practice, often works in terms of Prototypical ‘best fit’ categories. Zacher takes this on by pointing to a form of practical assessment, in which categories operate as *practical kinds*, valued for their utility as part of the treatment and care of people diagnosed. Practical kinds exist on a continuum, rather than by a strict set of necessary criteria:

‘Thinking of psychiatric disorders as practical kinds makes it possible to ask whether someone has a generalized anxiety disorder or an anxious personality disorder without believing that this is an either/or question. There may be sound reasons for preferring one category over the other in terms of the consequences that the labels have, but choosing between these two categories is not a question of diagnosing the “real” disorder.’ (2001: 168)

Classifying psychiatric disorders as *practical kinds* is to adopt a non-essentialist conceptualisation, whereby categories are not taken as representative of stable and unified disease processes, but are formed and operate in regard to their possible use. Whilst Zacher’s drive was to reformulate the theoretical claims behind diagnostic categories, i.e. that they refer to inherent stable properties, in this chapter it is a sense of the practical kinds of categories produced by service users that are concentrated on. This enables service users to work up categories that better serve them, and represent

their lives in a more positive light than that of stating their experiences are entirely defined by an enduring illness that is highly likely to remain indefinitely. Of course, one recognises that their ability to do this is harnessed by their social identity as a service user, but that at a micro level there remains some scope for re-working categories.

4.4 Diagnostic Problems

We have seen so far that practices of classification in mental health, based upon the manuals of DSM and ICD, are multi-layered and have their work cut out in attempting to categorise such a diverse set of experiences. These systems are challenged by critiques that argue that current systems constituted in DSM and ICD are far from useful, and indeed fall well short of appropriate and useful concepts with which to think about mental health difficulties. For instance, in Chapter One Boyle's (2002) questioning of the category 'schizophrenia' was discussed, and Bentall (1990; 2003) has provided an equally valuable contribution, in terms of highlighting the very fragile foundations that claims as to the validity and reliability of psychiatric diagnostic classifications are based.

The practice of classifying mental disorders has been seen to be a complex historical one. What the debates highlighted by Bowker & Star and Zacher do not tell us are the processes and methods by which service users relate to such prominent forms of expression that code their experiences. So far, we have seen that arguments have theorised that categorisation is something done *to* people, in a top-down sense. This is valuable, but additionally insight can be gained regarding service user experience if we also analyse the ways that service users 'own' the category, i.e. how they relate and discursively account for their experiences in light of diagnostic categories, and attempt to overcome the challenges of being obliged to enter into the signifying regime of diagnostic knowledge. Doing this involves working at overcoming the problem of producing a category about oneself that is an acceptable one. In this way, it is a sense of the *practical kinds* of classification produced by service users that is the concern. Additionally, it involves accounting for a varying set of experiences and behaviours with understanding that a medicalised system of knowledge is the primary form which 'captures' service user experience (i.e. psychiatry). Thus there is an inter-relation of a

variety of factors, including those drawing on psychiatric knowledge and from the mediated nature of service user experience itself.

4.5. Diagnosis Talk not related to Mental Health Difficulties

The starting point for analysis was highlighting how service users related talk of diagnosis to their mental health difficulties. This would require recruitment into a language of diagnosis, and it was of interest how service users manage the relationship between their own mental health experiences and the formal diagnosis. Consider the following extract:

Ian: but do you feel (1) have you ever been given a diagnosis or anything like that then? (.) or would you have wanted one or?

Jim: such as what?

Ian: er well (1) depressive o::r a..anything like that?

Jim: well they told me I got scarring of the lungs [I: uh mm] (.) well I (.) had a lot of bacteria in me (.) body when I was a kid like you know [I: mm] and that's what done that and er (2) they said "have you smoked" (1) and I said "no" (.) never smoked in my life and I wouldn't thank you for one [I: mm] (1) and I (.) I said "I used to drink" (.) but I (.) I've cut down (.) hell of a lot now cos I used to be (.) twenty odd pints a night [I: mm] (.) no thinking about it like you know (1) I cut.....(lines 443 - 453)

In this extract Jim works to highlight one of the problems that can face service users when discussing issues of diagnosis. This is the issue surrounding knowledge of what is and is not relevant in regard to how a particular category was given to someone. Jim highlights that knowledge of what drives the application of a category is not always clear and straightforward. An understanding of diagnosis according to a psychiatric definition was not apparent. When faced with the opportunity to name his past experiences according to a psychiatric diagnosis he does not undertake to do this. By asking about his diagnosis, he is invited to enter a category that he may find problematic. What he does is to work to re-code his past experiences in an alternative way, with reference to his general health, rather than mental health. This indicates that he struggles to know what is relevant or not; in terms of the reasoning behind the question. His initial "such as what?" response suggests the uncertainty regarding the

reasoning behind the question. The response directly provides the opportunity to enter into the area of psychiatric diagnosis, namely the “well depressive, or anything like that”. This opportunity though is not taken up, as Jim produces an alternative narrative relating to a consultation focused on the condition of his lungs.

His account is corroborated (Potter, 1996) through inclusion of external witnesses to his poor health. He states that “they told me”, in reference to a team of medical practitioners, that he has scarring of the lungs. This works to make a stronger claim than to refer to just one individual. Jim goes on to provide greater detail of accountability for the scarring of his lungs, which he claims is, at least in part, due to him having a lot of bacteria in his body as a child. In addition he constructs an account which demonstrates that he is possibly in part responsible for his ill health, as he used to drink a lot. This claim is countered by his adamant denial that he has ever smoked, and although his admission of drinking lessens the external accountability, the statement that he does not drink heavily anymore allows for him to claim a current position of personal responsibility over his health. This is an example of one of the problems facing service users, namely that of understanding what is relevant, along with framing their experiences in such a way that coheres neatly with a language of diagnosis. Another example of this lack of understanding of psychiatric diagnosis as a concept can be seen in the following extract:

Ian: how do you feel (.) do you think (.) how (.) what have your experiences been like then with the (.) the psychiatrist, have they been ok (.) have you always agreed with what they’ve had to say and things?

Harry: er (.) I fully agreed (.) agreed with them [I: mm] I mean (1) they’re helping you [I: mm] they’re not (1) you know (.) they’re not going (.) t:o be horrible to you [I: mm] o:r (.) anything like that they’re helping you [I: mm] (.) e:r (.) at the end of the day (.) um (.) you can’t be (.) exactly (.) harsh to them [I: mm] (.) they’re the ones (.) helping you [I: mm] u::m (2) but (.) that’s [I: mm] (.) that’s my reason really

Ian: did they like (.) did they give you a diagnosis or anything then?

Harry: e:r yeah [I: mm] (.) got that everything [I: mm] check me out (.) I had (1) my injections and some [I: mm] (1) everything [I: mm] (.) it was great

Ian: what did they (.) what diagnosis did they give you?

Harry: u:m (1) it was (.) ten out of ten [I: mm] (.) I mean [I: mm] (.) they said that you're (.) you know (.) reasonably fit [I: mm] (.) stocky [I: mm] (.) e:r very very fit [I: mm] (1) at the end of the day (.) it's just the zinc [I: mm] that (.) it's (.) tearing me apart (.) basically.....(lines 201-217)

Harry's understanding of diagnosis is similarly linked to the concept of physical health, as seen in Jim's extract. Harry frames the administration of diagnosis as part of his incorporation into service use, through his initial assessment, in which he was 'checked out', given some injections; an overall experience which he is positive about. The use of stating that he was given injections works to further laminate the account with scientific credibility, as it refers to a well established scientific practice, based upon firm scientific evidence that a chemical (of which he does not specify) is effective as part of a medical practice. Inclusion of the injection claim allows Harry to buy into this kind of knowledge. Diagnosis is understood and presented as part of the assessment of Harry's general health. Harry does not specify who the psychiatric team consisted of, preferring to use the general term 'they'. This is utilised to corroborate his account, as the claim that his fitness is good, and overall assessment was positive, is framed in terms of what the psychiatric team said. The use of third party corroboration is a useful tool for contributing to the credibility of claims (Edwards & Potter, 1992).

The last sentence is interesting as it appears to contradict his earlier claims to good health. He states that "the zinc" is the only problem left, as if for fear of painting too rosy a picture of his current physical well being. This seems reasonable, but is followed by a very strong statement that, despite being "only" the zinc left as problematic, it is actually "tearing him apart". Edwards and Potter (1992) point out that variability in accounts is a central function of descriptions, in terms of people's stake and interest. In this interaction Harry is positioned as someone of whom a response to my invitation to discuss diagnosis is required. This he duly obliges, with a general health account. The strong ending operates to lay claim to his current position, as someone who has been approached due to poor mental health. His narrative of general health negates any recognition of this, and as such, the ending serves to do this recognition work. His avoidance of entering into psychiatric talk leaves his current state as service user unexplained. His solution to this is to include the rather ambiguous "tearing me apart",

which constructs severity, but in a non-specific way, but goes some way to producing him as someone 'in need', even if that need is not thoroughly detailed.

What we see in these accounts is the invitation to enter into a category of psychiatric definition taken on and worked into an alternative diagnostic framework. A system of general health is produced, that positions the account away from psychiatric diagnoses. Indeed, in developing this system, no mention of psychiatric diagnoses is required. The general health framework provides an excellent tool through which any integration with psychiatric categories can be avoided. In this sense, a form of category avoidance is worked up, which requires no form of denial or counter explanation to defend against potential stigmatisation of psychiatric diagnoses, as to talk only in general health terms is a tangential move that negates any requirement to manage an identity in relation to psychiatric diagnosis. By avoiding entering a psychiatric category, none of the potential negative implications of becoming a member need to be overcome.

4.6 Diagnosis not Understood

In accounts in which knowledge of diagnosis is worked up with relation to mental health experiences (i.e. entering a language of 'psychiatric diagnosis'), a set of concerns stand as obstacles to a straightforward narrative being produced. In this section we can see what some of those obstacles are, along with a taste of the strategies utilised in attempting to overcome them. In the following extract Frank is discussing his diagnosis and its impact upon his life:

Ian: how did you feel about your diagnosis?

Frank: u:m (1) I didn't understand it [I: mm] (1) it was just a word to me [I: mm] um (.) never just says "oh you're a (.) a schizophrenic" [I: mm] (what the hell is that?) (.) I didn't know what it meant [I: mm] er (2) um (3) and then I looked er (.) I was (.) looked (.) as I um (1) you know got a bit more um (.) alert (1) I er (1) I started to say what's (.) you know what is schizophr[↑]enia [I: mm] and er (.) it's (.) um (INAUDIBLE) some people say a dull personality and er [I: mm] (2) you (.) there's lo.. loads of different (.) things covers a multitude of sins (.) schizophrenia does [I: mm] (.) er (.) but my main thing was hearing these (.) bloody voices everywhere (.) it was (.) I couldn't watch (.) I couldn't

have the television on (.) they were just coming out of television (.)[I: mm] I thought (.) there was people in the loft (.) with microphones [I: mm] (.) listening to me (1) and se.. (.) sending er (.) morse code huh huh and all this (.) it was (.) horrible experience (.) horrible.....(lines 367 - 380)

Frank's description sets out straight away to represent his diagnosis, schizophrenia, as something of which he did not have knowledge. This works to take a 'step back' from the question I put to him. Rather than having to immediately account for his feelings about the impact of a diagnosis of schizophrenia upon his life, he at first introduces the fact that the diagnosis itself did not have a significant meaning for him. In doing this, his account becomes one regarding responsibility, in that Frank frames himself as taking responsibility for gaining knowledge about this word 'schizophrenia' that had such an impact upon his life. This in turn has a number of functions, primary of which, is that to construct responsibility upon oneself additionally enables one to claim a position of control.

Frank's narrative provides a strong example of the dilemma facing users when accounting for their diagnoses. His way of demonstrating the complexity (and uncertainty) surrounding 'schizophrenia' is to state it covers a "multitude of sins". The ambiguity of the concept can mean users struggle to know what is relevant when framing their experiences within such a category. A psychiatrist may respond to the complexity in a different manner, such as referring to the range of clinical research investigating the concept (e.g. brain studies, drug treatments, genetics), of which Frank does not have expertise. The result is the same though; to represent the complexity that exists due to the vast range of factors that can be involved.

For users, this feeds into a second problematic; managing a category that will re-code one's experiences. In itself, this is not always a problem. People with health problems can often welcome a diagnosis, particularly if it means they can be effectively treated, as it can provide an explanation for what may well have been a difficult experience (Tucker, 2004). In mental health, diagnosis can operate differently, in that accepting classifications can mean taking on potentially stigmatising identities, e.g. as a schizophrenic (Douki, Taktak, Ben Zineb, & Cheour, 1999). Frank faces this in at first not knowing what is relevant in terms of the classification applied to him

(schizophrenia), and then developing an account that is acceptable to him. He does this through relating diagnosis to a particular experience, hearing voices, which is positioned as an event in the past. Administration of diagnosis is represented as occurring because of an episode of hearing voices. Beyond this initial event, an identity based upon the diagnosis is not taken up. In psychiatric practice, an initial psychotic episode would be the catalyst and start of an identity, e.g. as a schizophrenic, which could be long lasting. Frank works an alternative account, which serves to identify only the initial voice hearing as 'schizophrenic', and not his subsequent life since. Diagnosis is used only to account for this past event that by its unusual and distressing nature required an explanation. Frank utilises the category to provide this explanation, but in a way that does not impinge on his current identity.

4.7 The Problem of Acceptance

So far we have seen some of the discursive strategies of resisting entering into talk of diagnoses in psychiatric terms, along with narratives of struggling to understand the meaning of diagnostic classifications such as schizophrenia. The following section focuses on the problems involved in accounting for mental health difficulties once their labelling as diagnoses is recognised by users. Namely, what is the impact of recognising that you have received a diagnosis? Firstly, by focusing broadly around strategies of accepting diagnosis, which relates to the issue of producing a classification system that users feel more comfortable with. This indelibly involves the problem of acceptance, which is clearly illuminated in the following extract:

Ian: mm (2) what about your diagnosis then? Have you always agreed with it?

Ben: °well I always knew° there was something wrong cos you don't hear voices for (.) no apparent reason (I: mm) (3) and I kept, when wh..wh..when they didn't diagnose me at first (.) I kept saying you know (.) I know there's something wrong (I: mm) (1) and then when it was, the diagnosis was given (.) to me it was like (1) finally some closure (.) you know what I mean I..I have got something wrong (I: mm) (1) but then I (.) on the other hand it was like schizophrenia (.) I've got to live with that for the rest of my life (I: mm) (1) so it was kind of mixed emotions (I: mm) (3) so

Ian: so you (1) you think it's something then (.) that's it then you'll (.) you'll have for the rest of your life.....(lines 342-352)

In this extract with Ben we can see the way the dilemma of acceptance works. Ben's diagnosis of schizophrenia came after a period in which he claims he knew something was wrong. He had identified his experiences as problematic, which positioned them as something requiring an explanation. He states his concern at the time that he was not provided with a diagnosis immediately. Thus, he was very relieved when a diagnosis was given, and his experiences were categorised as schizophrenic. Receiving an explanatory diagnosis can be a distressing event, as it means that fears regarding ill health are confirmed as an actual illness. However, the reception of diagnosis can be a positive event, as it allows for prior distressing experience to be accounted for, which in turn facilitates a course of treatment and (hopefully) positive outcome. In Ben's account though, this posed a new problem; that of accepting a category that re-coded his past experiences in a potentially stigmatising way. Ben states that "it was schizophrenia, I've got to live with that for the rest of my life". On the one hand he was relieved to have an explanation for the behaviour, but on the other, the explanation came at a cost, namely a stigmatising category. This is a prime example of the problem faced by users when it comes to diagnosis. That is, how to accept entering an explanatory category, that in turn re-codes one's life in a stigmatising way. A strategy aimed at overcoming this dilemma can be seen in the next section of Ben's extract:

Ben: yeah, that's the way I look upon it \\ cos it's not getting any better \\

Ian: \\ but is that \\

Ben: it's not getting any easier

Ian: mm (1) have you been told that have you or?

Ben: I haven't been told that no I just, my mum's got it, my my real mum, biological mum (I: mm) she's got it (.) she's got schizophrenia, and my uncle has (I: mm) (.) and my biological dad had a personality disorder (I: mm) so (1) there was an increased chance that (I: mm) (.) I'd get it but (.) only by a little (.) so

Ian: mm (3) so do you think there's sort of a (.) gene.. genetic element to it then?

Ben: yeah (I: mm) (1) yeah definitely (1) sometimes when I'm off on one and I
(.) can't come back (1) er (.) come back to (.) society (2) I'll always say,
Frances, that's my real mum, shouldn't have had kids (I: mm) (1) cos I'm not
going to have kids (.) cos I wouldn't like to pass it on (I: mm) so (1) and e.e...er
that's just a decision I've made (.) (I: so you..) I wouldn't like, I wouldn't like
to wish this on anyone you know what I mean (I: mm).....(lines 404-420)

Ben's 'answer' to this is to produce a category based upon both psychiatric knowledge and personal experience. He states that he knows his diagnosis is long-term as his mother suffered from schizophrenia. This turn is a key one. By introducing a family history of schizophrenic prevalence he can categorise a system based upon the notion of genetics. The problem presented to him by knowledge that his diagnosis is long-term is subtly worked so as to introduce the notion of genetics, and the biological determinism it brings. If the category is placed upon him due to his genes, then there is not a great deal he can do about it, and, more importantly, there was not much he could have done to avoid it in the first place. Thus, responsibility for his mental health difficulties can be framed in genetic terms, rather than as part of personal control.

By stating that "he always knew" something was wrong "in the first place", Ben works to provide himself as having a position of expertise over the following claims. This is a form of category entitlement, as it presents Ben as the expert regarding his own mental health difficulties. It follows that he welcomes his diagnosis, something that as he points out, is difficult due to the stigmatised nature of the 'schizophrenia' classification. The initial category entitlement allows for the development of an understanding of the reasons for his own diagnosis that is acceptable for his identity. Namely, the genetic explanation, which whilst not ideal, at least can be located as part of Ben's identity that he has no initial control over, in the same way as the colour of his hair or gender for example.

Towards the end of the extract Ben's position regarding control moves from being externally represented to something he claims back for himself. Initially, control over onset of mental health difficulties resided in genetic factors, something Ben had no

command over himself. Ben regains authority over his life through positioning himself as choosing not to have children. This enables control over genetics to be taken. His argument being that he may have had no control over onset of his mental health problems, but he can take responsibility over whether he passes any genetic potential on to anyone else.

4.8 Risky Lives

This section will explore further the concept of stigmatisation, with focus upon the ways it is constituted and operates as a threat to identity. Primary in this, with reference to the diagnosis schizophrenia (which the majority of service users interviewed had received), is the association with potential risk. Reports in the media of people diagnosed with schizophrenia committing violent crimes form a high proportion of total media coverage of the diagnosis (Philo, 1996), resulting in cultural understandings being formed that people who receive a diagnosis of schizophrenia pose a threat to the general public. This operates as a central problem when faced with being positioned as someone with a schizophrenia identity; an issue which can be seen in the following extract with a male service user Mark. The notion of self-achieved knowledge also works up possibilities in relation to notions of risk associated with some mental health classifications. Mark provides a similar account of active information seeking:

Ian: what about what about um (.) your diagnosis has (1) have you always been happy with the diagnosis, has it changed at all or...?

Mark: cos I mean I read up on it and I (1) I know bits about it and schizophrenic (1) I mean (1) what I've been told about it I'm just saying (1) if you have a person who's schizophrenic (.) you can even sink lower or (.) or be (I: mm) (1) you can be (1) gentle or more aggressive (I: mm) (1) I mean (.) that's all I know (1) I mean I'm not I'm not aggressive to no one (I: mm) (1) I mean I might get mad but I wouldn't lash out (I: mm) I mean cos it's not in my nature.....(lines 127 - 135)

Here Mark produces his own tailored definition of what a diagnosis of schizophrenia means. In a similar vein to that of Ben seen earlier, Mark's account firstly works to frame him as someone with authority to talk about his diagnosis. This is done through

stating that he has read up about the classification, which operates as a form of category entitlement. The use of ‘aggression’ serves a specific function here. It works to relate to, but be distinct from, the notion of risk, which is clearly the main problematic for identity at stake. Aggression, whilst having the potential to adversely affect identity, does not necessarily have the same direct impact of admitting one is a risk to others. In Mark’s account, he recognises the stigmatised nature of his diagnosis, but constructs it in such a way so as to allow recognition, but with minimal adverse impact on identity, given the circumstances.

Through this Mark can manage the difficulty associated with living with a category that re-codes his life. The re-coding in question is problematic as it involves coding him as a potential danger, a risk to society. This presents a problem. How can Mark accept this category that is so threatening to his identity? His subtle way around this problem is to produce a set of categories that firstly works to position him as self-learnt. Mark’s is a more honed down version, just involving the notion of risk. Key to this hybrid version is the construction of a continuum of risk, with gentle at one end and aggressive at the other. This hybridisation enables Mark to position himself at the gentle end of the spectrum, and in turn manage the difficulty of aligning his identity with such a problematic category. This allows users to produce their own tailored version, working to re-code their past experiences in a way that is acceptable to them. Having been invited into a category, through the question enquiring as to any diagnosis Mark had received, he was positioned as needing to provide an account of the category through which he had been identified as someone in need of psychiatric care and treatment. His strategy to formulate an account was to represent schizophrenia as relating to a notion of risk. This itself, was a risky strategy, due to the implications this has on the societal perception of himself as potentially dangerous. To counter this, through recognition of the risk perception of schizophrenia, he introduces a polar scale of less or more ‘aggressive’, which in turn enables him to position himself at the ‘less’ end.

4.9 Acknowledging Perceptions of Risk

The association of the diagnosis of schizophrenia with the notion of risk featured in other users’ accounts, with the associated issue of producing an account that enables an acceptable identity to be produced. Consider the following extract with Beatrice.

Ian: mm (1) have you then (.) I mean do you agree then with your diagnosis?
(1)

Beatrice: I do (.) especially when I get paranoid (.) it's awful (I: mm) (2) you think everything's against you and (1) it's awful being paranoid (I: mm) (.) I'm quite shocked that I am a paranoid schizophrenic because (.) you hear in (.) you hear about these paranoid schiz..., well (.) schizophrenics (.) committing murder (I: mm) don't you (.) in the news (.) so I was quite shocked to learn that I had the (.) the the the (.) disease really

Ian: mm (1) have you always seen it as a disease then?

Beatrice: I think so yeah I think it is (I: uh mm) (1) yeah (1) the..the (.) there's been a couple of times (.) the first time I was ill (.) I wanted to (.) well I I felt like (.) hurting some..well killing someone (1) there was a child (.) a little child at (.) at the newsagent just by the door and I felt like going over and (.) hurting them but I didn't (.) (I: mm) I stopped myself I says no I can't do that I mustn't do that it's wrong (.) and then this time round when I became ill I was in the bus (.) I was (.) waiting for a bus (.) I was in the bus queue (.) and there was this old man in front of me (.) and I thought that in my mind (.) my mind was showing me to put my hands around his neck like that (I: mm) (.) and strangle him (.) and again I had to force myself (.) it was (.) it was a really strong feeling you know (I: mm) I had to force myself not to (.) not to do it (I: mm) (1) but I've (.) that was when (.) I was still under the effects of the side effects (I: mm) (1) of this drug (1) but once I took the Procyclidine I..I didn't feel that way anymore (I: mm) (.) I told my psychiatrist about it and he says "you know what will happen to you if you did that don't you?", and I says "yeah I'd go to prison" (I: mm) (1) and he says yes you would (.) and we wouldn't be able to help once you (.) that happens.....(lines 176 – 201)

Here Beatrice states that she does agree with her diagnosis (paranoid schizophrenia) as she has experienced (and still does) periods of 'paranoia'. She goes on to narrate an account in which she positions herself firmly as a paranoid schizophrenic. This classification is then framed within an understanding of *risk*, in which to be a paranoid schizophrenic is to be a potential risk to others. Indeed, this position is firmly reinforced through the claim that schizophrenics commit murder. Interestingly,

Beatrice does not seek to position herself away from this understanding as Mark did, but narrates an account in which she could be assessed to be a risk herself.

Beatrice's account of her mental health difficulties in diagnostic terms serves several functions. Firstly, it works to produce a factual description of the diagnosis 'paranoid schizophrenia'. Beatrice introduces this through the rather general claim that "you hear about these.....", which itself proves inadequate in terms of factual credibility. This is followed by the much stronger "in the news", which draws on understanding of the impartial reporting of news services about factual instances. The pathological nature of the paranoid category is activated through the association of potential severe criminal activity (i.e. committing murder), and the representation of the category as a "disease". Beatrice's experiences are framed within an objective account of a disease process at work, with an associated severely problematic identity, that of potential murderer. This is further concretised through narrating an instance in which Beatrice felt the urge to cause physical harm to someone else. Indeed, the severity of this is emphasised as the experience involved a vulnerable group in society, namely children.

Beatrice's discursive strategy for managing this problematic identity is to narrate an account of personal agency overcoming underlying disease processes. This enables her firstly to apportion blame for the potential to commit murder with the disease process, a 'natural category' outside of personal control. This is a useful way of associating dangerous acts with the disease identity, rather than her personal identity. As the narrative develops however, she makes the move of accounting for her agency in terms of overcoming the dangerous urges emanating from the underlying disease. In making this somewhat contradictory move, Beatrice is able to produce a two-pronged defence against the stigmatised identity of being a potential risk to others.

Constructing the severity of illness is an understandable outcome of Beatrice's account. Her experiences were extremely distressing, and positioning them as potentially risky to others firms up the claim to seriousness. How this works in Beatrice's account is in terms of illness, with the representation of risk associated with the illness, rather than herself *per se*. A story of personal action of overcoming the urge to engage in dangerous acts follows, through which Beatrice demonstrates a personal agency and determination to combat the urges emanating from the illness experience. Recognition

of the moral and ethical failings of the dangerous acts works to shore up the claims that Beatrice overcame the forces of potential risk that originate in the illness, rather than herself. This move is continued through apportioning blame for such urges as additionally constituted by the medication she was taking at the time. Illness and medication are documented as the root causes for risk, both whose causality can be positioned in factors that protect Beatrice's identity to an extent that is perhaps the best she could enact once positioned as a 'paranoid schizophrenic'.

This risk framework indicates one of the sources of information that users draw upon in seeking understanding of their mental health difficulties. Given the prevalence of alluding to media reports in users' accounts of diagnosis classifications, it can be seen that they simultaneously inform general public perceptions of mental illness, along with the understandings of people who experience mental health difficulties themselves. Beatrice produces knowledge of classification that clearly draw on societal formulations regarding what a diagnosis of paranoid schizophrenia can mean. She states that people labelled paranoid schizophrenics are presented as potential murderers by the news media. This works to produce a semi-passive account, in which the news media, through their representations of people with a diagnosis of paranoid schizophrenia, are positioned to some extent as at fault for the perception of risk. This societal perception then feeds into the ways Beatrice understands herself, and consequently is part of her production of someone who *is* actually a potential risk. Thus, she constructs the role of the media not as passively reporting the *facts* of paranoid schizophrenia, but actually producing a specific meaning which users then use to understand themselves. This then also opens up the possibility of Beatrice to position herself as in some form not responsible for her (potential) actions. Yes, she may be diagnosed paranoid schizophrenic, but the personal understanding of her mental health difficulties, which provides the foundation on which her actions are built, is not of her making.

The second formulation that Beatrice constructs is an account of chemical determinacy. After producing a classification system based upon the notion of risk, she then further cements this with a narrative of personal risk where she nearly abused a child. This is a curious tale, in which the potential risk is firmly associated with a personal identifying experience. Beatrice states that once she took the medication given to her to alleviate

the side effects, her feelings of aggression disappeared. This works to classify this behaviour as fundamentally neuro-chemically determined. It was an effect of the medication she was taking, rather than a personally motivated act. Here then a classification system is produced that is multi-layered. Knowledge of the potential for risk is constructed as partly produced by the news media, thus the system incorporated an aspect of the social existence of the mental health difficulties. Additionally though, the 'natural kind' of neuro-chemical activity is incorporated as a determining factor.

Through this multiplex classification system, Beatrice weaves an intricate web that fundamentally works to produce a category she can accept. She was not able to produce an account that held her responsible for the potential risk she posed, rather she produced an account that served to lay responsibility at the hands of the medication's effects. Her strategy for producing a classification that was acceptable to her was to construct it as due to natural processes, namely the neurochemical effects of the medication she took. In this way, her classification is presented in such a way that opens up the possibility to place responsibility away from herself per se, as an *interactive* kind (as seen, along with *indifferent* kinds, in Chapter One). Thus, focus is on the ways that people respond and exist in awareness of the categories in which they are placed. In the case of Beatrice, her response is to turn the classification around in framing it as an indifferent kind (Hacking, 1999). For her, interactive becomes indifferent.

4.10 Recognition but not Acceptance

In the previous sections we move from looking at understandings of diagnosis, and the problems of acceptance, to strategies for resisting acceptance. This relates to the sustained threat to identity that being a long-term service user can have. Focus now turns towards the long term potential for adverse impact on identity for those receiving a diagnosis of schizophrenia. In the following extract we return to Frank, who received his diagnosis seventeen years ago. In discussing this, instigated by my question regarding the stability over time of how he has related to his diagnosis, Frank faces accounting for such a lengthy identity threat:

Ian: and how (1) how do you see your mental health difficulties now then (.) you say your quite stable and stuff [F: mm] so you don't (1) d..do you (.) would you still (.) kind of (1) associate yourself with this diagnosis you were given (.) what (.) seventeen years ago (.) or?

Frank: I spose it will always be there [I: mm] (.) but I don't see myself as a sch..schizophrenic [I: mm] I don't see myself as a me.. (.) um mental um (.) health (.) patient (.) I see myself as a person [I: mm] (1) er (2) and um (1) after all it is an illness [I: mm] and there is a person behind each illness [I: mm] um (1) and I think er (.) a lot of (.) people with mental health (.) see see the (.) illness (.) and not (.) their own qualities [I: mm] which everyone has (.) some qualities (.) um there's a lot of creative people (.) within our centre [I: mm] really er (.) creative people [I: mm] (.) talented people [I: mm] (.) and anyone would be (.) proud (.) to have that talent [I: mm] it doesn't mean er (.) because you're a mental health you (.) develop a mental health problem you're on the scrap heap [I: mm definitely definitely] (1) so er (1) and that's what (.) trying to get across to the er (1) public [I: mm] and (.) we're getting there but er (.) you'll always have (.) stigma [I: yeah sure] (.) but um (.) it's not as bad as it used to be [I: mm] but you'll always get the er (1) the one (.) the people who will not move with (.) the times (1) they'll always be stuck there with their own opinion [I: mm] (1) and the media don't help.....(lines 386-405)

In this extract with Frank, diagnosis is represented as permanent, but not something that he identifies with. To articulate its permanency is a problematic construction for Frank, for it implies an exposure to a continued potentially stigmatising category. Frank's 'answer' to this problem is to formulate an existential account which emphasises the human side to illness. In doing this, the severity of schizophrenia can be marked out, through its construction as an illness. Additionally, a demarcation is made between individual self-reflexive human experience, and the physical location of illness and disease. Frank works up an account that draws on the distinction between *indifferent* and *interactive* kinds, in which he frames the illness schizophrenia as an indifferent kind. In doing this, as Hacking (1999) demonstrated, the self-reflexive nature of human experience can be brought to the fore, and crucially here, differentiated from the physical operation of schizophrenia. Frank is formulating a resistance to a form of illness determinism, as he is emphasising that a level of

phenomenological experience exists in addition to the underlying illness experience. In this way, the severity and recognition of schizophrenia is addressed, which serves the function of being able to discursively make visible the human side to illness, which is distinct from the physical side. For Frank, he may have an illness, but his personal identity is not determined by that illness, as he constructs a separately distinct set of experience, which he formulates as constituting his identity.

4.11 Blurring Boundaries

In terms of narrating an account in which diagnosis is represented coherently, a number of factors exist that render this difficult. Pivotal is the boundary between natural and social, which Bowker and Star (1999) highlighted as an important feature of classification systems. Namely, how we make complex social experience and activities *look like* neatly ordered objective 'natural' categories. This is the aim of classification systems, for Bowker & Star, namely, to appear made up of objective neatly ordered categories, but in practice, this is a tricky job to pull off. In the following section we see this problematic at work in Malcolm's account in which he attempts to provide an explanatory framework for his diagnosis:

Malcolm: I don't know just (1) um (2) well it's in the mind (I: uh mm) um (3) well I say (.) when you've got voices and things these you just (1) they just appeared in the min.. er (1) there's no cau.. they do (.) you know there's (.) there's no cure for schizophrenia and they don't know what the cause is but um (1) well they think it's something to do with Dop.. (.) Dopamine ninety in the head and the brain (I: uh mm) which I've read I know about which I've read about (I: uh mm) that there that the (.) enlargement (.) the some of lobes in the head (I: mm) (.) are a bit different size from an ordinary person (I: mm) that's what that's what they think it is (.) I think it's in..in..in the brain i..i..i. I'm pretty sure (I: mm) I feel, from what research I've read what I've (.) read about that um (.) i..i..it's probably in the brain (I: mm) (4) um (3) I don't think it's caused by um family um (2) um (1) other people i..i..in the families or anything (I: uh mm) um (2) my opinion is certainly schizophrenia i..i..it's (.) , they're doing research into it now and um (1) they'll find out eventually wh..wh..where it comes from (I: mm) and er obviously as time goes on the the the (.) drugs that they're producing are better..... (lines 101-116)

Malcolm's extract highlights the work performed in constructing a category based upon treating schizophrenia as a *natural* (or *indifferent* in Hacking's (1999) terms) kind. Interestingly Malcolm does not attempt to define why the physiological differences that he listed occur, but just that they do. His narrative differs to the earlier one of Frank, who produced a more social account of his experiences of hearing voices. They both seek to work up a category based upon the defining feature of hearing voices, but manage the boundary between natural and social in different ways. Malcolm states that the voices he heard were firmly located in his mind, and that they were caused by particular physiological abnormalities. He struggles to detail exactly what they are, in that he mentions both a particular chemical – Dopamine 90 – along with a suggestion regarding abnormal neurological features. He does though firmly locate the voices – his identifying feature for diagnosis – in the mind. This differs to Frank who accounted for his voices in terms of their social existence, namely how they operated in alliance with artefacts, such as the television. This highlights the difficulties posed to users in producing classification systems according to strict borders. Indeed the blurring of boundaries, in terms of accounting for both natural and social categories is inherently problematic for them, and something they manage in different ways.

Throughout this extract Malcolm struggles to author a definitive explanatory framework to account for his diagnosis of schizophrenia, which as we saw earlier regarding its complexity and contested nature, is unsurprising. He starts off by discussing one of the less complex claims about schizophrenia, that it can involve hearing voices. These are firmly located in the mind for Malcolm. This works to frame the overall account in terms of individual pathology. He manages his interest, as someone attempting to explain something that is a defining feature of themselves, particularly in the interview interaction, through drawing on external factors to both shore up his category entitlement, as well as provide credibility to the narrative. So, Malcolm states he both read up about his diagnosis, and adds to this by stating it was “research” he read. This is a strong rhetorical tool, as it draws upon a body of scientific knowledge, which could not be further removed from personal interest.

Similarities are present here with the literature on Chronic Fatigue Syndrome (CFS), in which people who suffer from CFS commonly face challenges to the legitimacy of

their illness. A lack of underlying aetiological evidence for the syndrome (as seen with schizophrenia) is at the heart of the contestation surrounding CFS. Literature has demonstrated the discursive tools utilised by CFS sufferers in managing their identity and attempting to produce explanatory frameworks for their ill health that position it as a legitimate physical illness, rather than one psychological in nature (Horton-Salway, 2001; Tucker, 2004).

4.12 Half Man Half Animal

Managing the boundary between natural and social was relevant to accounts that drew on notions of mental health difficulties as being at some level manifested in a form of mental *split*. This can be seen to be primarily associated with the notion of a *split* personality being at the root of experiences labelled 'schizophrenic'. Interest lies in the nature of the split articulated. Consider the following extract:

Ian: mm (2) so did you (.) when you first started seeing a psychiatrist or whatever, did they give you like a diagnosis or something then did they? (2) did they say like you've got x or something or?
(3)

Rick: (sighs) Dr Davis says I've got schizophrenia [I: mm] (3) cos one half of my brain world tell me we (.) human beings [I: mm] (2) but the other half of my brain told me we're bloody animals [I: mm] (1) the reason being (.) when we were kids, torches [I: mm] (1) and this played havoc on my (.) in my brain.....(lines 471 - 479)

Here Rick talks about receiving his diagnosis. The pause between the question and his response suggests that he is reluctant to engage in talk of diagnosis, or unsure how to. He does though detail his classification as coming from his psychiatrist, and provides his tailored account of why he has received a diagnosis of schizophrenia. In doing this, Rick draws on the same idea of a *split* that was a key part of Rob's account and drawing on a common cultural understanding of schizophrenia, that of referring to a 'split personality' (Katschnig, 2002). In itself, this is inadequate as it lacks detail. To be utilised as part of a descriptive account of his diagnosis, a more substantial understanding is required. This we see as Rick works the idea through a personal account, namely that in some form his brain is split, with one side 'telling him' he exists

as a human in a human world, whilst the other telling him he exists as an animal in an animal world. This provides the substance to his split account, despite its apparent questionable claim to believability, a fact that does not impact upon his willingness to utilise it as an explanatory tool. The split account is continued slightly further on in the interview:

Rick: I thought schizophrenia was (3) a person that had (1) two or more [I: mm] (2) er (4) what do you call it (.) personalities? [I: mm] that's what I thought it was

Ian: mm (1) what do you think it is now?
(2)

Rick: the same [I: mm] (3) even a person that hears voices in his head [I: mm] (.) telling him to do this and that and the other and [I: mm] I've never had that (.) never had anybody talking in my head.....(lines 494 - 501)

Personal experience is worked through a more formal definition in this sector. Rick's knowledge of what schizophrenia relates to is structured around the idea of a multiple personality, with the inclusion of the 'hearing voices' strand of defining experience. Despite the earlier declaration that his experience is based on some form of split, in his case between animal and human, Rick goes on to define schizophrenia as referring to multiple personalities. He makes reference to psychiatric definitions by including the concept of hearing voices as a criterion for the diagnosis schizophrenia. This works, for him, to resist the labelling of his 'split' experience as schizophrenic as he states hearing voices has not occurred for him. He provides no further explanation as to why believing he is some form of half animal/half human does not constitute him as schizophrenic, just that, by his definition, which involves psychiatric symptoms such as hearing voices, he is not.

Rick's account of a having a split brain in which one half thinks of humans as animals, whilst the other considers humans as humans draws on a historical representation of people with severe mental health difficulties. In Foucault's (1999) lectures on 'abnormality' at the College de France in Paris in the 1970s he argued that representations of the 'mad' worked around three key ideas; the *Human Monster*, *individual to be corrected*, and *the masturbating child*. Rick's narrative draws on this

historical formulation of the 'monster', in which boundaries are mixed up, with the mad seemingly not existing within boundaries but between them. Foucault gives the example of people believing themselves to be both animal and human. Rick's narrative produces himself according to this historical version of the abnormal, a mixture (broken boundary) of human and animal. This is qualified through stating it was his psychiatrist that informed him of this. It is not a personal claim to knowledge he is making, but rather one coming from the expert, namely the psychiatrist.

4.13 'Delusional' Accounts of Resisting Diagnosis

Some of the data of the overall corpus collected for this project involved the reporting of 'delusional' beliefs as part of accounts of people's experiences, including those in relation to diagnosis. Despite the psychiatric status of 'delusions' as beliefs not grounded in reality, their inclusion in this project is no different to that of the non-delusional narratives. That is, as we will see in their section, they are analysed for their functionality as part of the discursive work of accounting for one's experiences, and in this case, in relation to diagnosis. Consider the following extract:

Ian: ok then (.) so (.) have you ever received a diagnosis then?

Roger: Yes a.. (.) acute schizophrenia

Ian: and when was that?

Roger: that was (.) nineteen (.) eighty

Ian: nineteen eighty

(2)

Roger: i.. in the wi.. in the winter er.. (.) I remember it was Christmas

Ian: uh mm (.) how old were you then?

Roger: twenty (I: uh mm) twenty one sorry twenty

Ian: ok (.) and um (.) how did that come about?

(2)

Roger: er (.) you mean the schizophrenia?

Ian: yeah well ho..ho..how did that come about you getting a diagnosis?

Roger: I don't know I..I..I (.) my GP I ju.. I just got a psychiatric report I.. (.) he didn't show, he showed it to me (.) and it said acute schizophrenia (I: uh mm) which, cos I hear things you see (.) but as I say it's my mind (.) which was

crack.. (.) which was falling apart and er (.) from the spirit world they could (.) they co..co..could er (.) sp..sp..speak you see (I: mm) so I could hear voices (.) but they're not hallucinations I don't think (I: ok) and I (.) there was an American psychiatrist (.) sent by Ronald Reagan he said er (.) diagnose me schizophrenic (I: uh mm) cos he said I (1) you know I was meant to be a po.. er (.) political leader (I: uh mm) I..I. was getting better you see I've been er (.) in and out of er mental hospital all me, all my life, from the age of eleven (I: mm) before that I was in an orphanage (.) and I came home from time to time (1) because of my (.) cracked mind you see (I: mm) I got this cracked mind when I was five (.) I was I was I was er (.) I was sacrificed to Satan (I: uh mm) and Satan (touched) my mind (I: uh mm) (1) and it was a bi..big party you see (I: mm) and they'd been drawing on my energy for, my family (.) it was a big family (.) thirty eight people in all (I: mm) they'd been drawing on my energy (.) fo..fo..fo..fo.. for talent (.) cos I'm very talented (I: mm) nine talents like it says in the bible.....(lines 5-35)

Roger begins his account with a quite specific recollection of the time when he received a diagnosis, that of Christmas 1980. Roger immediately presents knowledge of the concept of diagnosis and how it relates to his experiences. Its inclusion is somewhat unusual, as it is not introduced as part of a detailed interaction between psychiatrist and patient as to the reasons behind its administration. Rather, Roger states his General Practitioner (GP) showed him a form, with the diagnosis 'acute schizophrenia' on it. This serves to frame the diagnosis as part of the administration of psychiatric care, whereby documents and records need to be produced as part of the system of care. This leans towards an understanding of diagnosis as a necessary administrative tool, rather than solely an explanatory device for people's mental health difficulties. Additionally this works to locate authority over experience to a wider scientific community, rather than on a localised scale constituted by one's psychiatrist (this theme will be taken up in greater detail in the following chapter).

The diagnosis is accounted for by the admission that Roger hears things, stated in a matter of fact fashion. An alternate non-pathological description of the things heard is immediately narrated, which serves to counter the association made between the experience of hearing things and the diagnosis of acute schizophrenia. The narrative

that is worked up is distinctive in its apparent falsity, namely talk of beliefs that the former American President Ronald Reagan personally sent a psychiatrist to assess Roger. Despite this, the detail provided serves to produce a structured, internally consistent, account of the experiences that led Roger to be diagnosed in the first place. Consider also the following extracts:

1) **Roger:** but bu..bu...but as I say (.) I..I..I.. I'm not mentally ill but (I: uh mm) I'm insane because er (.) too much devil's power (I: uh mm) that's why I'm on the drugs, that's why I'm staying on the drugs (I: ok) but Dr Henry I don't know if you've met him, not Dr Price Dr Henry he's a very good guy (.) he::s my brother (I: mm), he's also a very good psychiatrist (I: mm) (.) h..he helped me (.) grow up when I was in (.) (NAME REMOVED) Hospital (NAME REMOVED) Hospital (1) and I continued with art (.) and er (1) and there were all those who were ill (.) they encouraged me too.....(lines 51-58)

2) **Ian:** is that something that you think that God helped you with?

(2)

Roger: yes (.) yes he (.) well I mean he strengthened my mind so I (.) didn't hear things anymore (I: mm) (.) from the spirit world (I: mm) they're they're, Dr Henry says they're vistas in the mind you see (I: mm) and these open (.) when your mind is weak enough (I: mm) and you know it makes you look like like schizophrenia but it isn't (I: mm) (1) see I don't hear voices now at all (I: mm) I..I..I'm meant to be schizophrenic they hear voices (I: mm) hallucin.. (.) I don't at all (.) only from time to time I hear them from the spirit world

Ian: so do you think then that (.) so.. that schizophrenia exists (.) a..as something, as an illness (.) just that you haven't got it? (1) or do you just not agree with it (.) a..a..as a concept (1) therefore you don't think you've got it *

Roger: I think (.) I think (.) it's only a poor opinion though but (I: mm) (.) I think (2) schizophrenia maybe exists but maybe they're reaction and their behaviour is to (.) experiences in their childhood (I: mm) (.) you know er (.) poor experiences evil experiences (I: mm) or or genetic, maybe it's genetic (I: mm) (.) maybe it's both I don't know (.) they say it's (.) due to dop (.) do.. (.) do..dopamine (I: yeah yeah) (3) I think I think that maybe it is an illness but (.) also it's (.) a reaction perhaps to (.) maybe a sane reaction to (.) insa.. insa.. who

said that? (laughs) (.) you know a sane reaction (.) a sane reaction to an
insa.....(lines 137-157)

The working up of the alternative account of experiences having Satanic rather than psychiatric origins involves a delicate balance. The language used is closely related, but is reported in a distinct fashion. For instance, Roger states he is not 'mentally ill', but 'insane'. Common cultural understandings of such terms may involve a close association of both terms to a notion of mental abnormality, but the use of the somewhat outdated, in terms of psychiatric terminology, word 'insane' enables the crucial distinction to be made which marks out Roger's narrative from the psychiatric account. Several problems are involved in regard to accounting for aspects of his continued care as a service user. Firstly, as we have seen, the need to frame his experiences in an alternative knowledge formation. In addition, there are the factors that are bound up with being a service user; namely continued contact with services, and the administration of treatment.

The continued prescription of psychiatric medication poses a significant issue for Roger's spiritual account, in that it is something usually associated with treatment of experiences labelled schizophrenic. Its work in the narrative is to provide a strategy for lessening the "devil's power" that is presented as the root cause of Roger's mental health difficulties. Medication is utilised here as a means of treatment within Roger's spiritual account, which counters the understanding of them as part of the treatment for his 'acute schizophrenia'. This works to add credibility to his claim to be suffering from Satanism, not schizophrenia. Further discursive credibility is produced through the corroboration of a third party voice, that of the psychiatrist. The psychiatrist is presented as part of the alternative spiritual account through the discursive recruitment of him as a key constituent, along with God, in the strengthening of Roger's mind, which in turn lessened the frequency of voice hearing. The account is elaborated with the technical description, corroborated through framing it as being produced by the psychiatrist. The language of vistas opening in the mind is drawn upon to describe the processes through which the experience of hearing voices operated. The defence against the diagnostic identity of schizophrenia operates through accounting for the voice hearing, which is the problem event that requires an alternative explanation if the diagnostic identity is to be successfully resisted, as part of the 'vista in the mind'

explanation. This is represented as commonly symptomatic of schizophrenia, but that the diagnostic explanation is not correct in this case.

In the final section of Roger's narrative, we see some category entitlement work occurring, as Roger, having detailed his non-schizophrenic satanic account of his experiences, faces the issue of needing to demonstrate he has some knowledge of what schizophrenia is, if he is to claim he does not suffer from it. This he performs, somewhat tentatively so as to retain a distance between the category 'schizophrenia' and himself, through producing a description of schizophrenia, that attends to the complexity of the category through offering several potential causal factors in its development, namely that it may be genetic in nature, or grounded in abnormal biochemical activity in the brain.

With Roger's account, the use of a 'delusional' narrative can be seen to be a valuable and useful tool in terms of formulating an explanatory framework for mental health difficulties that enables resistance to the diagnostic identity. This works to avoid a blatant denial of diagnosis. Rather, it works to account for all the aspects of receiving a diagnosis and continuing contact with services as a user, but bound up and produced in an alternative knowledge framework.

This last extract has raised a particular concern in regard to interviewing service users. Roger's account involves the reporting of 'delusional' beliefs, which for more positivist approaches, would render it as not *valid* in terms of understanding his experiences. I would not take this view, but would argue that in terms of negotiating the challenging terrain of managing identity in light of diagnostic categories, delusional accounts work in the same way as non-delusional ones. Roger's account of his mental health difficulties being the result of the Devil rather than due to a biologically based illness called schizophrenia works, as we saw, to position himself away from stigmas associated with schizophrenia, whilst still recognising his status as someone with mental health difficulties.

4.14 Discussion

This chapter has worked at understanding service users' lives in relation to the operation of diagnosis, and the strategies users produce to discursively manage their

experiences in these terms. We saw how complex the practice of classification is in psychiatric services, with Bowker & Star's useful model for theorising the kinds of systems that exist in practice. Through analysis a sense of the kinds of classificatory knowledge users produce was developed, which itself informed that diagnostic practice built upon a Prototypical system was not utilised in users' accounts as it is in psychiatric practices. Rather, the ways users understand themselves in relation to diagnosis are multiple and diverse, and primarily operate to form manageable identities. Considering the threats to identities of those given psychiatric diagnoses, we have seen that a broad armoury of discursive tools is necessary to maintain identities that work against forces of stigmatisation.

The main problem at the heart of the naming process of service users when classifying their mental health difficulties operates on several levels. On the one hand they are faced with naming something (or not as the case may be) that is a major factor in their lives. As we have seen, some users who do not want the mental health difficulties to be a major factor in their lives, or do not want to represent them in this way, may shy away from naming them. This classification comes at a price though. If users classify their difficulties according to psychiatric definitions, then an associated stigma comes with the diagnosis. This is salient in the cases of paranoid schizophrenia and the associated perception of risk. However, what would it mean to not classify in this way, or to move away from such classifications? This relates and depends on a secondary factor, namely the way that causation is constructed by users. Some users represent their mental health difficulties as being caused by some kind of physical neurochemical problem, such as abnormal dopamine levels in the brain. This serves to construct their own illness as due to a physical problem with their bodies, rather than some kind of unspecified mental 'abnormality'. This version of causation maintains that mental health difficulties are physiologically based, rather than psychologically based. Thus, although an initial exposure to potential stigma is risked, these accounts actually function to move away from a stigmatised position, through a reductive move to neurochemical activity.

What emerges from these analyses are the intricacies and subtleties employed by users in the discursive production of classification categories. Users are faced with the challenges of becoming members of diagnostic categories that expose them to a range

of potential threats to identity. In this chapter, a range of strategies have been employed to reconstruct categories in a more identity-saving way, or to partially-own them, so as to avoid maximum exposure to the implications of such category entitlements. In the next chapter, the focus shifts to medication (a theme that then flows through into Chapter Six), in terms of the ways that users manage issues of control and agency in respect of decisions about their medication.

Chapter 5:

Orienting to Formal Psychiatric Knowledge

5.1 Introduction

The data presented in this chapter analyses how the kinds of ‘formal knowledge’ that service users draw upon operate and exist as part of their overall experiences. As with the previous chapter, it is forms of expression that are the analytic concern. Formal knowledge is used to refer to aspects of mainstream psychiatric practice, such as treatments. What is of interest are the ways service users orient to formal styles of psychiatric knowledge, and the purposes and achievements for users’ accounts that these bring. This follows on from the previous chapter in terms of illuminating how people negotiate the challenges of being obliged to pass through the psychiatric signifying regime. In this chapter we see some of the other factors that capture service user experience, which contribute to the variety of forms of knowledge that inter-relate to produce experience. In the last chapter we saw how this operated in relation to diagnosis. A pivotal area of practice that impacts on service users’ lives involves treatment, and decisions about treatments; this forms the main analytic strand of this chapter. In a sense, service users are obliged to orient to forms of formal knowledge so as to make diagnostic categories ‘liveable’. In the previous chapter we saw how users re-specified diagnostic categories. In this chapter, it is how users manage the obligation of passing through other forms of formal knowledge (expression) that is the focus.

Discussing how users orient to forms of formal knowledge raises a particular set of questions concerning how they authorise themselves as someone who can reliably speak in terms of formal knowledge. More specifically, how do users locate themselves in a position that allows them to make such claims to formal knowledge? One way of thinking about this is in terms of the nature of the ‘position’ users inhabit by virtue of the forms of knowledge and power structures in which they are understood as ‘subjects’. This raises an additional problem for users, namely, how they negotiate a position in which they draw on forms of formal knowledge from a ‘subject position’ in which they do not have the relevant expertise, as it is unlikely they have had any psychiatric training. Psychiatric professionals are seen as the experts in the field, not the people who experience mental health difficulties. This raises further questions, such

as, whether this is managed by constructing the service provision team (i.e. psychiatrist) as completely in control, or whether it is a more complex web of subjectivities that are narrated? It is the purpose of this chapter to investigate these key problems and questions.

It is not a traditional sense of subject positions that is utilised here (e.g. Harré, 1998; Henriques et al, 1984; Hollway, 1989). These have tended to consider a rather limited take on positioning, in that dominant forms of knowledge (e.g. psychiatry) position people in particular ways, e.g. as a schizophrenic, and subsequently people become *subject* to a particular set of forces that can impact on identities. For instance, a person positioned as someone with a diagnosis of schizophrenia can become the focus of stereotypes of riskiness to the general public (Coppock & Hopton, 2000). In this chapter, I would like to develop the idea of *subject positioning*, in terms of thinking of forms of positioning producing a space within which people can produce multiple subjectivities with regard to the kinds of knowledge forces that impact on their lives. Not in terms of offering multiple subject positions, as discrete points in discourse, but as considering these 'discrete' points as fluid. That is, not as static, but how they flow one into another in the complex web of forms of content and expression. They are part of the overall *process* of experience, always-already in a state of flux. In this way, rather than considering people as positioned, that is having their subjectivities defined and molded by external forces, the current conceptualisation requires a recognition of the space that is produced by external forces, within which people engage in *positioning* practices, that is they actively produce subjectivities in relation to the complex web in which their space is constituted. This works through re-organising what has gone before, into subjectivities that are functional for the context at hand. Service users face a variety of contexts, each with a different demand on their subjectivity. For instance, in consultation with their psychiatrist users may have to manage being visible as an adherent medication taker. Whilst, in an interview context (as will be seen) users face having to negotiate an identity where on the one hand decisions over key aspects of their lives appear to be externally controlled, whilst on the other hand users seek to retain a sense of agency over their own lives. Thus, a complex web of multiple subjectivities can exist, produced through both external and self-devised forces. In this chapter, it is how users construct subjectivities in relation to adherence that is of focus.

5.2 Adherence and Non-Adherence

In focusing on orientation to forms of formal psychiatric knowledge practices, the position of service users needed to be taken into account. More specifically, consideration of what is at stake for service users in relation to psychiatric practice. Contextualising effects of psychiatric practices on the non-discursive experiences of service users was important, so as to highlight the issues involved in orienting to some of the factors involved in the formal practice of psychiatry. One of the key areas in which formal practice impacts upon daily life is the area of treatment. Analysing how treatment regimens could operate and how power over changes to regimens existed primarily in the hands of psychiatric staff, become a pivotal strand in accounting for strategies relating to mainstream practice (see Campbell, Cobb, & Darton, 1998, for discussion of the 'problem' of treatment for users, i.e. issues over lack of control). As the data was analysed it began to emerge that users' own daily activity levels (in terms of their embodied capabilities) could be limited once a change in medication regimen had occurred, which could result in them no longer being in everyday control of their medication. For instance, as will be seen in the data in this chapter, changes from self-administered tablet medication to service provider-administered regimens can produce contestation over control of users' bodies. This raises the issue of control over decisions regarding medication administration. The question as to whether it would be a possible course of action for service users to refuse proposed changes to their medication administration raises specific issues of adherence. Adherence has also been referred to in literature as compliance, and both terms are still used, although for the sake of clarity 'adherence' will be used throughout in this thesis.

Adherence has long been recognised as an important issue in psychiatric treatment (Cramer & Rosenheck, 1998). Treatments are designed to improve and be beneficial, so obviously having people to whom they are prescribed actually take them, is deemed an important task. In psychiatry, focus on adherence has been strong due to the perceived high rates of incidences of non-adherence, where people fail to take their medication (Ley, 1997), or, where their regimen is not adhered to exactly, with some deviation, although not a total failure. In psychiatry, non-adherence is a serious issue because of its potential consequences (Gelder, Mayou, & Cowen, 2001). These mainly focus around a re-occurrence of 'illness', and more specifically on the actual factors that can be involved in that. For instance, a return to in-patient hospital care and/or re-

commencement of psychotic episodes (which can include perceived potential for violent behaviour).

Generally, the notion of non-adherence is associated with perceived 'risk' of the return of psychotic symptoms and the negative life experiences they can bring, if service users stop taking their medication (Buchanan, 1992). Thus, users may be told that risking any return to illness is not something they should do, and that service providers are strongly against such a course of action. If past mental ill health has resulted in admission to a mental hospital ward, then intentional non-adherence may result in a return to hospital, which some service users may resist due to the lack of perceived control over their lives that it brings. The 'stability' that medication can bring is deemed to be very important, so anything that can jeopardise it is taken seriously. This is the paradox for users, namely that adherence can bring stability, but can also involve ceding control.

Given these negative connotations, the position of users in respect of whether they can refuse proposed changes to medication regimens is a complex and difficult one. To be visibly non-adherent and remain as part of the service provision practice is not really an option, and given that all users in this study were in contact with service provision, control over their medication administration was not something that was perceived to be theirs. Thus, room for a sense of control over this aspect of their medication administration was severely limited. However, in the interviews it became clear how important for users it was to represent these changes in terms that served to construct themselves as not completely controlled by external provision, and as such the methodological and empirical focus was one of analysing the discursive strategies of users in accounting for the *dilemmas of stake* (Edwards & Potter, 1992; Potter, Edwards, & Wetherell, 1993) facing them. More specifically how do they manage their stake as 'service user' in the interview interaction, in terms of the issues involved (i.e. perceived lack of control over medication decisions) with being a service user?

Research into adherence has focused on many areas. A dominant strand adopts a preventative approach, in terms of investigating predictive variables that can lead to non-adherence. For instance, Compton, Rudisch, Weiss, West and Kaslow (2005) have analysed socio-demographic, gender and race data. Another strand has concentrated on reasons behind non-adherence with a variety of factors identified, such as side effects;

lack of understanding of illness (Torrey & Zdanowicz, 2001); difficulty in recognising symptoms (Olfson, Mechanic, Hansell, Boyer, Walkup, & Weiden, 2000); and use of alcohol and illicit drugs (Kamali, Kelly, Clarke, Browne, Gervin, Kinsella, Lane, Larkin, & O'Callaghan, 2006). Given its prominent role as part of psychiatric practice, and as a key issue for both service users and psychiatric staff, it forms a central thread through this chapter. The focus is primarily on how users discursively orient to psychiatric practice in terms of accounts of adherence, through analysing the ways that service users reflexively orient to and manage the problems posed by issues of adherence in interview context, and the ways this exposes some of the resources they bring to bear in doing this in other settings (e.g. in home environments). The next chapter will approach more closely issues of the operation of non-adherence, and how they operate as non-discursive embodied concerns in daily lives.

5.3 Constructions of Medication Administration Mechanisms

The first point of focus are parts of interviews in which users are discussing changes in their treatments, specifically the ways that medication is provided and taken. Changes to medication administration, from tablet form to depot injection are the main concern. The key difference between these administration mechanisms exists in terms of management, as the actual administration of depot injections are managed by a member of the service provision team, whereas tablets are managed by the user themselves. Through the first set of data it will be shown how users relate to decisions regarding changes in administration from tablets to depot injection, and the enforced change in management from self-management to service provider-management. As will be seen, this raises issues regarding control over medication regimens. Consider the following extract taken from an interview with Beatrice:

Beatrice: there I hated I hated everything (I: mm) (1) I even trashed some plants (.) cos I thought they shouldn't be kept in (.) in the building I thought they should be kept outside (.) and I (.) I went round knocking all these plant pots all over the place (1) and they sent (.) they sent for security and the security took me to my room (I: mm) (.) and then they said they'd have to give me some medication (.) for my actions (1) before my (.) my medication used to be in tablet form (I: mm) but now I..I have um (2) have it by injection (.) once

every fortnight (.) my key worker gives me it (at home) (.) it um (2) I think they put me on medication to make (.) I think they've done it this way to make sure (.) that I don't um (1) stop taking my medication (I: mm) so I don't come off it.....(lines 39-49)

Here Beatrice is narrating an account of a period of time spent in hospital following a self-instigated cessation of medication, due to the belief it was causing considerable pain in her legs. In this extract Beatrice's account involves a story of non-conformative behaviour in hospital as she "went round knocking all these plant pots all over the place". This unacceptable behaviour, in regard to everyday psychiatric practice in the hospital, was dealt with through the inclusion of "security", and the administration of further (in this case sedentary) medication. The narrative then becomes one that constructs Beatrice as needing to be 'punished' for her behaviour, in that she constructs an account of a change in her medication administration as brought about by her misbehaviour. She states that her medication "used to be in tablet form" but "now I..I have um (2) have it by injection". Here then medication administration by depot is constructed as a 'punishment'. Since, had Beatrice not deviated from her prescribed medication then she would not have behaved in a manner that resulted in her being sectioned and then receiving the externally managed depot administration. A similar example can be seen in this extract:

Henry: at all (.) that's tablets (.) and er (.) so I stopped taking that (.) but um (.) I stopped taking my medication and I relapsed [I: yeah] and I didn't, the reason I stopped taking it was I didn't li.., I didn't (.) I couldn't see any benefit from the medication to be honest [I: yeah yeah] and then they put me, they took me back to (ward) cos I relapsed and er (1) then er (.) changed my medication to Risperidone which I really like [I: mm] like (1) within (.) within about three or four days after being on it I was (1) my mind was focused [I: mm] (.) felt like I was in control again [I: mm] rather than (.) just sort of (1) all over the place [I: yeah] um (.) so (.) and that that's an injection °cos they don't trust me with tablets° [I: yeah] um (.).....(lines 60-69)

This extract is from an interview with Henry who is talking about a time he stopped taking his medication and then “relapsed”. This resulted in hospitalisation and his medication administration changing from tablets to depot. This construction of depot administration can be seen to be very similar to that of Beatrice. Henry constructs a narrative of willing and intentional non-adherence to his prescribed medication regimen leading to a period of time in hospital and then depot injection. Indeed, Henry actually states – albeit quietly – that “they don’t trust me with tablets”. His non-adherence is constructed as leading to a loss of trust in him by the service provision team. One consequence of this is the ‘punishment’ of depot injection and the resulting change to his medication administration schedule.

Here we see the dilemmatic nature of orienting to formal knowledge for users. On the one hand claims are made about formal knowledge, but on the other recognition exists of their position as one of non-expertise with regard to these forms of knowledge. It is the service provision team that have the relevant training and experience to understand what the effects of medication should be, not the users themselves. This problem can be seen in Henry’s extract with the three part claim “didn’t li...,I didn’t (. I couldn’t”, in which he oscillates between the personal “didn’t” and the technical “couldn’t”. The first two “didn’t” parts serve to orient to means of personal preference, i.e., he didn’t like it, whereas the third “couldn’t” part serves a form of technical language, which constructs the decision as based on more objective formulation of formal knowledge. However, Henry is then faced with the problem of recognising his position as non-expert which leads him to finish the formulation with “to be honest”, which qualifies the ‘technical’ view as one that is still personal. So here is evidence of the complexity of the problem facing users when faced with producing themselves as subjects existing in the psychiatric mesh of epistemic and power structures.

It is seen in the data then, that one way of orienting to formal knowledge is to represent changes in administration mechanism resulting through the need to punish users for deviating or non-adhering with prescribed medication regimens. Formal knowledge is consequently constructed as the correct way to take medication due to the non-adherent acts being framed in punishment – thus negative – terms. This could be argued as an indication of the ways that service providers and users see things differently. Whilst both sets appear to see the result of non-adherence to be the

'punishment' of depot medication, users seemingly face the problem of justifying their own initial punishment-inducing actions, rather than the punishment. That is, for users there is a difficulty in accounting for their original actions in terms that allow them a sense of self-control, whilst fitting into the formulation that to intentionally non-comply was wrong in the first place. Service providers do not face the same problem as they simply formulate the initial non-adherence as 'wrong'. For users though, this is a complex dilemma.

This is perhaps not a surprising finding, given the benefits provided to users if they are seen to be adhering to prescribed forms of behaviour (Misdrahi, Llorca, Lancon, & Bayle, 2002). For instance, continued care in the community rather than potential re-hospitalisation; possible reduction in contact with psychiatric services; and greater sense of autonomy. Indeed acts of non-adherence can be perceived negatively by members of users' social networks (family, friends etc.). An overarching framework exists in which users need to be seen to be positively moving away from the risky behaviour that may have led them to develop mental health difficulties and/or come into contact with psychiatric services in the first place. As was discussed earlier, the perceived 'risk' of non-adherence of both service providers and users' social networks (if they have a close set of family and friends) places pressure on users to adhere to prescribed regimens. Should they not do so then they potentially face being distanced from social networks. Thus, users often need to be seen to be engaging in mechanisms of action to prevent relapses with their illnesses. If they are non-adherent this can be seen to be risking current stable states for previous unstable ones.

5.4 Depot Medication as Beneficial to Treatment

This construction of depot as punishment is not the only representation of depot medication emerging from the interviews. In another form it exists as beneficial to treatment for medication to be administered via depot. Consider the following extract:

Ian: mm (2) so that's better now you just have an injec., well (.) that some of that's now (.) in form of (.) in in a form of an injection then

Beatrice: yeah it is (I: mm) (.) I quite like that yeah (.) I don't like having the injection though (I: mm) (.) but (.) the fact that I don't have to take it by tablets

it's quite good (I: mm) (.) plus you don't have to remember to take your tablets.....(lines 293-298)

In this extract Beatrice narrates a short account that serves to construct depot administration as unpleasant, but not without its benefits. The beneficial element is that having one's medication externally controlled reduces the chances – and lessens personal responsibility – that users may forget to take tablets at times. This section works to normalise the account, in terms of framing it at a level of everyday forgetfulness, a very normal occurrence as everybody can be expected to forget things from time to time. This extract, when related to Beatrice's earlier one constructing depot medication as punishment, highlights some of the complexity of the use of this discursive formulation by users. To highlight the potential benefits of depot injection after representing it in a negative framework serves to perform a particular job of spinning a positive light on the 'punishment' of depot.

Additionally, this serves to separate 'being compelled' and 'being adherent' as two distinct, though closely related concepts. It has been demonstrated that adherence is seen as an overarching aim of both service providers and users. However, one of the numerous difficulties facing users is the sometimes undesired associated factors that come with the adherence. Adherence has meant fitting into a prescribed set of actions, such as necessity to keep appointments and medication routines that may reduce personal autonomy over bodies and time. However, service users still seek to construct adherence as good. Thus by separating adherence from compulsion, the reduced control can be represented as negative, whilst adherence is represented as positive.

By constructing depot injection as beneficial, a follow up positive light can be placed upon depot administration that serves to represent Beatrice's current position – as receiving depot injections – as a more positive one than a framing of punishment at first allows. In the first instance, to state she was punished frames Beatrice's current state, as someone receiving depot medication, as negative. If she had not misbehaved, a change in administration mechanism would not have occurred. However, Beatrice seeks to frame this as positive, notwithstanding the negative process of punishment that occurred as part of the journey to the present. It is argued here that it is important for users to have a sense of positive thought regarding the present, as it is a key part of

their psychological make up in terms of their mental health difficulties. Recovery is seen as a progression, so it is not surprising that service users represent their current state as positive, as part of a process of recovery. This construction of depot administration as beneficial can also be seen in the following extract:

Ian: mm (2) do you prefer injections or taking *

Peter: I prefer injections I don't like taking tablets cos I think you can shy away from them like you know

Ian: mm (2) where do (1.5) you (0.5) who do (.) where do you get the injections done do you do them yourself?.....(lines 82-86)

Here Peter responds to my enquiry regarding his preferred medication administration mechanism by stating that he prefers injections as he does not like taking tablets since he believes that “you can shy away from them”. This statement is interesting in its ambiguity. To shy away from something can have a number of meanings: an acknowledgement of personal weakness, lapses of control, or failure to be responsible. More broadly, it is a comment that suggests an awareness of potential personal ability to not take medication in tablet form. His response is salient in its immediacy in terms of constructing depot injection in this way. Indeed I had not actually finished my question as to whether he preferred injection or tablet administration before he interrupted so as to state he preferred injections. This construction of preference also serves to represent Peter as an adherent user as the desire and liking of injections is borne from his underlying drive to maintain and stick to the prescribed regimen. Indeed, his awareness that there is less chance of this happening if he is prescribed tablets rather than be given injections serves to strengthen this construction of adherence. This claim is strengthened through the ‘shy away’ phrase, which constructs a sense of control. Peter was aware that he had the ability to not take medication if given them in tablet form, so was doubly keen to receive depot injections. Not only does he recognise the need to appear adherent, but is actively aware that it may not happen if receiving tablets, so affirms the presentation of depot as beneficial. Additionally the ‘shy away’ formulation works to set up non-adherence as a routine, predictable act. We tend to shy away from things that we find unpleasant, and as such it becomes quite a ‘normal’ routine thing to do if faced with such events. The medication here is acting as the unpleasant factor, and through utilising terminology of shying

away, the potential of non-adherence is constructed as a normalised, common and routine thing to happen. It is not something specific to Peter, but rather a much more generalised activity, and given its prevalence, his construction of personal responsibility over recognising its potential and avoiding it is strengthened.

The two analytic threads regarding depot medication position users as currently adherent with their medication, which can then be associated with a current active state of moving forward to maintain progression towards good mental health. In this way users are positioned as clearly focused upon being seen to be mentally stable, a perception attained through alliance with the prescribed service provision practice. So far we have seen an overall production of service user knowledge that coheres closely to formal psychiatric knowledge of treatment as needing to be taken, and subsequently leading to improved mental health. Some of the issues associated with doing this have been identified, but within an overall framework of adherence to the system of thought, posited by mainstream psychiatric practice, that treatment is beneficial for service users.

5.5 Claims to Expertise

The use of formal knowledge by users relates to the kinds of claims and counter claims made regarding expertise concerning their treatment. The discursive formulations of depot medication as ‘punishment’ and ‘beneficial to treatment’ have served to position users as positively adherent with a regimen that is deemed the most appropriate mechanism towards stable mental health. This places issues of expertise in the hands of service providers, rather than users. However, other claims to expertise were made in the interviews, and how the following representations inter-relate with the previous ones is of central interest in terms of understanding how users make sense of medication decisions. Consider the following extract:

Ian: mm (.) mm (1) what about the future then I mean (.) you say that (.) they’ve cut down your (.) um medication a bit (.) because you’ve gone from four hundred grams to three hundred grams [R: yeah] (.) do you think (.) Dr Davis would (.) continue cutting it down do you or?

Rick: I asked her the last time I was (.) she reckoned [I: mm] (1) no way [I: mm] (.) because they did a (.) she gave (.) the (.) certificate for them to (.) see a

blood level (.) of the Clozaril in the blood [I: mm] to see whether (1) they can take it down some more [I: mm] (.) now there has to be a certain amount (.) in your, in your blood stream for (.) to work effectively [I: ok] and I, now that I'm on three hundred milligrams it's (.) just a bit low [I: mm] but she's going to leave it like that (.) for the time being [I: mm] (.) but she's not going to take it down any more.....(lines 346-357)

Here Rick and I are discussing whether there is likelihood that medication would be reduced any further – it had already been reduced by twenty-five percent – in the future. The first part of Rick's response to my question is to state that he has asked his psychiatrist whether there is a chance his medication will be reduced in the future. Straight away, Rick constructs a position of non-expertise with regard to his medication. Discussion whether his regimen will be changed at any point immediately involves recourse to his service provision team. Rick goes on to further legitimate and evidence his psychiatrist's knowledge by detailing the blood test results that are used by the psychiatrist to explain why reducing medication any further is not a viable option. Indeed, not only does Rick construct an account based upon the statement that his blood test showed his medication levels should not be lowered any more, but he actually provides a scientific narrative of the workings of the blood test, further supporting the claim for non-reduction. He states that “there has to be a certain amount (.) in your, in your blood stream for (.) to work effectively”. The emphasised “has” serves to provide unequivocal evidence that his medication should not be reduced. Rick's account then is not just based on the psychiatrist stating that she does not think a reduction is workable, but in addition an objective scientific discourse of laboratory medicine is drawn upon. The privileged status of objective scientific discourse in Western culture provides these claims with a strong footing.

The use of the certificate is noteworthy in this extract. The psychiatrist is represented as operating according to normal procedure, namely measuring the level of medication in the blood and this information being relayed back to the psychiatrist through a certificate. This allows the psychiatrist to form authority through the objective evidence provided by the certificate. It also serves to represent Rick as not simply controlled by the psychiatrist, as the decision regarding medication is based upon the objective statement on the certificate, rather than solely the psychiatrist's interpretation. It may

well be that this decision regarding 300 milligrams is part of an interpretative practice of the psychiatrist formulated through knowledge of patients' history. Rick though does not frame it in these terms. He draws the certificate into a central role, which serves to introduce and relate to a series of activities that occur outside of the consultation, allowing control to be spread beyond the realm of the psychiatrist alone. Rick can perform what can be a delicate balancing act, that of retaining autonomy whilst orienting to formal knowledge, through his separation between authority (i.e. psychiatrist) and expertise (i.e. certificate).

The positioning of expertise in the hands of service providers continues from the earlier representations of depot medication. However, users interwove the combinations of discursive formulations regarding formal knowledge with alternate claims of expertise. The interviews not only contained formulations positioning expertise of medication in the hands of service providers, but additionally, claims of self-expertise were made. Consider the following extract:

Ian: mm (2) but do you, do you feel in control of your medication?

Mark: no (3) I mean they were talking about giving me er (1) certain days supply and then self-medicating then (1) they's talking about (.) I've done good with my medication they might give me the whole lot to (1) take when I need it and (I: mm) and I got I got (.) some days I get to the stage where you have (.) have have medication I wouldn't trust myself (.) cos I took overdoses in the past (I: mm) so I mean (.) I told them that (.) don't give me the whole lot cos I mean (.) I might get the urge to take them all.....(lines 301-308)

When asked whether he feels in control of his medication, Mark constructs an account drawing on the formal knowledge of his service provision team when discussing the issue of his prescribed medication. He states his provision team was considering a change in his medication administration from depot injection to self-administered tablets, which was communicated to Mark. This initially constructs an account of expertise as existing in the domain of service provision, as it is they who consider changing administration. However, Mark goes on to narrate an account of risk associated with him self-administering medication through tablets. This serves to represent Mark as the 'expert' here, as he is the one to question whether

self-administration is a wise alteration to make to his prescribed medication. This kind of deliberation and decision are part of the service providers' role, and indeed a change in administration pattern from depot to tablets in someone that had a history of suicide attempts is not something that would be entered into if there was any perceived risk of further suicidal behaviour. However, the way Mark constructs the account is salient due to his claims to expertise. He is stating that *he* had to communicate his unease about an alteration *to* the service provision team, rather than the other way round. Thus he represents himself as the person with the most appropriate knowledge to make such a decision, rather than the service provision team. The way he does this though is to draw on the formal knowledge of mainstream psychiatry, in that he constructs an account of risk associated with administration patterns, but uses this to construct himself as the expert. This kind of claim to expertise can be seen in the following extract as well:

Sarah: no (.) not now (1) they're talking about taking me off the (1) the Clopidol which I'm a bit worried about you know [I: yeah] because (.) I'm worried in case I go back to that you know [I: mm] but (.) they must know what they're doing I should think you know cos they're talking about taking me off them now so

Ian: so (.) when was the last time then so you haven't had (.) last time (.) ho..how long have you (1) n..not been having them

Sarah: no (.) they're talking about taking me off them

Ian: oh ok sorry I mean the the hallucinations

Sarah: oh the hallucinations oh (.) well since I've known Fred and that's five years I haven't had any so

Ian: ok [S: no] but they've continued with them an..an..and still are but now they're thinking that perhaps

Sarah: yeah yeah (1) so I'm a bit worried about it you know [I: mm] in case I go back

(1)

Ian: do you think (1) so you think the drugs (.) are effective then?

Sarah: yeah yeah.....(lines 147-164)

In this extract Sarah is discussing the prospect of coming off the medication she is prescribed, but then does so in a way that voices her concerns regarding the proposed change. Initially Sarah represents expertise of her medication in the domain of the service provision team, by stating it is they who consider a cessation of medication. She states that “they must know what they’re doing I should think you know”, an interesting construction as it draws on a more culturally based explanation of psychiatric expertise. She is not providing some psychiatric formulation of medication efficacy and physiology – as we have seen in Rick’s extract of talk of levels of medication in the bloodstream – but rather draws on a common sense explanation that given their position in society – as professionally-trained psychiatrists - they must have the relevant expertise. The three part formulation of “they must know what they’re doing” “I should think” “you know” is a complex performance. Sarah appears to want to appeal to something, although she is systematically vague in the way she does this. Firstly, she appeals to a common sense formulation in stating that they (psychiatrists) must know what they are doing (given the position as trained experts), then follows this with a formulation appealing to a personal perception, before falling back on the common sense “you know”. This appears to be another example of the dilemma facing users, who make claims about formal knowledge, in this case the psychiatrist’s knowledge, whilst recognising the non-expert position users hold. Additionally this works to construct a sense of autonomy, in that Sarah is seemingly willing to accept some level of expertise over her experiences, exemplified through stating that her psychiatric team “must know what they are doing”. This is a rather hedged formulation however, as it is not overly committal that they do in fact *definitely* know what they are doing. This section works to present a sense of autonomy, through only a partial acceptance of expertise over her experiences by psychiatric services. To suggest the psychiatric team have the relevant expertise through drawing on a common sense explanation, leaves open the option however, that they might not actually know what they are doing. In doing this a sense of autonomy can remain intact in the account.

Whilst this appears an eminently reasonable claim to make, it is challenged by Sarah’s own claims to expertise in the way she constructs her own worry regarding any proposed change. She stated that she believes that the drugs are effective and as such draws on an overall psychiatric discourse of medication as an effective treatment, but within this claims that she holds a position of overall expertise of her own medication

and body. Expressing concern that a relapse may occur is to represent knowledge and expertise over the experience of not taking medication. Sarah's account constructs her own knowledge of what may happen to her body if medication ceases. By stating that she is worried positions her as somebody that can make a valid claim to worry, which in turn comes from a position of knowledge. One has to know something to be worried about it. Thus, Sarah does not construct herself as entirely confident in the psychiatrist's knowledge. Rather, she is claiming an element of self-expertise, which in turn qualifies her to be worried about the proposed change.

5.6 The Problem of Agency

The line of argument regarding the constructions of depot administration as 'punishment', 'beneficial to treatment' and related 'claims of expertise' is one formed around the notion of agency. Pivotal, how users deal with notions of agency in accounts of administration mechanisms, and how constructions 'work' to solve the problem of agency. The problem of agency relates to the difficulties facing users whose administration mechanism have been changed from tablets to depot, in an attempt by their service provision team to ensure adherence with regimens. Through the formulation of 'depot medication as punishment' that was narrated in the previous accounts, it was seen how users drew upon formal knowledge of medication related to the mechanisms of action service providers engage in when faced with a user who ceases to comply with their medication regimen. Users were positioning themselves as 'wrong' for their non-adherence, and this 'error' lead to the punishment of depot injection. The issue then becomes one of agency, and more specifically how users construct a notion of agency in an account that appears devoid of any potentiality of agentic actions.

Through the delicate oscillation between the discourses of punishment, treatment and self-expertise seen in this chapter it is argued that an intricate notion of agency is worked through, despite the surface difficulties. This exists in addition to the delicate separations of adherence and compulsion, and expertise from authority. Separating adherence from compulsion is one mechanism through which users can manage the problem of orienting to formal knowledge whilst negotiating the position of non-technical expert. The separation of expertise from authority allows a sense of autonomy to be constructed through defending against the authority figure (i.e. psychiatrist) being

in total control. If expertise is represented as existing elsewhere (i.e. laboratory in the case of Rick), then users are not constructed as being totally controlled by their service provision team.

The relation between the discourses of punishment and beneficial treatment appears at surface level to be a simple one. It could be argued that users construct the depot administration as beneficial to treatment as a way of providing an alternative representation than its existence as punishment. By constructing it as beneficial they can narrate an account of themselves as actually receiving appropriate valuable medication now, although they had to be 'punished' to get to this position. This construction serves two purposes. Firstly, it allows for their current state to not just be shrouded in negative terms, as in 'punishment', and secondly it enables a sense of agency to be constructed regarding the administration mechanism.

In the case of 'punishment', the narrating of an alternative account to punishment is an important one as the positions available to users to construct their current states are limited. Briefly, the importance of being able to narrate a positive account is vital for users so as to position themselves away from the previous negative experiences of the past. Thus to be able to construct depot medication as currently positive – in that it allows for a proper medication regimen to be enacted – is valuable to users through the positioning it enables away from the initial punishment construction first narrated.

This element of agency constructed here emerges through the way that users narrate the change in administration mechanism as instigated by their own actions. Whilst in the first instance it may seem that the construction of punishment emerging from an initial act of non-adherence only serves to frame users in negative terms - as 'wrong' in some way - it is argued here that this is actually part of a complex construction of agency narrated by the users. What it allows, is for their current state of receiving proper medication in an adherent manner to be actually in part due to their initial actions in the first place. As we have seen in the extracts of Henry and Beatrice, both framed their initial non-adherence as due to a problem with their particular medication regimen at the time; for Henry he could not perceive any element of efficacy in the medication, and for Beatrice the medication was causing a lot of pain in her legs. Thus, by narrating this account of initial agency users can actually assume some control over their current

regimen – which as we have seen is framed as positive – which serves as an important function of self agency. Within the narrow range of subject positions available a construction of agency is still enacted. Indeed, given the lack of positions available and the apparent element of power exerted by mainstream psychiatric practice over users, it can be seen how important this sense of agency becomes. In the face of adversity users are still able to enact some complex notion of agentic behaviour, by representing the change in administration mechanism as due to them rather than as an act entirely in the control of their service provision team. Given the privileged position of service providers with regard to administering medication regimens, the problem of agency is overcome to a certain extent through constructions of responsibility for changes in administration mechanisms.

Another strand of this complex agentic construction can also be seen to emerge from the formulation of expertise that was seen earlier. The claims to self-expertise appear to be doing the ‘business’ of developing an adequate sense of agency through some control over the current medication regimen to be narrated. This is similar to the previous agentic construction as it relates to the issue of alterations to medication regimens and administration mechanisms. In the extract of Mark, it can be seen how a construction of agency is developed through the account he provides of the issue of changes to his medication. In stating that his service provision team have considered changing his administration mechanism from depot to tablets he first raises the issue of control over his medication – through the construction that his service provision team have the power to consider and effect changes to his medication. However, far from passively allowing this element of control to be constructed as existing entirely in the domain of his provision team, Mark actually constructs a notion of control over his medication himself. He does this by stating that he has communicated to his provision team his unease regarding their consideration of a change in administration mechanism. He accounts for this as being due to his belief that a chance exists that if he is provided with the control over his medication – an option in overall control of provision team – he could engage in suicidal behaviour as he has in the past. Given his realisation that this is an option – and one that Mark does not want to occur – he utilises some sense of control over his medication in attempting to ensure that control is not going to be placed in his hands. This is interesting as it constructs a level of control for Mark at an overarching level – that of administration mechanism – whilst resisting the option of

control at the everyday level of managing actual tablet administration. Mark's claims to self expertise enable him to be seen to be in some sense in control of his administration regimen as he is the one who has acted to ensure that it remains in the form of depot injection. This exists even though common sense tells us that actual control over his administration mechanism would surely lie entirely within the domain of the provision team, especially given a history of suicide attempts.

A similar construction is seen in the interview with Sarah where she narrates an account in which the issue of medication change is discussed along with the role of her service provision team in considering a change. Sarah states her provision team communicated to her their consideration of a gradual reduction of her medication with the possibility of cessation, and she voices her concerns regarding this. Her concerns focus around the possibility of hallucinations re-emerging should medication cease. Similarly to the extract of Mark, common sense tells us that any consideration of medication cessation would only occur in accordance with the professional opinion of service providers that psychotic symptoms would not return. Indeed, across the corpus of users in this study the possibility of a cessation of medication was only raised twice, so it can be seen how unusual this is. Sarah, however, is not narrating an account of passive adherence with any proposed change, but rather is constructing control as existing to a degree in her hands, as she can express her misgivings. Now whether these concerns are listened to or indeed would actually change the decision making process of the provision team is not really the issue here. Rather it is the ways in which users rhetorically work to construct agency as a possibility for them, and the resultant beneficial position of being seen to be in some way in control of one's administration mechanism. Indeed the issues of agency occur throughout the accounts of users.

5.7 Medication as Dominant Form of Treatment

The extracts covered in this chapter highlight the kind of mainstream psychiatric discourses that users in this study have drawn upon in constructing their medication regimens. It can be seen that the dominant mainstream discourse relating to treatment is one of psychiatric medication as the most widely used and appropriate treatment for mental illness. Users did not construct versions of treatment, such as Cognitive Behavioural Therapy or any other kind of treatment. Indeed the use of medication was drawn upon in stark exclusion of other treatments, and alternatives were not involved

even as part of a wider regimen incorporating medication. More explicit evidence of this can be seen in the interviews where the notion of alternative treatments was mentioned. Consider the following extract:

Ian: mm (2) mm (1) has any (1) has anything else ever helped?
(6)

Rob: in what respect?

Ian: well just made you feel better (.) anything else you know (.) the medication you say has helped, is there anything else you've found that's (.) helped you

Rob: er ..hh I used to take a lot of amphetamine (I: mm) and I mean everyone used to say to me (.) all the doctors (.) they knew I was taking it and saying (.) oh you'll make yourself really ill (I: mm) you'll ruin your life but (I: mm) I thought it were great at the time, I...(lines 171-180)

In this extract I ask Rob whether anything else – other than medication – has ever helped him. This question was followed by a six-second pause, before Rob asks in what respect is the question framed. Clearly, the notion of anything other than medication helping is one that is not immediate to conscious experience. It could have been that Rob had received other forms of treatment that he felt were beneficial and this would be an appropriate time to talk about them. Instead, Rob was quite unsure as to the whole notion of other things helping. I respond by directly mentioning his construction of medication as beneficial and relating my question to this. Consequently, Rob states that he used to find taking amphetamine helped, but that he was told it would not be beneficial in the long run, and as such, constructs it as something that he knows he should not have done. The further statement that he “thought it were great at the time” constructs it as something that he does not do anymore. Consider this further example:

Ian: yeah [S: yeah] (.) has it (.) have they have they changed your medication at all have they or have they?

Sarah: yeah (.) through the years it's been changed a lot (.) yeah

Ian: um (.) what sort of different things have you had then?

Sarah: Librium (1) um (1) Largactil (1) Lithium (2) Pipothiazine (1) um (DRUG NAME) (1) and (.) quite a few

Ian: yeah (2) yeah (1) what reasons do they give from changing them do they just suggest it's not working very well or something do they?

Sarah: yeah they just suggest it's not working very well and change it [I: mm] (1) if I'm depressed or if I'm (1) not well you know then they change (1) just lately they've not changed it they've they've upped the dosage you know and [I: ok] yeah

Ian: so what (.) what are you on at the moment?

Sarah: I'm on (DRUG NAME) Lithium (1) and Clopidol

Ian: ok (2) and they are (1) you're diagnosed them (.) for different (.) difficulties are you?

Sarah: yeah (.) yeah....(lines 99-115)

This extract is from a section of an interview with Sarah in which we are discussing her medication and the nature of her prescribed regimens over time. On being asked whether her medication has been changed over the years since she started taking it she states that it has “been changed a lot (.) yeah”, and then she goes on in the next line to list some of the medications she has taken. Of interest is the way medication is constructed to a certain extent as an exploratory journey. It may be that the medication users are first prescribed do not work, and if that is the case then different types of medication are tried. In response to my question Sarah states that medication is changed if it is not working, and that changes are not exclusive to actual types of medication, but prescribed dosages as well. Sarah constructs a version of medication taking as one that may involve a continued changing of medication type if previous ones are not proving effective, along with potential changes in dosage if type changes are not deemed effective enough. It can be seen that Sarah is drawing on mainstream discourse of medication as the dominant most appropriate treatment for mental health difficulties. The ways in which this is done further strengthen this discourse, as highlighted in the earlier extract with Rob. Namely, that even if medication is not effective, the alternative treatment is to try a different medication rather than an alternative treatment. Indeed Sarah's account demonstrates that even if a change in medication is not effective, then dosage altering is performed rather than treatment type

alteration. This is further strengthened through the way that Sarah lists all the names of her medication over time. She has paid close attention to her prescribed regimens and the changes that have occurred with it over time, further demonstrating how cemented in psychiatric knowledge medication is as the primary treatment for mental health difficulties. In addition, placing dominance on medication helps to reinforce the notion that mental health comes from outside in the sense that the treatment is externally provided. One could construct treatment as something that one does, for instance in the case of Cognitive Behavioural Therapy. This poses the danger that continued ill health becomes the result of personal responsibility; medication allows for responsibility to be externally located.

5.8 Discussion

The construction of treatment being predominantly in the domain of medication was one that existed across the users in this study. Drawing upon this kind of psychiatric discourse is indicative of the kind of information and practices that users are prescribed and provided with, both historically and in current practice. Namely, that medication is the single most effective and appropriate treatment for their mental health difficulties. In addition to this users have drawn upon mainstream knowledge in constructing medication regimens as needing to be adhered to, and, as has been seen from the users extracts covered so far, any departure from prescribed practices was something that occurs as a one-off and as such prescribed regimens are adhered to in the most part. The ‘problem’ facing service users in accounting for their experiences in relation to mainstream psychiatric forms of expression operates around the focal point of agency, namely how any sense of control is constructed with regard to decisions for which control is predominantly in the hands of service providers. We saw a couple of discursive strategies utilised as attempts to overcome this, or at least lessen it, which were the various ‘claims to expertise’ made and representing changes to depot medication administration, at least in part, as actively sought by service users themselves, rather than as entirely the result of a lack of responsibility of users when self-managing their regimens.

In this chapter the positioning of service users as subject to a variety of forms of knowledge has grounded the analysis. As we have seen, service users’ ability to construct accounts of their engagements with forms of formal knowledge practices are

very limited. In terms of illuminating as closely as possible, their underlying experiences however, an approach was utilised that recognises the potential of ‘re-workability’ of accounts. That is, to produce a space in which multiple forms of subjectivity can be constructed, which although limited by the social forces of positioning, still retains the facility to re-work according to self-devised discursive activity. Additionally, this production is performed through the *flow* of subjectivities into one another, rather than operating as distinct stable points. This web of subjectivities is produced through the relation between discursive and non-discursive (expression and content), that is constantly in a state of flux and change. In this chapter, it is a sense of how users’ capture this in multiple forms of subjectivity through the way they talk about their experiences. This was important for understanding how users attained forms of agency in areas in which control appeared a very difficult factor to grasp.

In this and the previous chapter we have seen a range of discursive strategies utilised in regard to issues of diagnosis and formal knowledge practices, which has involved focusing very much on the forms of discursive *expression* of service users, in talking about their experiences. In the next two chapters we will shift the focus on to the forms of content that inter-relate with discursive strategies, but which operate as part of a series of non-discursive concerns, whose production is distinct from the forms of expression that they interconnect with. The following two chapters set out to analyse how the forms of expression in the last two chapters relate to forms of content with regard to how relations of force become driven into the production of non-discursive experience. In doing this, some of the ways relations of power impact upon and shape the content of service users’ lives, along with how such relations are taken on and re-worked by users themselves. Utilising a Deleuzian Discourse Analysis enables an approach that involves describing the organisational forms of content, and how they are captured, based on the interview transcripts collected for this thesis. I will use specific concepts in order to restore the movement in experience, that is, to deduce something of the experience of being a service user through using particular concepts, drawn from Deleuze, and Deleuze and Guattari.

Chapter 6:

The Medicated Body

6.1 Introduction

The focus of this chapter is the non-discursive experience of living with mental health difficulties in community settings. In the previous two chapters we have seen the discursive strategies utilised and produced by service users to manage their experiences in relation to forms of formal psychiatric knowledge and practice. Now, I would like to shift focus from discursive strategies to the non-discursive experiences they inter-relate with, but that have a distinct set of patterns of activity. It is the forms of *content*, rather than *expression*, that are focused upon; that is, I am looking at the non-discursive operation of experiences to which forms of formal psychiatric knowledge (as seen in the previous two chapters) refer. In this chapter, it is embodied forms of content that are of interest (in the following chapter the production of the spatialised experience of service users' lives is focused on). A key lesson being that the administration of psychiatric medication, and its effects, can produce bodies as a challenging space in terms of everyday living.

6.2 Social Understanding of Medication

Medication as a form of treatment for mental health difficulties has largely been researched within a biomedical framework of producing a scientific understanding of the effects of medication on neuro-chemical factors. Thus, empirical studies of medication have been dominated by scientific exploration, rather than social scientific inquiry as to the social meaning and status of medication. In more recent times though empirical efforts have been made to address this, with, for example Gabe (1991) analysing social meanings of tranquillisers, from across a range of perspectives including contributions from economics and communication studies along with psychology and sociology; Rhodes (1984) analysing metaphorical meanings of the effects of psychiatric medication, in looking at how sense and meaning are produced by clinicians and service users when discussing their medication; and Rogers, Day, Williams, Randall, Wood, Healy and Bentall (1998) focusing on the meaning of anti-psychotic medication for people diagnosed schizophrenic.

These kinds of studies have aimed to address the dearth of literature focusing on the *social meaning* of medication for individuals. It has been people's beliefs and understandings of their medication that has been of focus. For example, Rogers et al. (1998) identified a number of reasons why people took medication, or not, which covered issues such as suppression of auditory hallucinations; requirement to be visibly adherent; or to counter effects of cannabis smoking. What these, and similar, studies have done is to address and make salient recognition that whilst the experience of taking medication is clearly grounded in biochemical change, it is far more expansive and complex than that in itself, i.e. it is irreducible to physical effects alone. Whilst each piece of research has identified a particular aspect of medication experience to focus upon, no approach so far has analysed the way medication becomes infolded into, and acts back upon, service users' experiences. More precisely, how psychiatric relations of force operate through medication, in terms of how it becomes part of service users' experiences through bodily phenomenon, and subsequently how it feeds into experience. Thus, it is not just how users make sense of and relate to medication that is under the critical gaze here, but a more fine-grained analysis is sought that analyses the role of the user in the self-management of medication regimens, along with the role of medication in the operating of user embodiment. The body becomes a site at which many relations cross and inter-relate. For instance, the power of psychiatry in terms of administration of medication, along with the role of service users to manage *their* bodies in relation to medication. It is a sense of how these factors operate that is of interest in this chapter.

6.3 Virtual and Actual

In considering the concepts utilised in this chapter, it is necessary to address the concepts of *virtual* and *actual*. These concepts refer to the notion that experience is always limited. That is, the way we experience the world through the sets of relations that constitute everyday life is necessarily selective. We see the world through circuits of action and reaction, how social processes influence experience, and how our actions feedback into these, forming feedback loops (Hacking, 1999). For Deleuze, this is entirely necessary, and yet does not tell the whole story. These circuits of action and reaction are the *actual*: that which is experienced. However, there are always far more connections between relations that are not actualised, which do not come to be organised social phenomena. To understand *change* as a reality, we have to recognise

that there is always far more potential, more connections than our particular position and bodies can apprehend. This is the *virtual*, the sense that there exists the capacity for new connections beyond those that have been formed. In every sense the virtual is immanent in the actual. What the virtual refers to is the constant and ever present potential for experience to spin off in a new direction, along a new line of flight. Until this happens, a new line of flight cannot be apprehended, as it has not yet *become*. And yet, it is firmly grounded in the actual: new lines of flight can only spin off from the socio-non-discursive matrix of the present, the actual as currently experienced. As soon as a new line of flight is experienced it is no longer the virtual, as it is then the actual. In this sense, the virtual can never be experienced. The potential though is in some sense beyond our experience, but not necessarily outside of it. A rather banal metaphor for this is the notion that ‘tomorrow never comes’. We are aware that the potential for tomorrow to arrive is present, but once it comes, it becomes today, and as such, tomorrow is never actually experienced. This is exactly why it is the *virtual*, it is the ever present *potential* for new experience.

6.4 Affect

The concept of *affect* is being used here to refer to the aspects of experience that are not directly linguistically mediated (i.e. forms of content), but, nevertheless, relate to discourse. The aim is to gain an analytic hook into the ‘felt’ tone of experience. So far we have developed an understanding of the captured nature of service user experience, through recognising the multiple reifications offered by the variety of different forms of knowledge that represent mental health. This understanding presents us with a problem - how to avoid offering yet another reification of service users’ experiences? One means through which to approach this is through drawing on the concept of *affect*, which was introduced in Chapter One. This concept allows us to talk about experience without solely re-formulating it through the myriad extant representations already available. At the heart of this is the notion of the *infolding* of social context into experience. Throughout this thesis, we have seen a number of ways that service users’ experiences are formed through the infolding of context. For instance, the experience of having a diagnostic identity is formed when service users are forced to negotiate a set of culturally prescribed meanings and categories around ‘schizophrenia’. Service users then have to re-code their experience in relation to these categories and find ways of ‘living them out’ in their own lives. In this sense

something of the tone of their experience is constituted by transforming the social and cultural context into a liveable life. Experience is then *infolded*, so that the outside (culturally derived categories) become inside (lived experience).

Affect denotes this infolding. It is precisely the *event* of bodies coming together and forming new connections. It is the colliding of previous codings, and the action of the subsequent re-codings of previous relations to form new relations. With regard to the present chapter, affect is required as a concept to illuminate some of the ways that service users' bodies inter-relate and connect with medication, and the subsequent new connections and relations formed. More than this, affect is the production of these relations in such a way that we recognise the potential for new experiences to be formed. In this way, affect is not just the infolding of context, but also the infolding of biology. It is not that biology then drives experience, but it is taken up in experience, through being recruited into various forms of experience by service users. Affect is the knot of multiple infoldings, cultural and biological.

In the following chapter we see how connections made by service users' bodies flow into the production of spatialised experience. In this way we are drawing on a Deleuzian idea of the body as not defined in terms of its form, or as an individual subject, nor even by the organs held within it (Deleuze & Guattari, 1987). Rather it is defined according to the flows of relations through which it passes and is produced. So, it is not appropriate to consider bodies as definitive individuated beings separate from the contexts through which they are produced. Bodies are the products of any "given relations of movement and rest, speed and slowness (longitude); the sum total of the intensive affects it is capable of at a given power or degree of potential (latitude)" (Deleuze & Guattari, 1987: 287). Affect is this very aspect, the potential that exists in any set of relations to shift direction, form new relations, spin off on new *lines of flight*. To understand the body for service users, we need to analyse it as a movement, a process, as constantly changing through the inter-connecting non-discursive elements that produce it.

'affect is precisely this two-sidedness, the simultaneous participation of the virtual in the actual and the actual in the virtual, as one arises from and returns to the other. Affect is this two-sidedness as seen from the side of the actual

thing, as couched in its perceptions and cognitions. Affect is the virtual as point of view.’ (Massumi, 2002: 228)

By way of an extended example let us take the cognitive model of mental health: that which purports that service users’ experiences which become labelled as mental disorders (i.e. false beliefs, hearing voices) are the result of faulty cognitions (Garety & Freeman, 1999; Maher, 1974). Somewhere along the line there is a discrepancy in perception that results in an erroneous set of experiences emerging. Service users’ experiences become captured by a cognitive knowledge framework, which claims them as its own, and negates any desire to explore alternative ontologies of experience. This is problematic, as it organises service users’ experiences in such a way that reification is impossible to avoid. Mental health experiences are taken as wholly embodied within the cognitive operations of the ‘mind’. It is perception that is given primacy: we start with perception and see that for service users a fault occurs, which leads to their mental health difficulties. What *affect* opens up is the potential to introduce change as an analytic. It de-individualises experience, through offering a way of thinking that recognises that experience is not wholly captured by cognitions, and that to make perception the starting point is problematic, as it embodies a static stability that negates movement. *Affect* enables us to avoid setting out from a static starting point of, for instance, cognition. Rather, we can think of bodies as defined not in terms of being driven by cognitive processes, but as produced according to the multiple fluid relations that form them.

The starting point for an analysis of service users’ bodies in relation to medication is to begin with the kinds of relations between bodies that form their experiences, and then to analyse how these relations work to produce forms of spatialised experience. What is required is a way of analysing how service users’ experiences are generated through an infolding of the relational contexts they operate within. How it is that social context, and the multiple forms of socio-linguistic forms of knowledge and meaning work to capture and organise experience. And, how this operates in a way that pushes commonly understood individualised experience (e.g. emotions) into spatialised settings. This works through relations of force engaging us into different *tendencies* (Massumi, 2002), which are organised patterns of experience. The potential to produce

new tendencies is an affective matter. An understanding of affect is the central hub of this process: that of framing *change*.

In laying out the concept of affect, we are considering the body in a quite specific way. Traditional theories of the body have considered how bodies are captured, and then questioned the different paradigms in terms of their utility with regard to informing about human experience. The obvious example is the Cartesian mind-body split, which has not only served such a prominent role in the way we think about bodies (Turner, 1984), but also has been the stubborn mule that so much critique has gnawed away at (Burkitt, 1999; Crossley, 2001). What all these approaches share is reification, concentrating on de-coding the body, and offering up a new coding, although they all have the body there as a factor in the first instance, however unstable and socio-historically contingent they claim it to be. Massumi (2002), following an analytic thread that takes in Spinoza, Bergson, along with Deleuze and Guattari, wants to shift focus, move the starting point. He argues that to begin with analysing the body according to the multiple grids of coding in which it is captured, however much variance exists between them, is to essentially be dealing with captured forms, with stability, however complex such stability may be. Massumi wants to start with movement and feeling, to think nothing else of the body at this stage aside from these two things, “[I]t *moves*. It *feels*. In fact, it does both at the same time.” (2002: 1). We should never lose sight of this for Massumi, to do so is to forego the ability to think *change; process*. In this chapter, the aim is to think change, and to consider how service users’ bodies are captured by different codings through the multiple relations of force. However, we also need to be aware that since change is precisely what evades capture, we will not be able to ‘see’ it directly in the data itself. Hence we will be using concepts to extrapolate or deduce change from what we can see. That is, restore movement back to experience. It is this aspect that constitutes the novelty of what I am calling Deleuzian Discourse Analysis. In addition, we will see points at which dimensions of both previous codings and new codings interchange. These occur through the production of spaces that illuminate change and process, rather than solely reify bodies without a sense of the potential of process.

6.5 The Body without Organs

Let us consider how and why Deleuze and Guattari incorporate the body as a central concept in their philosophy. They consider any set of organised relations a 'body' (this is not meant in the physiological sense), that is a set of connecting relations that form an organised system is a body. For instance, the sentence I am currently writing is a body, as it refers to an organised set of relations, i.e. words that have a common meaning connected into a structure in a way that makes sense through including relevant constituents (nouns, verbs etc). In thinking this way, Deleuze and Guattari are considering the ways that experience is bracketed off and organised into sets of cultural understood forms of knowledge. It refers to how we structure experience, not that this suggests these structures have no flexibility or flux, but that experience becomes organised into particular sets of relations that have a cultural currency. For instance, we understand the relations of a congested nose, high temperature, excessive fatigue and aching bones as an instance of an illness commonly called 'the flu'. For Deleuze, any co-ordinated sets of experience into culturally understood phenomena, is a body.

To think of the body in this way is to subtract all sense of movement and change from it. The constant potential for new connections to be formed is at the heart of Deleuzian theory. This is the problem Deleuze and Guattari faced here, namely how to restore a sense of movement and change. They argued that it is necessary to consider a body in terms of its movement, which means thinking of the potential modifications and connections the body might make. From this thinking comes the *Body without Organs* (BwO) (the term was originally used by Antonin Artaud in 1947 (1995)), which frames the potential that, despite the common sense reality we perceive of experience as organised into sets of cultural phenomena, experience is always imbued with the ability to create new connections of relations into as yet unknown patterns. For Deleuze and Guattari, that this potential exists is unquestionable, as if it did not, change would never occur. And, one thing that can be commonly accepted is that change exists (this relates to ideas of the aforementioned concepts of virtual and actual). Following on from Deleuze and Guattari's belief that philosophy's 'job' is to create concepts as solutions to problems (1994); BwO is a concept created as a way of overcoming the problem posited by Spinoza as to 'what can a body do?' (Buchanan, 1997).

Deleuze and Guattari's thinking owes much to Spinoza, and his writings on the body, which are worth briefly noting here. Spinoza's concern was essentially an ethical/political one, in that he was driven to articulate a way of thinking about allowed real change to be considered. Frustrated with the Dutch political system at the time, he sought to capture a sense of the potential for change (Negri, 2004). Spinoza defined the body in terms of relations of movement and rest. To understand change, within an ethical-political framework of urging social thought of change, one has to consider 'what can a body do?' What are the sets of relations that work to reduce or increase the body's power that are available for them? The central premise being that what is good for a body is to enter into more relations, to create new connections.

The influence of Spinozist theory is most clear in the change of foundation in thinking occurring when bodies are considered in terms of what they can *do*, rather than what they *are*. This re-conceptualisation is worked through in Spinoza's (1996) *Ethics*, and taken into the realm of inter-relations with other bodies (Deleuze and Guattari take this to consider both human and non-human 'bodies' – more will be said about this in Chapter Seven). They state "[A]fter all, is not Spinoza's Ethics the great book of the BwO?" (Deleuze and Guattari, 1987: 170). So, in asking what a body can do, we need to ask how it relates to other bodies, more specifically, how its capabilities (i.e. power) are produced through the ways it affects (both negatively and positively for Spinoza) other bodies. This leads into the concept of affect, in referring to bodies powers as affected by the connections they make to and with other bodies. More specifically, this constitutes the duality of affect as power to affect others and the capacity to be affected (Brown & Stenner, 2001).

'We know nothing about a body until we know what it can do, in other words, what its affects are, how they can or cannot enter into composition with other affects, with the affects of another body, either to destroy that body or to be destroyed by it, either to exchange actions and passions with it or to join with it in composing a more powerful body.' (Deleuze and Guattari, 1987: 284)

Deleuze and Guattari suggest bodies require a more *active* conceptualisation, which theorises the body as a much more dynamic site, constantly being (re)produced according to the territorializing forces at work. This can be contrasted with a

Foucauldian thinking of bodies which takes them as a pre-existing material, which relations of power 'discipline'. Rather than be seen in stable identities, the BwO is a site constituted by the dynamic sets of relations at work in any given context. This conceptualisation helps formulate the notion of potentiality, in highlighting the possibilities of what can happen at any given moment. That is, the idea that experience can spin off in new directions, in new patterns of capture (or *lines of flight* as they frame this possibility), Deleuze and Guattari are at great pains to draw awareness to this potentiality of new experience, rather than thinking that experience is wholly pre-determined in stable patterns by what has gone before.

It is what the body can *become* that is the concern of the BwO. In this sense, in terms of psychiatric medication, it is a concern with the way that biology is infolded into experience through the taking of medication that is of interest. As we will see, medication can have some very negative effects, but to only focus on them, without taking into account the re-territorializing forces of the body once taking medication is to conceptually simplify the experience under focus. The focus is on the body as a space and site for the inter-connection of a series of heterogeneous processes, and what forms of experience and activity can be enacted by service users. And, how these factors are managed. It is a sense of what a medicated body can *do*, in terms of psychiatric medication, rather than what it *is*, that is of focus.

6.5.1 A Viagra BwO

Let us consider Potts's (2004) analysis of the Viagra BwO. Potts sets out to investigate the kinds of bodies produced by medication given for erectile dysfunction. Her focus is on whether medication such as Viagra works to reterritorialise bodies into previous normative sexual practices, i.e. penetrative sex, or whether it works to deterritorialise habituated practices formed through mainstream concepts of masculinity (e.g. as needing to 'perform'). Potts argues that in some cases the experience of using Viagra led to the development of new experiences being formed that served a sexual function. These instances were largely existent in the cases where Viagra did not 'work' as such, that is sustained erections did not occur. What did occur though were forms of experimentation between bodies into non-normative penetrative sexual practices that were reported to be differently, but equally, enjoyable to previous penetrative practices. In this way, a 'Viagra-body' could *do* things that were not normally part of

conventional sexual practices, or indeed, the kinds of practices the drug was designed to assist people to (re)engage with. In this sense, people's bodies were deterritorialised into new patterns of experience.

In this chapter, it is the aim to illuminate the kinds of things that medicated bodies can do. That is, to analyse how medication impacts upon service users' bodies, and the kinds of experiences produced by medicated bodies. Similar questions are asked as those of Potts. For instance, how do service users' bodies become deterritorialised by medication, and do users seek to reterritorialise their bodies with the aim of re-working bodily experience in alternative ways?

6.6 The Medicated Body

Understandings of the body drawn from studies of health and illness are informative as to the kinds of embodied processes that can occur when faced with factors that can impact upon our bodies. In mental health, the process of transition from the 'unmedicated body' to the 'medicated body' is one that is associated with a different experience of one's body. For Frank (1991), bodies tend to be more consciously attended to when they encounter some form of resistance. Experiences, such as illness, can produce resistance to our everyday embodied existence. For instance, a cancerous tumour creates resistance to the healthy body, both in terms of the illness experience itself, and the associated treatment, e.g. chemotherapy. 'Normal' embodiment is thus disrupted by resistant experiences, such as illness. At these times bodies become a more salient part of daily conscious awareness. For service users, this resistance can operate through the effects of medication prescribed for their mental health difficulties. It can produce a range of negative 'side effects', which are predominantly somatic in effect. The medicated body becomes a body of illness in a more traditional sense of managing one's body in terms of overcoming (or at least lessening) somatic symptoms. Through medication the body is transformed from a 'normal' body to a vessel of *dys(ease)* (Williams, 1996), where *dys* refers to the way the body emerges into consciousness as requiring attention due to its *dys* (i.e. bad, ill) state. Side effects of psychiatric medication can produce these *dys* effects, which make the body emerge out of the subconscious automated mode of existence it primarily has normally. Leder (1990) conceptualises this as the *absent body*, which is to refer to the way that the body is largely ignored (read 'absent') in everyday experience, until something 'goes

wrong'. For service users this 'going wrong' occurs when medication is taken and subsequently extra-pyramidal effects are felt.

When addressing how medication practices are produced and experienced by service users, it soon became clear that a range of potential somatic challenges were faced, in addition to those distressing experiences labelled as 'mental' difficulties that led to them coming into contact with psychiatric services initially. Taking medication can mean service users' bodies become an active problem, in terms of physical side effects, in daily experience. It is this that results in embodiment being a central theoretical concern when considering the non-discursive experience of living with mental health difficulties. Thus, it is precisely due to the medication that users' bodies can become vessels of ill health, for which (as will be seen) users develop such intricate practices in attempting to counter the *dys* state. In a sense *dys*-ease presents a challenge to the ordered body, in that it cannot be captured in a clear set of changes. Parts of the virtual and actual are present, as *dys*-eased states engage in the potentiality of new connections being formed. Understanding the BwO can help us to understand the ways that *dys*-ease presents both actual and virtual dimensions to experience.

6.7 Accounts of Dys-Embodied States

Let us now consider some of the ways psychiatric medication produces *dys*-embodiment in service users. That is to illuminate some of the ways that, akin to a BwO, *dys*-eased states throw normalised body states out of balance, disrupting the stasis, and forming new connections that offer the body as a challenging site for users to manage. Of course, different medication can have different effects, coupled with the individual variability that exists in how effects are experienced. In this way many different forms of *dys*-embodiment operate in the relation between service users' bodies and medication. Scarry's (1985) analysis of the *The Body in Pain* is useful in conceptualising the problems in verbalising painful experiences. Language, for Scarry, has no means by which to adequately represent the experience of pain, which exists as non-discursive embodied experiences. Such experiences can be talked about, but not represented in language in such a way that exactly describes how they *feel*. Scarry (1985) talks about the experience of pain as being inexpressible in language, summed up by the argument that pain has no 'object', as it is not pain *of* or *for* something. Most

experiences that would be called conscious, or subject, have an external referent. For instance, feelings *for* something, be it love for a person or a job. Whichever, an external referent exists, which has a cultural currency in language, so we can draw on common understandings in expressing such internal experiences in language. Pain cannot share the same form of expressibility, as it does not have an external referent. Consider the following extract with Dave:

Dave: well the tablet is just a side effect tablet (I: ok) (.) because you get stiffness in your joints (I: uh mm) sometimes you get tremors in your hands (I: mm) but I've been ok (1) when I was in er (.) hospital (.) in (1) I was in (NAME REMOVED) Hospital in (NAME REMOVED) (.) um in ninety eight June, I was on (.) um (1) my injection (INAUDIBLE) and I was also taking tablet form as well three times a day (1) three tablets of two tablets I can't remember three times a day (.) that was giving me tremors and that (1) when I came out of hospital with just my medication just the injection and side effect tablet (I: mm) (.) um (1) as you can see I'm just (.) I'm (.) I'm normal now more or less, my coordination (1) um my hands have got a little bit fatter (.) I've put a little bit of weight on (.) so holding a pen and writing it's (.) it's a little bit (.) my handwriting style's changed a little bit you know (.) I'm not as neat as I used to be but apart from that I'm.....(lines 23-35)

Some experiences produced through the taking of medication are more easily articulated than others. Somatic activity that is visible to others is of course more easily verbalised. In the extract above Dave discusses how his medication resulted in him experiencing 'tremors'. These are experiences that occur 'through' the body, rather than 'in' it: a distinction concerning visibility. Experiences 'in' bodies, such as pain, prove more problematic in expressing through language, as they often are not visible to others. With visibility comes an objectivity, which allows for a common verbal register to be drawn upon. Tremors involve shaking, which when visible can be corroborated by others who witness them. Scarry (1985) argues this is what makes the experience of *pain* distinct to other forms of bodily experience which can be problematic, in terms of

producing dys-embodied states. Namely, that in the main, it has no visible referent that others can observe. Let us continue with a look at an extract from Dave:

Ian: is there more you think (.) they could do for you?

Dave: I just feel (.) twenty minutes (.) every six months isn't (.) isn't much you know (1) I feel he could ask me a few more questions (1) probing questions (.) I mean he's been very good to me he told me my libido (.) I told him about my libido (.) and he said "don't worry about it (.) it's just the medication you know we can arrange things through your doctor to improve that" (.) if you ever (.) get that far (.) if you ever get a relationship you know (2) um (3) he just doesn't seem to ask me enough questions he.....(lines 189-196)

Other affective experiences are less obvious. Dave reports on his loss of libido as a consequence of taking his medication. This is a different form of somatic issue, as it does present itself in the same visible way as tremors. It is not the same as a subjective report of an internal event like pain, as it refers to a less problematic issue in terms of immediacy and level of discomfort. Additionally, this does some normalising work, as it leans towards the emphasising of a disruption to normative function, rather than, say, balancing aberrant mental functioning. In itself it does not actually provide any somatic discomfort, but, it is equally problematic in a more social sense, in terms of providing a somatic curtailment of possible relationship building with potential partners. A further example can be seen with Henry:

Ian: but does it feel (.) different to the (.) original medication you were on?

Henry: yeah I didn't like that it (.) that just made me feel dodgy [I: yeah] (.) I took that and it (.) it made me feel ill (.) and I did moan about it but I didn't moan very loud [I: mm] um (.) and they're always like "oh we don't like changing medication" anyway (cos they like) to (.) see how (.) c.. and it seemed to be working but (.) I just didn't (.) it just made me feel really ill (.) um (.) like ab..about about forty-five minutes after I'd take it I'd (.) virtually pass out and fe.. (.) and feel like I was going down with flu [I: mm] (.) and I'd go to bed (.) and then I'd wake up in the morning (.) and feel a bit better but (.) I just (1) I

just didn't like the way i::t (.) it made me (.) it made me feel at all.....(lines 83-92)

The experiences of Henry relate more closely to those that are not visible to others, and, as so, are more difficult to objectify. The use of words such as 'dodgy' act to present the underlying experiences as problematic, but do not specify their exact nature. Some of the somatic problems experienced through taking medication have the same problem as that of pain. They have no external referent, and as such, service users struggle to describe them in language. This is a good example of the distinction between forms of content and expression, and the irreducibility of either one to the other. The content of somatic discomfort cannot be entirely captured in the expression of describing such experiences. This leads to the use of non-specific words with common understanding as some form of negativity, a problem. Henry's use of the word 'dodgy' performs this. To feel dodgy, is to have a negative somatic experience, one for which no external referent exists. But, at least it can express that somatic difficulty exists, even if not adequately enough. In the following extract with Graham some of the sensory language used to attempt to express pain is seen:

Ian: yeah (1) what about (.) have you ever had any (3) well we sort of (.) mentioned it earlier on you know what sort of side effects (.) do you think you've had then have you? (.) think have been caused by your medication (.) have you had things that you think may have been caused by your medication or not?

Graham: um (3) when I was on the Chlorpromazine (.) my skin used to burn and I used to feel er (.) like a tingling in my legs and it was ever so bad (.) like a er a (1) restless feeling (.) in my thighs [I: mm] on the Chlorpromazine [I: mm] (1) er they gave me Procyclidine for that but (1) um (1) they eventually put me on (benshexal) [I: mm] which stopped the er (.) restless feelings [I: mm] but my sk..skin (.) still used to burn [I: mm] (2) but they gave like a (.) cream to put on and that but [I: mm] but I didn't really (.) like it on my fa.. (.) you know skin and that.....(lines 231-243)

Efforts can be made to specify somatic experiences, beyond the common claims of 'dodginess' and such like. In the extract from Graham above, we see attempts to

express the *sensory* nature of experience. He states that his skin used to ‘burn’, and he felt a ‘tingling’ in his legs. Despite their invisibility as events, they are given a representational value through the metaphors used. Scarry, in discussing the McGill Pain Questionnaire, highlights the utility of the three dimensions of word use to describe pain. These being temporal, thermal and constrictive. We can see examples of two of these in Graham’s extract. In talking about how his skin *burnt*, a thermal dimension is drawn upon, which could include other words such as ‘scalding’ or ‘searing’ (Scarry, 1985). Dimensions of heat are understandable to others, and as such facilitate others to comprehend, to a degree, the discomfort felt.

Graham also draws on the temporal dimension in using *tingling* to describe discomfort in the legs. Tingling is temporal as it refers to a rhythmic pattern of feeling: a tingle is a repetitive multi-layered lightly felt ‘on-off’ sensation (Scarry, 1985). In trying to find ways of objectifying somatic difficulties, the use of thermal and temporal dimensions is seen to be effective. In doing this, it is concerned with the loading up of sensation into discourse. In this sense, it is capturing affect, ordering it into patterns of socio-linguistic knowledge, although, as we have seen, this is not a simple task.

6.8 Functional Aspects of Side Effects

Previously we have seen attempts to represent and express aspects of the somatic problems brought on by taking medication themselves. For instance, the sensory nature of ‘side effects’. In this section, we see alternative methods used, which focus on the functional aspect of side effects, rather than try to express the internal nature of experience. Here we see a different relation of forms of content and expression:

Ian: was it all in this country was it?

Rick: yeah (1) well the same tablet that they gave me in South Africa (.) [I: oh right} when I told Dr Davis about it she says yes but when I told her I was taking twenty five milligrams she said (INAUDIBLE) [I: mm] it won’t help you [I: mm] (.) you need to have more [I: mm] so she put me on (.) I think it was a hundred and fifty milligrams (2) a day (.) and I was on that for what (.) round about three weeks [I: mm] and then I saw her again and I (.) told her no (.) I’m still, so she changed the medication (.) and then I couldn’t blummin (.)

my fo.. (1) I couldn't sit still [I: mm] for two minutes [I: mm] my mu.. muscles and everything went (.) I had to get up and walk around [I: mm] (.) whether it was in the house or in the street it ju.. (.) I just didn't stand still [I: mm] (2) and then she'd sa.. (.) then she reckoned no (.) they've got a new medicine, Clozaril [I: mm] but (.) they have to (1) watch me at er (.) (NAME REMOVED).....(lines 195-208)

In describing his somatic problems, Rick reports that he could not 'sit still', that he had to 'get up and walk around'. In doing this Rick is representing some form of somatic issue which leads to a constant agitation, making bodily rest difficult. A new form of embodiment is produced, in which rest is made a difficult state to achieve, a *becoming agitated*. Rick experiences an agitated body, one constantly in need of movement. This is very troubling for Rick. Bodies require rest as part of daily existence. If rest cannot be had, additional somatic problems will be experienced. The medication produces a body that can only *do* agitation. Rick's body is territorialised by the agitation brought on by medication. This is a time where dimensions of both actual and virtual are presented, the medication captures the body through agitation, but Rick is unsure what kind of connections this agitated state will lead into.

In this section a variety of ways in which service users' bodies are transformed into dys-embodied states by the medication they are administered have been highlighted. This provides a pretty straightforward account of the effects of coming into contact with psychiatric services, and the subsequent treatments that can be applied. One could conceptualise this as the product of psychiatric power at work. Psychiatrists hold the power to prescribe, which they practise *upon* service users who are diagnosed with mental health difficulties. In a Foucauldian sense, their bodies are physiologically inscribed by this power. One can think of this in terms of the punishment given in Kafka's (1992) short story *In the Penal Colony*, in which the bodies of the condemned are inscribed by needles, so that their status as criminals is actually etched onto their bodies. Running water washes away the blood so that inscriptions are visible, relations of power and discipline somatically marking out the punished. Thus, the body needs to be conceptualised as more than just a 'docile body' controlled and positioned by the

dominant institutional power relations. The various forms of dys-embodiment are the visible markers of the inscription of power.

Foucault's notion of inscription is a useful and valuable one, but it focuses on power in a one directional way: power *on* bodies. In the following section we will see some works of resistance. Conceptualising the body as a 'body resistance' allows for illumination of the ways that the body acts as a site at which resistance operates. Not to be thought of as purely resistance of power, thus negating any of the products of the power. These are only too obvious in the forms of dys-embodiment previously seen, as enacted by the 'power' of the medication on users' bodies. Resistance is to be thought of in terms of 'experimentation'. Namely, the ways that the body is experimented with to form and enact alternative 'modes of being'. And, specifically how these operate and are produced with respect to medication. Additionally, Scarry's ideas about the inexpressibility of pain and somatic factors feeds into the overall conceptualisation of this thesis: that forms of content, in this case, the somatic pain, are distinct from forms of expression, in this case, how people talk about the pain. It is not just the case that pain is challenging for expression because it has no external referent. This is part of the problem in drawing on common systems of thought as to how to talk about somatic factors. It is also problematic as it is not possible to purely represent pain in forms of expression. Somatic experiences are distinct experiences that cannot be merely represented in talk. That is why service users struggle to adequately account for their somatic feelings.

6.9 Somatic Challenges of Managing Adherence

We now turn to medication regimens. That is, the kinds of practices that are involved in the management of regimens on an everyday basis. The extracts seen below are taken from sections of interviews in which users were discussing their day-to-day practices of taking medication. Let us begin with a narrative of a reasonably straightforward regimen:

Ian: has it always been easy to remember to take it and \ things like that

Malcolm: \ oh yes, yeah that's another problem is a lot of people can't (.) have great problems trying to t.. trying to take their tablets they have to take (.) I don't I never have (I: mm) (1) I've always, always, about the forty years I've been in I never had any problems taking the tablets, you'll find that a lot of people that have problems (.) a lot of people who come out of hospital (.) well (1) completely forget to take their tablets when they've had their tablets and course then they're ill again (I: mm) um so you know that's something that I (1) fortunately I've never had to worry about that (I: mm) cos I've always been very, I've always been very (1) conscientious about th..th..th (.) when I took the tablets I was told to take I took them (I: mm) when when th..they asked me to take them yep.....(lines 303– 315)

The managing of everyday regimens has never really been an issue for Malcolm. He has always been able to remember to take his tablets, and states that in 40 years he has never had any problems. He does though recognise and acknowledge that difficulties can arise in remembering to take medication on a day-to-day basis. He states that a lot of people do have problems. Indeed, he gives a reason for this in suggesting that problems are often related to times when users come out of hospital. This appears to be a logical point given that users do not have to worry about when to take medication in hospital as it is wholly managed by staff. The section of overlapping speech at the beginning of his response is salient as it indicates his eagerness to respond to my enquiry. This eagerness could be seen as indicative of the importance of the issue to Malcolm. Additionally, Malcolm does not provide any real detail as to the actual taking of his medication, but just states that it is not an issue.

This demonstrates that adherence is closely associated with the body. Malcolm has not had problems maintaining adherence, and has also not had periods in which he has experienced severe physical side effects. His body has largely remained an *absent body*, in that close monitoring was not, on the whole, necessary. His medication has been satisfactory for him, and as such, he has been happy to remain adherent.

Whilst the above extracts evidence how maintaining regimens can be straightforward and not problematic, this is not the case for all users. As Malcolm intimated, many users do have problems remembering to take their medication. As has been seen, failure to take medication can result in quite severe effects, in terms of very negative somatic effects. The following extract indicates how problems can be experienced in regimen taking:

Ian: what sort of, what times of the day do you take them?

Ben: um morning and night (.) before I go to bed

Ian: ok (1) do you ev.. (.) and that's easy to remember and stuff, you never forget it do you?

Ben: I do forget it yeah (I: do you) but my m.. (.) I live with my mum (.) so (I: ok) she generally reminds me but I forgot it a couple of times (I: mm) (.) if I lived on my own (.) I'd forget it all the time and I'd be ill (I: mm) so

Ian: what (.) wh..what do you think (.) makes you forget it then?

Ben: I don't know, just general forgetfulness, I do forget things (I: mm) (.) I've got a terrible memory (I: mm) (2) (I: mm) short-term memory anyway, my long-term memory's alright (I: mm).....(lines 349-359)

For users that experience difficulties in remembering to take medication a variety of aids can facilitate the easing of such difficulties. For Ben his prescribed regimen dictates that he take his tablets in the morning and at night, before he goes to bed. Ben incorporates his regimen into his daily domestic activity, such as taking the night tablet before he goes to bed. However, this strategy is not wholly effective for Ben, as he states that he does forget to take his tablets. He attributes his forgetfulness to his poor short-term memory. It is Ben's mother that operates as the 'safety net' to 'catch' any failures in regimen adherence. Ben states that he lives with his mum, and that she generally reminds him. Even so, there have still been occasions where he has forgotten, a couple of times, but this is not enough to represent a severe problem. In this case Ben is fortunate to have his mother present to aid in his medication taking. He lives in his family home, so he has the presence of other family members to support him. Ben's medication regimen is formed through a different set of relations within a family relationship, i.e. his mother, through which his regimen is produced, rather than the

non-discursive factors seen in the following extract with Dave. This is an example of how people can be recruited as *mediators* in action. For Ben, his mother becomes a mediator in the action of his medication regimen. This exemplifies, as Vygotsky (1962; 1997) pointed to, how cultural contexts (i.e. other people) mediate our actions. The overall operation is constituted through a set of relations, primarily those between Ben, his mother and medication. Mediation is not only something performed by other people though, as physical objects can also become mediators:

Ian: has it ever been difficult then to remember or (.) has it ever been difficult to remember to take your medication?

Dave: no (.) that's no problem (.) I've got an appointment card (.) and um (.) my tablet bottle says take one every evening (1) it's not a problem now (.) I've just (.) I've got a routine (.) before I have a sh.. (.) my evening (.) after my evening meal or before my evening meal about six o'clock time (.) I go and have a shower (.) and before a shower I take my tablet (I: mm) (2) just a routine I'm in I (.) it just (.) automatically remember it now.....(lines 66–73)

Dave here details how he has no problems in remembering to take his medication. Maintaining his regimen is aided by the use of an appointment card, and the label on the tablet bottle that states the daily requirement of medication. His ease of adherence is further aided by the incorporating of his regimen into the mundane activities of everyday domestic activity. In this case, it involves the link between having his evening shower, which he does at around six o'clock, and taking his tablet before he showers. This routinisation of regimen contributes to the maintenance of his regimen. This extract also highlights how medication practices are produced through a set of relations involving both human and non-human factors. In Dave's case this involves the appointment card and tablet bottle. Dave's remembering to take his medication is not solely an act of cognitive processes. Remembering becomes part of a social rather than cognitive practice. The non-discursive factors of the appointment card and tablet bottle become constituents of the remembering process. They are not distinct from the operation of memory at work in Dave's medication practice, but are part of the set of inter-connecting relations that constitute and produce the memory practice. In this way,

memory is as much part of the non-discursivity of the appointment card and tablet bottle as it is Dave's cognitive functionality (Middleton & Brown, 2005).

Here we are drawing on Latour's (1987) concept of *mediation*. By this we refer to the role that objects play in the operation of medication regimens. Objects *mediate* the relationship between the subjects (users) and the aim/goal of the relationship (the regimen). Dave's regimen is mediated by the non-discursive factors that make up his regimen, e.g. appointment card, tablet bottle. These factors inter-relate with Dave to enable the regimen to work. Crucially, it is not just Dave's actions that manage his medication that defines his regimen, but it is actually produced through the inter-relating of multiple factors, both non-human and human. In this sense, some of the work of maintaining the regimen is delegated to the tablet bottle and appointment card, they become the *actants* that facilitate operation of regimen, in terms of *enrolling* Dave into an adherent regimen (Latour, 1999). By way of a further example consider this extract of Sarah's:

Ian: yeah (1) is it (1) I mean is it (.) cos it seems so many I mean ho..how many do you have to take (.) is it easy to like remember to take them and?

Sarah: well I have one of those dispensers [I: oh] you know (.) box where you (put them in)

Ian: (is that like a) (.) it's like an A4 size box isn't it (.) [S: yeah] and you put them in and you open it up and it has them all [S: yeah yeah] does that (.) have they always been do.. (.) they haven't always done that have they?

Sarah: no (.) no

Ian: but is that easier to do it like that?

Sarah: it's easier to do it like that yeah

Ian: so that's so (.) yo..you're fine (.) sorting that out yourself and stuff

Sarah: yeah (.) yeah.....(lines 125–136)

For Sarah, remembering when to take her medication is not really an issue. She has been provided with a medication dispenser, which houses her medication in sections according to the time and day of when she has to take it. This dispenser then acts as a

key facilitator for Sarah to maintain her prescribed regimen. The dispenser acts as the overseer, regulating and producing adherence to regimens. Sarah states it is easier to receive medication in this way, and she reports that dispensers are often used in cases where service providers perceive users may have difficulties in remembering to take medication.

Sarah's practice highlights the importance and role of non-discursive (in this case referring to non-human) factors in medication regimens. We can see how the medication dispenser is a key part of the factors that make up Sarah's regimen. In doing this, it becomes the means through which the regimen is enacted. Without the dispenser, the regimen would face the potential for failure. The control of the regimen, that which keeps it in place, is that of the dispenser, with its departmentalised holes for different days and times. The power of the psychiatric practice flows through this dispenser, each hole providing a space through which power flows before inscribing itself both on and in the body, capturing *affect* according to such relations of force. The holes for different times and days play a pivotal role in enacting the regimen exactly as prescribed. Prescriptions often state something like 'take four a day', but the structure of the dispenser means that the specific times each day are set in place within individual spaces for each tablet required at the specified times. Any kind of experimentation is guarded against in the design of the dispenser. In this way the dispenser *enrols* (Latour, 1999) the user into a particular practice, in which the dispenser plays a central role of mediating the regimen. It is not just Sarah acting *with* the dispenser in operating her regimen, but the dispenser itself enlists her into a particular practice, which in this case is adherence. The dispenser plays an *active* role in the production of the regimen. The process of remaining adherent is delegated to the dispenser, with its compartmentalised categorisation, that dictate at what times of the day each tablet should be taken. It becomes an active part of the network of factors at work in the operation and production of an adherent regimen, through acting as a pivotal part of the coding of experience through the circuit of action-reaction produced through the relations of psychiatric force at work in the administration of medication.

The extracts in this section have highlighted the variability in ways that users maintain adherence to prescribed regimens. Although problems are not faced by all users, if some do experience difficulties in remembering to take medication then there are often ways to help them (e.g. family members, medication dispensers). As was seen in the previous chapter though, for some users adherence to regimens is not acted towards, and we have seen some of the consequences for users of non adherence.

The previous section highlighted forms of absent body, whereby daily routines and activities of medication were not overly troubled by physical effects of medication. This largely meant that adherence was not threatened by unwanted somatic factors. The following section illuminates the concept of the experimental body: two analytic strands will be focused on. Firstly, the production of the experimental body in relation to adhering to medication regimens; and secondly, with a concern about the body more generally. Here, somatic factors play a more prominent role in adherence, with a variety of strategies developed in manifesting what medicated bodies can do.

6.10 Tailored Adherence

As was detailed in the last chapter, adherence has been a long-term concern in psychiatric practice. Service provision has been strongly advocating of users being, and remaining, adherent. Indeed, in many cases adherence can be enforced, if in individual cases that enforcement of treatment is seen as a necessary requirement for the best interests of the user, which often incorporates considering the best interests of those around the user as well. In this chapter, an analytic thread developed throughout the data which indicated particular forms of *tailored adherence*. That is, when users adhere to their prescribed regimens in terms of taking the daily required levels of medication, but develop their own daily practices. In the previous sections the focus was primarily on the ways medication acted as a territorialising force through capturing the form of content of service users' experiences of embodiment in a quite straightforward manner. In the cases that follow, adherence, and *territorialisation*, become a more complex problematic. An example of tailored adherence can be seen in the extract with Roy:

Ian: how how um (1) how (.) how often do you have to take that then?

Roy: oh I take it every day

Ian: yeah (.) on..once a day or (.) twice a day?

(1)

Roy: supposed to take it twice a day but I always take it in the evening [I: ok] I'm supposed to take four in a da.. (.) in a day [I: yeah] but because I take other medication as well (.) I..I..I sort of limit that to the evening [I: mm] and the rest of the ones I do in the morning [I: ok] so it (.) sort of evens out in the same way [I: yeah yeah] (.) I know you're not supposed to do that but [I: yeah] (1) but it does what it's supposed to do for me anyway

Ian: so do you kind of (1) um (.) how did you kind of work out that that was the best way to do it for yourself?

Roy: well I noticed (.) I was doing that for a while [I: yeah] (.) and while I was doing that I thought (.) I don't think it really matters (1) so lo.. so long as I'm taking the four a day you know what I mean [I: yeah] Clozipan (.) and er (.) while I was doing that I found that it didn't really make much difference [I: yeah] (.) so long as I was just (.) taking the same amount of medication

Ian: so had had you (.) had you like previously (.) taken them in the morning and then in the evening or whatever like (.) like perhaps the (.) CPN would say to do or something

Roy: (INAUDIBLE) I was keep getting confused when I was taking them that way (.) when I found my own way of taking them [I: sure yeah] (.) it was it was doing the job [I: yeah] if you know what I mean.....(lines 201-223)

In this extract I ask Roy how many times a day he has to take his medication. He states that he is “supposed” to take it twice a day, according to his prescribed regimen, but that he actually takes it all in the evening. He goes on to detail his total daily tablet intake – “four in a day” – and adds that he takes other non-psychiatric medication as well. This results in him taking a large number of tablets on a daily basis. Indeed, it is this very fact that has led to Roy being confused about what tablets he is supposed to be taking, and when. He states that he “kept getting confused” when he was taking them, and that when he found his “own way of taking them”, it resulted in a regimen that he could adhere to. He only felt confident and not confused about taking medication when he developed his own regimen practice. In this way, Roy adheres to his daily prescribed regimen of taking four tablets a day, but how he actually takes them during the day is regulated by his own practice. Thus, a notion of *tailored*

adherence is a useful and valid conceptual framework under which to detail such practices. This notion continues in the next section, but in a wider form of addressing in greater depth the reasons why tailored practices are felt to be needed by users, along with relating to user embodiment.

Roy's experimenting with his regimen created a less confused and troubling regimen. This was not solely due to somatic factors, Roy does not report experiencing physical side effects as the reason behind his experimenting with his medication. It was more driven by the confusion caused in attempting to maintain a regimen as it was prescribed. In experimenting however, somatic issues were prominent, as he states that he noticed that in trying his tailored regimen, "it didn't really make any difference", demonstrating a sustained period of somatic monitoring, during which no severe negative physical effects were experienced. The territorialising forces at work on Roy's body are a combination of those of the medication, and the way it infolds on experience and acts back upon it, along with self-directed forces of Roy himself, with the latter working as reterritorialising his body into a captured pattern of ordering.

Additionally, times of experimentation operate as points which present aspects of both actual and virtual dimensions to experience. They are territorialising experience through re-working previous codings (the prescribed regimen) into new codings (self-devised regimen). Periods of experimentation with the body demonstrate how the power of the psychiatric treatment is re-worked through an active period of self-devised activity, in which Roy develops his own practice of medication taking. The relationship changes then, from the body as inscribed in entirety by the medication, to a form of embodiment enacted through the relation between medication (power *on* the body) and power produced *through* the body's self-directed actions.

In this section a greater exploration of the development of tailored adherence practices will be undertaken. This is because they form the opening to a wider set of issues relating to both users as agentic beings, in terms of managing their difficulties on a day to day basis, and also how this relates conceptually to the overall everyday production of user embodiment, which provides key examples of offerings of both the virtual and actual. These two factors inter-relate, and can be seen to be evident in relation to medication regimens. This evidences that users do not just passively receive

medication and take no role in the management of it, but rather play a key active role in their medication regimens. Consider here the extract of Rick:

Ian: ho..how many times do you have to take it a day then?

Rick: I'm supposed to take it (.) in the morning [I: mm] (.) and at night (1) but if I take it in the morning (1) two hours after I've taken it I'm fast asleep again [I: mm] for another three or four hours [I: mm] and I take it at night and I'm (1) passed out until (.) bloomin [I: mm] (1) ten o'clock in the morning [I: mm] so I take them all at night [I: mm] (.) have a decent sleep, when I wake up I stay awake(lines 229-236)

In this extract Rick describes his daily medication regimen. After I ask him how many times he has to take his medication a day, he states that he is “supposed” to take it twice a day; in the morning and at night. However, he goes on to say that this prescribed regimen is not how he actually takes it. Rather, he takes them all at night. This is a further example of the tailored adherence we saw with Roy. Rick then maintains his prescribed regimen in terms of taking the correct amount of medication on a daily basis, but does so according to his own individually tailored practice of taking them all at night, rather than twice a day. What is of interest then is the question as to why Rick has felt the need to develop his own tailored practice.

What Rick has done is to develop his own regimen, based upon his own embodied experience of his prescribed regimen. He has sought to re-capture his experience, reterritorialise and transform it, from the actual state produced by his medication regimen, through a period in which forces of actual and virtual were present (the experimental stage in which the outcome, in terms of body state is not known), to a changed reterritorialised actual. Over time, he has worked out for himself that if he took his medication at the ‘right’ (as defined by the service provision prescribed regimen) times - once in the morning and once at night - then this has quite severe somatic effects in terms of impacting upon his everyday activity level. These negative physical effects are the catalyst to experimenting with alternative regimens, in the hope of lessening the impact of the somatic factors. Indeed, when adhering to his prescribed regimen his activity level was very low through the day. Rick states he had to go and

sleep for “another three or four hours”, only two hours after waking and taking his morning medication. Rick’s day was then severely disrupted by the somnolence, which grossly restricted his level of everyday activity. This experience led him to experiment with medication, through trying different strategies of regimen practice. This *tailored adherence* led him to discover that if he took all his medication at night, he then has a “decent sleep” throughout the night, and subsequently when he wakes up he “stays awake”. What we have is a form of *active experimentation*, through which Rick is able to maintain a more satisfactory level of daily activity than when he spent so much of the day in bed asleep. On a daily basis, it is often required of users to attend very closely to somatic factors, as it is only through enacting an adequate level of somatic state that users can function daily. Were Rick not to have developed his own regimen, his level of everyday activity would be much lower, consequently affecting his ability to function 'normally'.

Roy’s extract also highlighted the close monitoring of their bodies that users undertake in the development of everyday medication practices. It can be seen that through mindful attending to somatic factors, detailed regimens are self-produced. Roy “noticed” through experimentation that “it didn’t really make much difference” if he continued with his tailored practice of taking all his medication in the evenings. He feels that as long as he is taking the prescribed daily amount, it is not an issue if he administers it all in one go, rather than twice a day. Similarly to the account of Rick, Roy’s self-management practice was built upon a prolonged period of closely attending to and monitoring his body. His close monitoring of body state operated for a sustained period of time, as he states that he was monitoring his body state whilst he tried his own regimen practice “for a while”. It was through detailed somatic vigilance that Roy was able to identify and make decisions regarding more effective ways to take his medication. His concerns were different to those of Rick, in that it was not reported to be a severe somatic factor – such as sleeping through the day – that led to Roy experimenting to identify a more productive practice. Rather, it was to reduce the confusion brought about by trying to remember all the separate administration schedules of his different (both psychiatric and non-psychiatric) medication. However, the same close attention to bodily state was required to achieve the desired goal, and his self-management practice served a second purpose as well. Namely, to reduce the

confusion caused by attempting to adhere to the prescribed 'twice a day' regimen. Whilst Roy was undertaking the prescribed practice he was getting confused, and finding it difficult to maintain active adherence "when he was taking them that way". Rather, for Roy, when he devised (through experimentation) his own tailored practice, he found maintaining his regimen far easier. Indeed, Roy states that when he was taking them his way, "it was doing the job".

6.11 Medication and Stimulants

So far, the close monitoring of body state, and development of self management practices has involved the administration and taking of psychiatric medication, be it the 'main' treatment or side effect medication, or both. We have seen that users can enact adequate body states on an everyday basis through development of these strategies. However, this has remained within the framework of psychiatric medication. For some users, managing their bodies on a day-to-day basis requires the inclusion of additional factors. Namely, the use of alcohol, and illegal drugs. It is widely reported in the literature that many users have had - or continue to have - problems with alcohol, tobacco, recreational, and other illegal drugs (Owen, Fischer, Booth, & Cuffel, 1996). Whilst many users remain adherent to their prescribed regimens - or tailored adherent - and the often present stipulation that alcohol and other drugs should not be taken whilst on psychiatric medication, for some this is not easily achievable. When such factors are present in daily life, they become as much a contributing part of embodied experience as the psychiatric medication. Consider the following example taken from a male service user (Mark) who has been diagnosed schizophrenic and received anti-psychotic medication for a number of years:

Mark: well it did at the beginning but (1) it's (1) my body's (1) my body's got used to the medication now (I: uh mm) cos I took it for th.. that long time (I: mm) (1) the Tem (.) Temazepam was helping me sleep in the (INAUDIBLE) but (I: mm) cos it's a muscle relaxer, relax (1) helps you (.) helps you (.) helps you to relax (.) do you know what I mean (I: mm) I was mixing it with drinks and that (I: mm) (2) and then (.) just to get that buzz to keep me on that level and (1) then they (.) just (.) they wrote me.....(lines 233-240)

After being asked about the effectiveness of his medication, Mark states that it worked at the beginning, but that his body has now got used to it. In other words, he has monitored and evaluated how his body reacts to medication over time. Mark has constantly monitored the relation between the medication and his body ever since it was first prescribed. The question then becomes one of how has he managed his medicated body on an everyday level? Mark goes on to demonstrate that somatic self-management can involve periods of active experimentation of mixing medication with other drugs, both prescription and non-prescription drugs, to try to “keep me on that level”. Thus Mark has an idea of where he wants to be, namely “on that level”, and this corresponds to a particular affective state from which he can attain an adequate level of functionality in terms of day-to-day life. It demonstrates how important issues of embodiment are to Mark, and also how the development of active embodied practices is important in everyday management. For Mark, this involves a delicate balance of medication with other drugs (e.g. alcohol) to enact and subsequently maintain a bodily state that allows for adequate engagement with life on a day-to-day basis. This monitoring is required on an everyday basis, and this emphasises its constant re-worked nature. Mark has to actively manage his body every day in a continual embodied negotiation between drugs (both prescription and non-prescription) and his body to attempt to enact an adequate state of functioning.

Through analysis covered in this chapter it can be seen that users’ everyday management can involve developing individual strategies and practices that produce a somatic state that enables a 'normal' level of bodily activity to be attained. Through the data analysed it can be seen that service users have a range of self-management techniques regarding the management of medication, which evidences the conceptual argument being made theorising service users as ‘active bodies’. Users demonstrate an active engagement with their bodies and medication through periods of experimentation, in which they try new ways of attempting to maintain satisfactory levels of bodily activity, through closely monitoring the effects of different strategies of taking medication. It becomes clear that the administering and managing of medication regimens is not as straight forward as it first appears. As has been seen, for many users the practice of regimens is quite easy to maintain, and consequently borders on the mundane. However, for many others, regimen practices can involve the

development of individually-tailored strategies. Forces of resistance are implicated in the production of user embodiment through reterritorialising body states initially produced through the relations of power that administer the medication, which infolded on user embodiment in a variety of, often negative, ways.

6.12 Somatic Management

Throughout this chapter I have sought to analyse the relation between forms of content and expression, with regard to the content of users' bodies, and the forms of expression that are at work in the prescription and administration of medication. The term *somatic management* is used here to conceptualise the multi-faceted ways that service users manage their bodies on a day-to-day basis, and a concept that links content and expression. For service users this monitoring of body-state is far more prevalent in day-to-day life than in a non-pathological population due to the many somatic effects of the medication service users take. Somatic monitoring and tailored regimen practices become a far more complex practice for service users whose lives involve a dedicated medication regimen, often involving many different drugs with separate administration schedules. Users constantly and closely monitor the state of their bodies in relation to their medication - and often non-prescription drugs as well - and many develop self-devised strategies of medication administration. The notion of *somatic* management is key to understanding how service users manage their experiences at an everyday level. It also highlights how important the body is in experiencing mental health difficulties. In the accounts featured here, users are not assessing the efficacy of their medication in terms of its effectiveness in treating their psychotic symptoms, but rather somatic factors. This is not to say that the relation between psychotic experiences and medication are not deemed important, but rather that they form a lesser consideration in users' everyday management than the physical factors associated with long term psychiatric medication regimens. The focus of the next section is a more detailed exploration of the effects on users' wider activity of operating and engaging in somatic management practices.

These activities can be thought of in terms of the body acting as a site upon which different relations interact, with subsequent frictions operating in terms of enacting

desired body states. Whilst the medication works to enact an adherent body state, self-produced activity resists a total adherence by experimenting with regimens and producing a slightly altered body state in the form of tailored adherence. These are forms of territorialisation at work. The systems of thought that govern treatments (i.e. psychiatry) put in place medication as the form through which people's bodies are territorialized. The effects of the medication, as seen in the forms of dys-embodiment, are the territorializing forces of the psychiatric system of thought at work. They are the miners at the coal face of the body. These forces though are resisted through processes of reterritorialisation, whereby the territorializing forces of the medication are re-worked through the experimental body, and consequently an alternative body state is enacted, which is preferable for service users. Affect is seen as the multiple ways that the fluid nature of service users' experiences is captured through the infolding of biology with regard to medication. In the next section I will expand on the work so far, in terms of looking at what the 'body can do' in respect of the reterritorialised body state.

6.13 Levels of Embodied Activity/When the Drugs Don't Work

The focus of this section is the forms of experience that service users' somatic management feed into. That is, what kinds of experience do they allow and enable. Already a number of strategies have been highlighted regarding experimenting with medication and self-devised regimens. In this section, a wider concern with the body itself is seen, in terms of active self-management. In the following extract, Beatrice discusses a time when she found maintaining her regimen very difficult:

Beatrice: no it wasn't work (1) \\ it was working \\ but it was just

Ian: \\ did you stop taking it? \\

Beatrice: hurting my legs so (I: mm) so badly (I: mm) (.) I was (.) restless (.) I couldn't sit still (2) it was awful the pains were in my legs so (.) I thought, I told my key worker (.) and she says "I don't know what it could be" (.) and um the (.) I think she told my doctor (.) but nothing was happening I (.) so I thought I'm not taking this anymore (.) taking this medication anymore (.) and (.) that's where it all started where (.) I became ill again.....(lines 404-411)

The physical effects of taking medication for Beatrice manifest themselves in severe pain in her legs. This led her to seek assistance, with a view to relieving the pain. Her key worker was approached, but is reported as failing to relate the pain to the medication. Beatrice understood that her doctor may be consulted, but all the time pain continued unabated. Although her first action was to seek help, when this failed to end the pain, Beatrice took matters into her own hands and ceased taking her medication. This self-devised action brought an end to pain, but had the effect of re-introducing mental health difficulties into her life, which, it seems, medication had been successful in reducing.

This example demonstrates some of the challenges facing service users when attempting to retain control over their bodies. Beatrice took control, which had the desired effect of cessation of pain, but additionally, resulted in re-emergence of mental health difficulties. Whilst previously, forms of tailored adherence had involved a self-activated manipulation of regimen, resulting in a manageable and functional body state, Beatrice had to cease medication completely. For her, it was the only viable option, and one she was willing to enact. The next extract is taken from slightly further on in the interview with Beatrice, in which she narrates an account of improving health, linked into her original cessation of medication. She is talking about an episode where she had been experiencing severe muscle stiffness, and this had been commented on by her Community Psychiatric Nurse (CPN).

Beatrice: says take two for now (2) and um (1) see how you go and I did (.) and I (.) I..I almost recovered straight away (1) well when I say straight away about (.) half an hour (I: mm) half an hour to an hour (.) I..I felt (.) really better you know (.) whereas before then I was (.) in bed all the time and (.) I only got up if I really needed to and (.) even then I wasn't feeling (.) great (.) I didn't want to cook I didn't want to clean (.) didn't want to do anything (I: mm) but (.) this Procyclidine (.) really helped and I thought oh I must be suffering from the side effects (I: mm) (.) of this drug (1) anyway I took two more the day after (.) then I I I (.) I'd completely recovered (I: mm) (2) and (.) I told my CPN who I saw, I see her on a Friday (.) it was the weekend (1) I think I rang her up on the

Monday that was it (.) and told her oh this Procyclidine, you'll have to get me some more (1).....(lines 466-478)

Firstly, further examples of somatic management - in terms of attending very closely to somatic factors - can be seen in this extract. This operates as a form of acute sensitivity to ongoing body state. Indeed, this can even form a *hyper-vigilance routine* at times, in terms of monitoring one's body down to very specific time periods. In the extract, Beatrice's somatic management is worked through at an hour-to-hour level, even more specific than on a day-to-day basis. When she took the medication that was suggested to her by her CPN as an aid to her stiffness, she monitored its efficacy immediately, and was able to make decisions how it was working after half an hour to an hour. Self-management is key here. Beatrice was not advised to monitor the side effect medication immediately, rather she was advised to just "see how you go". However, she actively undertook a self-management practice of analysing the effects it was having on her body straight away.

This extract shows that when the somatic management was not effecting an adequate body state, then the levels of embodied activity were low. Beatrice talks about being "in bed all the time", "only got up if I really needed to", "even then I wasn't feeling (.) great (.) I didn't want to cook I didn't want to clean". Thus it can be seen how unproductive and depressing such a low level of activity can be. This is of course quite a non-pathological aspect as well. If anyone was not able to get out of bed as they were feeling so bad physically, and were consequently unable to even maintain a modicum of domestic duties, this could be mentally distressing. This aspect of functionality of activity level can be seen to be crucially linked to somatic management. What Beatrice feels she can do is intimately related to her understanding of what medication is doing to her, which she is monitoring and evaluating almost continuously, and subsequently develops and maintains self-devised management strategies. In the following extract, taken from an earlier section of Beatrice's account, another instance of active somatic management is described:

Beatrice: another (I: mm) um (1) I've recently just come out of hospital again (I: uh mm) (.) because (.) the last medication I was on was (.) making my legs

hurt (I: uh mm) they were ever so painful (.) so I took myself off the medication (.) and um (1) I wen.. (.) I.....(lines 29-32)

We saw that the effects of psychiatric medication can be severe, and this severity can lead to users actively making decisions regarding their medication through experiencing negative somatic effects. Beatrice describes her experiences with her previous medication, which involved the effect of causing pain in her legs. Firstly then this further exemplifies the concept of somatic vigilance users undertake. Beatrice made a decision attributing the pain in her legs to the taking of the medication. This highlights the process of decision making users can undertake, namely, associating somatic effects with taking medication. Of course, it is not possible to know whether users are 'correct' as such in the decisions they make. It could be some other factor that led to Beatrice experiencing pain in her legs. This is not the issue though, as what this indicates is the active role that users do undertake in respect of their bodies and medication. The extract also illuminates the effects of Beatrice's somatic vigilance on her medication regimen. That is, once she attributed the pain in her legs to the medication, she stopped taking the medication. Control of administration was grasped and operated in Beatrice's actions. She did not seek assistance or service provision input before engaging in cessation of regimen, but rather self devised and carried out her chosen plan to alter her somatic state in terms of eradicating the pain. She decided the medication was causing her pain, so she stopped taking it. Undertaking this strategy enacted a somatic state from which Beatrice could maintain an adequate level of activity.

What we can see here is another form of somatic management. Beatrice was not devising tailored regimen practices in the same way as was seen earlier with Rick and Roy, nor was she enacting particular body states through mixing both prescription and non-prescription drugs, as seen in the case of Mark. Rather, her somatic management operates in terms of close monitoring of body state, and if a particular state proves problematic, the immediate action of seeking strategies to re-enact an adequate body state. This evidences how complex and intricate a practice somatic management can be. The following section demonstrates a dilemma for service users in terms of valuing and attending some of the activities and day centres available, and being physically able to do so:

Ian: what sort of times then (.) do you have to take your medication?

Chris: well I have to take it (.) once in the after.. (.) once in the afternoon and th..th.., and then once at night (.) but sometimes ..hh if I'm going on my courses I won't take my medication till the evening but I shouldn't be doing that cos it's not going to work properly (I: mm) it's just that if I take it in the afternoons once (1) I (.) if I (.) don't take (.) if I take it in the evenings (.) it's not going to work properly (.) and sometimes it makes me tired (I: mm mm) (.) but I need to take it at the appropriate times and it's.....(lines 49-56)

Chris states that his medication regimen involves taking it in the afternoon and evening. This seems quite a straightforward account. The difficulties however exist due to the effects that his medication can have on him. Namely, that it can make him tired, thus reducing his physical capabilities. Ironically, it is at the times that he needs to attend his courses, which provide key occupational therapy, that his medication regimen becomes problematic. Here a dilemma exists, as a cross-over of two factors designed to improve Chris's life, namely medication to reduce mental health difficulties, and occupational therapy courses, pull in different directions. Maintaining his medication regimen produces tiredness that reduces physical ability to attend classes. So, Chris sometimes tailors his regimen, by taking all medication at night, so as to enable attendance at classes. This 'works', in terms of both goals being achieved, but can only be enacted by Chris himself, and against formal knowledge which dictates he should stick to his prescribed regimen. Paradoxically, if he stuck to the prescribed regimen, as stated by formal practice, he would not be able to attend classes and receive the therapeutic benefit they bring.

This section has demonstrated the outcomes, in terms of everyday experience, that the reterritorialisation of bodies enacted. Had service users stuck by their original regimens, as prescribed by their service providers, their daily activity levels could have been negatively impacted upon. Their bodies were territorialized by the forces of psychiatric power at work in the form of medication. Not only did experimentation through which forces of reterritorialisation were produced result in a sense of control over experience for service users, but additionally, it formed a more positive flow of activity to be produced. Namely, facilitating a greater level of daily activity, enabling users to gain the potential to engage in more activities. A process of coding in relation

to the two previous chapters is at work here. Analysing how people deal with having to orient to forms of formal psychiatric knowledge involving honing in on forms of *expression*. In this chapter, we have seen how forms of expression have captured forms of *content*, i.e. users' bodies (which will follow through into Chapter Seven). In the previous two chapters we saw processes of coding experience whilst traversing the challenging terrain of psychiatric knowledge. In this chapter (and the next) we see the forms of content that inform the coding of forms of expression. Crucially, these are grounded in a different form of knowledge, i.e. personal embodied and spatially located experience, rather than the formal expression-based knowledge of psychiatry, which relates to a separate set of forms of content, that are based in laboratories, and medical and psychiatric experiments. It has to be recognised that these are distinct from the forms of knowledge produced by service users themselves.

6.14 Discussion

What has emerged is that embodiment is formed and constantly re-worked through a complex set of practices, which involves processes 'acting upon' users (i.e. service provision) combined with processes of 'acting' *by* users (i.e. self-management practices). For the purposes of this chapter it is the way that users' experiences of their bodies are mediated by medication that is of interest. Indeed, it is due to medication that users' bodies have become (*dys*)embodied and consequently salient in terms of illness. Medication is a key part of the meaning making process of users' experiences of embodiment, which in turn raises questions about the underlying conceptual structures upon which the administration of medication exists. For Foucault our experiences of our bodies are mediated by power relations, which is overtly applicable for service users. The administration of medication is part of the process of service provision which (as we saw in the previous chapter) is part of a power relationship in which service providers are located in a position of power and expertise over users' treatments. Medication, as part of this, then becomes a key operating aspect of this power relation, and users' own embodiment is duly formulated through power. As has been shown in this chapter though, this power is not totally determining, as users have developed their own agentic strategies that operate inter-relationally with and through power relations. There is not an expanse of agentic landscape for users to roam across, but rather limited difficult terrain is traversed as part of producing an active sense of

control over one's body. Affective states are produced by this web of infolding of both cultural and biological factors.

In this chapter we have explored a variety of ways that service user's bodies become a central site at which a number of factors are produced. Through incorporation into service provision users are, in the main, administered medication that can have considerable somatic effects, making the body a place where the forces of psychiatry are seen to physiologically inscribe themselves on and in users' bodies. In addition, bodies become a site for active experimentation with a range of factors, including medication and non-psychiatric substances, such as alcohol and illicit drugs. Through this, users work to reterritorialise their bodies, experimenting to produce new somatic states that enable them to enact a more comfortable level of embodied activity. Here, bodies become a site for the re-establishment of control, in terms of self-management. Bodies are a site through which forces of both psychiatric and personal power are played out.

Power relations of service provision operate as part of the prescription of possible treatments. Medication, as the dominant treatment, operates to (dys) embody the user through transition from the absent to the ill body, and finally, users own self-management functions in attempting (with varying success) to enact a body-state that allows a reasonable level of activity. Bodies are captured and coded according to the workings of medication, which for some service users is not a problem, but for others, maintaining any form of adherence presents a series of challenges in light of the somatic effects that some medication can produce. In these instances, we saw times in which aspects of both virtual and actual experience are presented, through the reterritorialising of previous codings into new codings. In the following chapter we will see how these kinds of coding operate to produce spatialised experience, which highlights some of the ways that the locations of care in the community exist.

Chapter 7:

The Production of Spatialised Experience

7.1 Introduction

In this chapter I focus on the production of spatialised experience, following on from the focus on embodiment in the previous chapter. Here we see how service user experience is not only pushed into the form of content of bodies, but how these are driven into space: how capturing experience, actualising it, involves both forms of content and expression. What I mean by the production of spatialised experience is an understanding of the ways we interact with and conversely are impacted upon by the layout and operation of the settings in which we spend our time. This involves incorporating the role of both human (i.e. bodies) and non-human factors (i.e. objects), along with taking a micro-analytic approach to how different forces inter-relate in the production of space.

To consider the spaces of service use is to recognise the current set up of mental health care as predominantly taking place in community settings (as described in Chapter Two). The settings of service use have thus undertaken a radical change, from the limited spaces of hospital wards and grounds to the open and apparent limitless terrains of communities. Here, no apparent barriers or boundaries exist. Although, as we have seen in Chapter Two, ‘control societies’ are not necessarily any less controlling than ‘sites of confinement’. In setting out to understand the production of service use I focused on where service users tend to spend their time, and subsequently the kinds of experiences that such spaces afford. As we saw in Chapter Two, the landscape of service use has changed substantially with the move from hospitals to communities as the primary care setting. In this chapter I will focus on some of the ways in which the community care control society operates, through looking at the ways service user experience produces the settings in which they spend their time. Codings are always driven into space, and it is a sense of how this operates that forms the analytic strand throughout this chapter.

7.2 Affect

When considering how space operates I will continue to draw on the concept of *affect* set out in the previous chapter. As demonstrated it is not a concept that can be neatly applied to a phenomena, as this would itself be an antithetical to the concept itself. To code any phenomena is to qualify it, to order it in some way. Affect is precisely a way of thinking experience that wants to emphasise the inherent fluidity of experience, its dynamism. It is a way of catching hold of bodies before they are captured in grids of socio-linguistic grids of meaning, but as they bear traces of previous codings. In doing this, we can approach an understanding of how the actualities of service user experience are driven into space, and the *territories* in which they spend their time.

In considering the production of spatialised experience, we are conceptualising the affective tone of existence. How lives are the products of the affective forces that are constituted in sets of relations between bodies, objects and space, in a fluid multi-directional fashion. Affect is not seen as entirely somatic or social (as in non-individual) but as an ever-contingent product of the forces that affect other objects (both human and non-human). Crucially, it is not space as constituted through the actions that give rise to affect, but rather, we take the idea that space is already made up of multiple sets of forces, that themselves work into different connections between bodies. We start with relations of forces, and then consider how these become spatialised. Following on from the previous chapter, it is analysing the kinds of movement and process that service users' bodies produce that work to code the settings within which they spend their time.

7.3 Territoriality

Macgregor Wise (2000) offers an interesting account of territorial acts, events and happenings. Territory here is drawn from a Deleuze and Guattari (1987) vocabulary, one based on conceptualising the production of spatialised experience. For Macgregor Wise, homes are not to be understood in terms of understanding the role of the home (house) according to cultural stereotypes, but rather in terms of the practices, objects, spatialised events through which the home setting is constantly re-worked. These acts connect with objects that *mark* territory. In developing this idea, Macgregor Wise (2000) gives the examples of marking out and laying claim to space, such as placing

one's coat to save a seat, or placing one's belongings on the adjacent seat on a bus to stop anyone else from sitting there. These are territorializing acts, but they do not only involve objects, but also sounds, such as the train conductor blowing their whistle to warn of the imminent departure of the train. This production of space is one performed through the relations between bodies (meant in its broadest sense) that become spatialised, e.g. the train moving through different territories as it travels its journey. The whistle has multiple functions, formed through a small chunk of space-time (a milieu) that interconnect and flow from one to another; signalling danger; do not go near the train it is about to start moving; stop running on the platform; get off your bicycle; let the passengers off the train first. Territorialisation, in this sense with regard to the production of space, is then about the ongoing production of what is experienced as space. All these events co-function to produce the particular operation of that setting. Affect is the doubling of this production of space, as we infold relations in our own body, where affect then resonates and offers up sets of potential action and reaction.

All these activities act as milieus (chunks of space-time), all coded by the periodic repetition of their activity. Some occur in different patterns of repetition, but all are coded. Coding though is not a static happening, forever set in one pattern of function. Rather, it is in a constant state of re-coding (transcoding). Deleuze and Guattari use the example of a fearful child sitting in the dark singing to himself under his breath (1987: 343). The repetition of the song acts to code that space. Milieus interact, mesh, interweave and spin off in new directions: “the notion of the milieu is not unitary: not only does the living thing pass into one another; they are essentially communicating” (Deleuze and Guattari, 1987: 345); “milieu effects are always the result of connections to elsewhere” (Macgregor Wise, 2000: 301). Territories are 'built' from parts of the milieus that operate in centres, they are produced through an accretion of milieu acts. It is not simply the additional consequence of the production of each milieu, but rather an autonomy, that only *becomes* in an action, an action built on parts of milieus. So, the operation of settings (e.g. train platforms) is created through the connections of multiple chunks of coded space-time (e.g. the conductor's whistle).

A central tenet of territorialisation with regard to space is the notion of expressivity. Deleuze and Guattari claim that territories only enter a state of becoming through the

transition from functionality to expressivity. Take the colours of a bird; which are at once physiological effects relating to internal hormonal states; functional effects in terms of relating to factors such as aggression; sexuality; but also *expressive*, in terms of becoming markers of a territory. Deleuze and Guattari (1987) draw on the example of zebra finches (which have both coloured and all white members), in which the coloured members maintain a certain distance from each other (the colour marking the territory), whereas the all-white members exist in much closer proximity to each other. Here we see that the territory at once becomes and is produced *through* the acts that define it (with zebra finches, the colour).

7.3.1 Territorializing Bodies

The work of Hester Parr (1997; 1998) in human geography is informative in terms of the empirical aims of this chapter. Parr empirically analysed the kinds of spaces made available for service use in what she describes as 'semi-institutional places'. These are the kinds of places that are not part of formal medical psychiatric care, but are not entirely absent of clinical associations, so include drop-in centres, charity run day centres etc. (similar to the places accessed in this thesis). Parr's interest lies in detailing some of the complexities of spatial relations in semi-institutional places, and how these work as identity producing for service users. Through an in-depth analysis drawn from a covert ethnographic study of an inner-city drop-in centre, Parr demonstrated the ways that members territorialized the space of the drop-in centre through expressing particular ways of becoming. The space of the drop-in would be tolerant of the expression of certain kinds of behaviour, such as members sitting alone, not communicating with anyone for hours on end, or members who would stand trance-like in the middle of the room, silent, and then go outside without a word to anyone. These kinds of behaviour would be seen as 'abnormal' in mainstream settings, which in turn would result in the stigmatising of those expressing such behaviours, but in the drop-in centre these activities were productive of the member expression. Indeed, the boundary formation of the drop-in centre was formed through the expression of such activities, but not entirely in and of themselves. Additionally, the response (or lack of - in terms of an overt response) of the other members and staff to such behaviour was co-productive in terms of setting boundaries. Member and staff tolerance was part of the expression of the behaviour itself. Indeed, such behaviour could only be expressed for the very reason that it was responded to in the way it was.

Parr's work identifies and explicates some of the territorializing functions of an inner-city drop-in centre, particularly in terms of the kinds of embodied behaviour that produced membership of the drop-in centre. We can see how the drop-in centre became territorialized through the expression of particular ways of behaving, and how these inter-related with other members and staff actions. This leads into the current analysis in this chapter of the territoriality of service use, and its production through the multiplicities of actions, events and practices that are expressive of service use. Parr's work is informative in terms of one of the central locations in which service use is produced and expressed. This is the location of the many day centres, drop-in groups, volunteer run sessions that provide a place for service users to attend. Parr informed us of some of the territorializing types of bodily behaviour that can occur in such locations. The body though acts as just one quality of service use in day centres, as the overall service use production involves a multiplicity of factors in addition to users' bodies. By addressing the complexity of the service use production we can see how a variety of objects, events and actions become bound up in a co-functioning space of service use.

7.4 Day Centres

The centres visited as part of this study were a variety of social service run and volunteer run locations. What they had in common though was a focus on providing a safe space in which service users could engage (or not) with a number of activities, such as more formal courses (e.g. computer, woodwork, cooking), along with less formal activities (e.g. days out, bingo, playing pool). Additionally, there was not a focus on drawing in medical model thought, in terms of dealing with people according to diagnosis, treatment schedule etc, but rather in inviting people to enter a location in which very little talk of formal diagnoses, treatments etc. would take place. The general aim is to provide a more user-centred approach in terms of attending to everyday needs of living in community settings with mental health difficulties.

We can see how day centres provide a key territorializing aspect of community service use. These are the places that service users feel comfortable visiting, and are drawn to on an everyday level, and as such they become a central producing space of community service use. What has to be considered are the kinds of activities that make up the

everyday running of such day centres, as these events are the actual expressive qualities of day centre service use.

7.4.1 Day Centre Milieus

The day centres under focus have different modes of function in terms of their general aims for the space they provide for users. For example, one centre has its onus on providing an essential safe space in which users can have a hot meal, interact with other members and staff, along with receiving some alternative treatments (e.g. holistic massage). These are general 'day' activities, with evenings generally taken up with more specifically focused activities, such as groups for those with alcohol problems. Users are free to interact as much as they like, or to just attend passively and not interact at all. It is very much designed to be a multi-functional space. Another centre has a range of activities including computer skills, cookery, woodwork, gardening, and textiles. These are all designed to be flexible, so users can work at their own pace, with 'in-house' and more formal qualifications and certificates to be worked towards if users desire. Thus, there are different modes of action between different sites. The aim here is to highlight how service use is produced in these centres, as examples of the kinds of places available to users to spend their time, and to demonstrate some of the ways that service use is *marked out* in centres within the Midlands in the UK. Consider the following extract:

Phil: I get involved here in (.) the games and that [I: mm] (.) pool [I: mm] snooker and e:r (1) having a chat and a cup of tea (.) with my mates in the Smoke Room [I: mm] (1) playing music (1) which I like to do (.) Sixties stuff [I: mm] e:r (2) that's about it really [I: mm] (1) i..i..it's (.) so nice coming here [I: mm] (.) you know [I: mm] (2) I have made a lot of friends here and all that [I: mm] and have a good laugh and everything.....(lines 77–82)

Here Phil is describing the activities that take place in the day centre he attends. The different bodies (referring to both human and non-human factors) impact upon each other in a variety of ways. Let us work through some of these. In Phil's extract it is evident how some of these relations interact in producing the setting. He talks about listening to music, having a chat and a cup of tea, having a good laugh. All these

activities are more than functional, they are expressive of a space that is 'normalising'. Sitting having a cup of tea with a friend, listening to music, are 'normal' things to do. They serve an expressive role in this account, marking the day centre territory out as 'normalised', an important task given the position of service users as 'abnormalised' in some way, as not part of mainstream society. In a sense though, what we see is how space here is the potential for new connections to be made, to be actualised. The space of the day centre is produced through relations that resonate 'under' the space, in processes of affect, through which change is possible. Becoming normalised opens up a new range of events, in terms of integrating into other areas of mainstream society, such as through gaining employment. Affect is present in the way the day centre space makes visible users' transition from abnormalised to normalised territories. Their role, and visibility, in that space opens up new spaces, that can facilitate greater integration into mainstream society.

The activities of the day centres allow for connections to be made to other bodies, e.g. other service users that facilitate managing and producing a space in which users are more satisfied. They experiment with a variety of activities, e.g. drinking tea, listening to music, playing games, which facilitate new more productive (and normalised) connections to be made. It is only in these spaces that these kinds of connections can be made. Activities listed allow for a sense of a whole range of normative actions to be apprehended, a sense that can only occur through the *doing*. Phil's expressed happiness about his time in the day centre demonstrates how the space opens up new connections that are, in a sense, productive and therapeutic. For instance, playing a game acts as a means of gaining a sense of different connections that can be formed through such an activity. Playing a game can be a family event, part of a traditional family setting, or one between friends. A normal leisure activity for many people, but for service users, these activities are ways of experimenting with forming new 'normalised' connections. Forces increase their powers to engage in normative practices, which is very important for people who have suffered the effects of forces of abnormalisation through stigmatisation.

As Patton points out, drawing on Spinoza, bodies may seek to increase their power by entering into relations with other bodies that "serve to reinforce or enhance their own powers" (2000: 79). This is what is happening in the day centre. Service users are

engaging in activities that serve to increase their own powers of normalisation, which as we saw, may allow them to enter into a greater number of socially integrative activities.

Other territorializing events are inflecting the day centre space, playing pool; having a cup of tea; listening to music. Each are milieus, blocks of space-time. These flow as the space is constantly subject to dynamic inflections. Drinking a cup of tea will flow into listening to music. Playing pool may flow into 'having a laugh' with other users. The space of the day centre is constantly bent, shaped and re-shaped through the flow of these territorializing events. Users gain a sense of identity through *seeing* themselves expressed as part of these activities, which in turn are *expressive* of service use in this day centre. Another example can be seen here:

Ian: um (.) I mean what sort of things so you do (.) here then?

Elaine: I do Mon.. I come in Monday nights for the Choices group [I: okay] and that can be (.) bingo (.) poetry (.) e::rr (.) go out for meals (.) [I: yeah] painting (1) different things

Ian: Yeah (.) so (.) have you met quite a few people then?

Elaine: Yep

Ian: Has that been nice?

Elaine: Yeah it has (.) [I: yeah] and then I come on a Friday group for snooker (.) pool (.) scrabble [I: yeah] all sorts or just for a chat.....(lines 39-47)

Elaine attends a different centre to Phil. Her time at the centre, primarily on Mondays and Fridays, is ordered through multiple connecting activities, be it bingo, poetry, painting, or "just for a chat". All these blocks of space have different functional rhythms - bingo operating through a group vector, painting at an individual speed between user, brush and canvas. These activities become infolded in a certain way, lending affective charges, which lead to space being produced in particular ways. Further examples of activities can be seen below:

Ian: Yeah and do you find it helpful?

Peter: Oh yeah very helpful, yeah.

Ian: What sort of things do you – in what ways do you find it helpful?

Peter: I do art here on a Wednesday afternoon with the art teacher, I meet people, I play games, listen to music, debate current affairs like you know.....(lines 19-24)

Peter's time at the day centre is made up of similar activities as those of Elaine and Phil. Like Elaine, he takes part in art sessions, along with playing games and listening to music. His interaction with other members is specified in terms of debating current affairs, which demonstrates how each event, in this case, user interaction, operates in different ways in different milieus. Peter produces a chunk of interaction based on debating current affairs, whilst other users may be more focused on producing spaces of humour-based interaction, such as Phil 'having a laugh'. Day centre spaces are produced through constantly re-working territorializing activities.

These events becomes *expressive*, in terms of producing a *marker*, a *signature* laying out this space of service use. A conversation, sharing of experience, passing of the time of day; all milieus marking out this space as a safe space. These operate as territorializing events, marking out the location as a part of service use. Interacting, forging alliances with other users, is produced as a central part of community service use. Day centres etc. become territorialized spaces in which user interaction can be developed and exist. So, we can see how these activities operate as milieus, through periodic repetition in the space-time block of day centre activity. Service users repeatedly inhabit the space-time that is the day centre, and in their time there, they constantly (re)produce the space through milieu effects: interaction; playing pool; drinking tea; shared production of 'safe space'.

7.5 Home Territories

One location in which service users spend a large part of their time is their home environment. These can involve a number of set-ups, including living in the family home; living in a self-maintained home; living in a service provision run centre; or local housing association run accommodation. A key territorializing factor in service use is the home space itself, in the way that users tend to spend so much time at home is directly related to their existence as service users. It is of keen interest how the space of home functions and operates for users. The territorializing activities of users relate

and connect to sets of events and productions. In the example of Chris, the territorializing of his flat was made possible by his ability to gather and store the required levels of sustaining objects to fill his flat. Consider the following extract:

Chris: and I do bulks and bulks of shopping, I get bulks and bulks of food and drinks in my flat (.) cos at the moment I spend my money on videos, cds, food (.) drinks (.) hot and cold drinks (.) clothes (.) and (.) cigarettes (.) and paying my bills (I: mm) and because I'm on special (.) benefits cos of my illness I can afford to buy things (I: mm) I never run out of cigarettes cos I always have a supply but I've had to change my brand again because I (.) had problems getting the other ones so (.) three days of the week I'm usually out doing things (I: mm) (.) and the other four days I'm in the house (.) relaxing.....(lines 114-121)

Chris has spent his time accumulating a large amount of food and drink in his flat. He uses the word “bulk”, intimating the direct relationship between the space of the flat and the objects of food and drink. To bulk something is to fill it, and this highlights how important the accumulation of grocery supplies is in terms of the space of the flat. The food and drink serve as acts of marking the flat out as a personal space for Chris. A space marked as self-sufficient; food and drink acting as signifiers of the sustainable nature of this space. Here Chris can exist with minimal outside contact if necessary. In becoming a highly personalised (territorialized) space, it is not just food and drink that serve as expressive qualities of home territories. Chris states he also has a variety of electronic goods and associated services, allowing him to create a functional, amenable and pleasurable personal space. He has a television, VCR, stereo equipment, along with services such as satellite television channels and tapes to play on his stereo equipment. These all operate to produce a home space in which Chris is happy to spend a large part of his time. They provide a range of entertainment activities for Chris to fill his time.

Bulking his flat to bursting serves as a defence against potential invaders for Chris. His concerns about having his own space removed lead him to undertake such practices. Evidence of this can be seen in his representation of the tenancy agreement he has on his bed-sit, seen in the following extract:

Ian: I just said do you live on your own, and you don't *

Chris: oh no (.) but like I said at the moment (.) the residents upstairs are only told they can stay a year (.) but I've got a different agreement (INAUDIBLE) I can live there as long as I like (.) but they've been living there longer than year and a half and I've also heard a rumour that this various person is moving into the address, which I don't believe is true but I've heard rumours so (1) they should be moving out soon and some more people be moving in (.) because (they) have said I can live there as long as I like where the residents upstairs can only stay their a year, year and a half and then they have to move out.....(lines 128-136)

Here Chris states that he has a 'special agreement' that allows him to stay in his flat as long as he likes. He has a different agreement to the other tenants, and thus control of his personal space is solely within his own hands, unlike the other tenants in his block who can only stay for a predetermined period of time (a year to eighteen months). Chris's space is thus *his* space. Bulking it up and filling it with a host of entertainment technologies becomes a barricading practice, defending against the stressors that exist in mainstream settings. This is like a hibernating practice. Chris, at any time, can lock himself away in a place that cannot be breached by others. It is so full that there is physically no space for others. This defensive strategy becomes a visible expression of Chris's autonomy, ability and facility to exist in solitude, crucially away from other people who may seek to take away his control over space. Given his position as a service user who has spent a great deal of time in mental hospital wards - experiences he views as negative - it is of critical importance that he is able to produce and express his everyday living as within his control. Through these practices he can position and express himself as a service user, but one who is in control of his own daily existence, which serves to demonstrate progression from the time when he was a service user whose time and space was controlled by others. This is done through a set of inter-relating practices that cannot be reduced down to singular threads, such as the discursive formulations used by Chris to detail his tenancy agreement, but rather, are produced by interconnecting aspects of object, technology, language and praxis. The items bulking up his flat serve as the visible face of this autonomy:

Ian: what music do you like?

Chris: I like Michael Jackson, Pet Shop Boys and Madonna, I got all the tapes (I: mm) I've got all the facilities (.) I've got stack system, I got bulks of videos, I got satellite (.) I've got all the fantasy channel stations what can (.) offend some people, adult stations (.) but the majority of time when I'm in my flat or on my own I just spend lot of time listening to my Walkman cd (I: mm) cos the most important thing to me believe it or not is actually my Walkman (I: mm) (.) the amount of time I spend listening to Walkman cd music.....(lines 447-454)

In addition to the physical filling of his space with food and drink, Chris has and utilises a range of technologies, such as TV, satellite channels, music, personal walkman. Whilst the food and drink operate and express the marking out of Chris's space through their physical presence, the entertainment equipment also provides sonorous events, acting as territorializing space through sound. Similarly to Deleuze and Guattari's (1987) original notion of birds marking territory through bird song, these facilities work to produce sonorous markers. The music, television, and the fact that he has adult channels that can offend some people, mark this territory as his. In the same way that adult magazines mark out top shelves at newsagents, and peep shows and adult focused shows mark out parts of city centres, Chris's adult channels act as visual expressions of his space. It is a three pronged territorialization producing Chris's space, with the physical presence of a large amount of food and drink; the sonorous production of music; and the visual expression of adult material marking out the setting. Given the variety in the nature of home environments there is a diverse range of territorializing strategies employed by users. Consider the following example:

Ian: mm (1) how do you like to (.) set out the space then (.) have you done particular things, brought particular things in and?

(3)

Roy: well there's (.) some things I've kept there (1) but only things that are absolutely necessary [I: mm] (.) and if there's any little bits of (rubber) I've got a little shoe box (INAUDIBLE) I don't know if you know what (Argos) shoe boxes are like (.) si.. (.) six tiers or something [I: yeah] and anything that I need to sort out I put in the drawers [I: mm] (.) you know I've got lots of drawers (INAUDIBLE) and they're all orderly (.) I think since my mum died I've been (.) completely orderly

Ian: are you quite an organised person are you?

Roy: yeah I am now (1) anyway eventually I know that (.) while I sort everything out (.) all the stuff is starting to disappear now all that was (.) cluttering [I: mm] (.) I mean (let's say you've got) a table like this [I: mm] (.) I don't like papers all over the tables [I: yeah yeah] (.) so I keep it clear [I: mm] (1) (only) thing I got for my birthday I got a chess set [I: mm] I put it on the Welsh dresser I got [I: mm] (.) and e::r (.) you know I have sort of strategically put things out just how I want them [I: mm mm] (inaudible) become (.) orderly in that way (.) sort of helped me become orderly in other ways.....(lines 367-385)

In this extract Roy is detailing the nature of his home environment. He lives in his own house by himself that was previously the house he shared with his mother, who has recently passed away. Roy has taken on the tenancy of the house, which, as we will see, has been of crucial therapeutic benefit to him. Roy states how the process of territorializing his home has operated, from the previous situation of how it existed whilst his mother was alive, to now, when it is in his sole control. He has only kept the things in the house that are "absolutely necessary", and the things that remain are subject to a rigorous ordering. Any little things have been put away in drawers, of which Roy has a great deal, which is part of the production of being completely orderly. He has sorted all the "clutter" through a "strategic" process of laying out his home space exactly as he desires. This ordering has been the key process by which he has territorialized his own space. In turn, this territorialization has become an active therapeutic process. It is not merely a process through which users organise their home environment, but becomes a crucial expression of the therapeutic process at work. Roy is visible as a user with mental health difficulties whose life is improving and working towards a better position through the therapeutic ordering and territorialization of his home environment:

Roy: but I do I feel as though I am becoming more stable and the (.) place is becoming more stable [I: mm] (3) and now I've got all the space I need (.) I can sort of look in other places for other things now.....(lines 394-396)

Here we see how important it has been for Roy to order the space that is his home. This strategic ordering has produced a stability that has flowed into other parts of his life. Stability has produced a foundation on which Roy can build and look for "other things now". What he feels he is able to do is indelibly linked to the operation of his personal space, and with this ordered, he can work towards the production of other parts of his life, such as finding a partner. Thus, the territorialization is expressive of Roy producing himself as a user whose life is improving. The ordering of his home environment is visible as an ordering event in Roy's life. It is not just functional in terms of easing his daily living activity, but is aesthetic, in terms of visually producing a stable being.

The possibilities created by these territorializing actions and events involve the setting up of personal space of which users are in sole control. Chris's space is so 'bulked up' that there is physically no space for others to enter his space, and Roy's strategic ordering means that anyone entering his space must do so according to his strictly ordered rules of action. For people who have spent a lot of time in the control of others, these practices are central in constructing a sense of identity, an identity in control of personal space.

7.5.1 Territorializing Shared Space

Chris highlighted how processes of territorializing personal space can operate and be produced in service use for a user who lives on their own. Many though live in family homes, which can mean living with parents and/or siblings or other members of users' families. Space operates in a different way here, in that users are not in total control of it, unlike Chris with his home environment. Other people live in the space, but in what ways does this shared space operate? How do productions of service use in a shared family setting connect to those in individual home environments? Consider the following extract:

Dave: I've been living with my parents ever since (I: mm) (1) there's just me (.) it's a three bedroom house so I've got my own bedroom (I: mm) and it (.) it's (.) we've got two (.) we've got a living room and a dining room and I (.) sit on one room and they sit in the other basically if (.) you know not to be anti-

social but (.) so we don't get on top of each other really it's (I: mm) (.) you know (.) that's (.) what I do.....(lines 151-156)

Here Dave is detailing his living arrangements, which involve living with his parents in a three bedroom house. This enables him to have his own bedroom, and thus his own personal space. The point remains whether this is sufficient space for Dave. To have one's own bedroom is a pretty unremarkable claim to make, and is not particularly salient in terms of enunciating one's own space. Dave goes on to detail the ground floor layout of his home environment, listing the existence of both a living room and a dining room. These two settings operate as key boundary forming family spaces. Dave states he will sit in one room whilst his parents sit in the other. He does not state which room serves which purpose, rather emphasising the functionality of this in terms of providing distance between the two key sets, Dave and his parents. This produces the home environment as one that is segmented according to the desired function, namely providing Dave with personal space in addition to his own bedroom. The space is not static, in that it is not one room (i.e. the living room) that serves as Dave's space, but rather is (re) produced according to the particular events and actions taking place at any one time. Connections of 'Dave space' and 'parent space' are not static, but in a constant state of re-working.

Through these examples the importance of users having a space, and territorializing space is made clear. This production of personal setting involves not only the setting out of a particular place (i.e. bedroom) as one's own, but a variety of practices and objects to *mark out* this space. Whether it is music systems, or the process of carefully practising separate modes of daily routines (as we saw with Dave), territorializing personal space is a key part of the operation and expression of service use in community settings.

7.6 Expressive Benefits

The marking out of personal space is performed through the processes of filling the home environment with items that sustain and mark out that space as bounded personal space. For this to occur, the presence of the means to acquire such markers is required. This connects to another part of service use, and as it does, becomes productive of service use in itself. Consider the following extract:

Chris: I'm the only one in the family that's got any money but (.) because of me illness I'm on special benefits so I don't need to worry about money (I: mm) I've always got cigarettes and I've always got the other stuff that I need for my flat and when I get the computer that will be the end cos there will be no room to put anything in my flat (I: mm) that's getting really packed solid now my flat is (.) I've got a thousand pound worth of food and drinks in my flat.....(lines 241-246)

To fill a flat with such a large amount of food can only occur with significant financial outlay, and indeed Chris states that he has accumulated a "thousand pound" worth of food and drink. Whether this is actually a literal description or not, Chris can only substantially fill his flat due to the benefits he receives as a service user, which crucially (from a financial perspective) include Disability Living Allowance (DLA):

Chris: hh (.) because of my illness I'm on special benefits and I've got enough money to live on and I don't need to go out and work for it (I: mm).....(lines 57-58)

The connection and relatedness between territorializing personal space through filling the home environment with sustaining items and having the means to do this is representative of one aspect of living with mental health difficulties in the community. It becomes one of the productive elements of service use, as territorializing the home environment can only occur through the receiving of benefits that are given to service users. It is then productive of service use, and key here is the notion of service use.

To be a service user is to be visible to service provision. Chris is part of the service provision activity in terms of being recognised as someone with mental health difficulties who needs support in his community setting (the underlying basis of care in the community). With this incorporation into service use comes the recognition of need through benefits, in this case DLA. Thus, a boundary is drawn here between those with mental health difficulties that are visible to service provision, and thus receive benefits and the financial stability these can bring, and those with mental health difficulties who are not visible to service provision. This is an expressive part of being a service user in

contact with service providers, rather than people who live with mental health difficulties, but have no contact with psychiatric services. Users receive benefits, such as DLA, through their visibility to, and hence incorporation into, psychiatric services.

We can see how the operation of home environment space is connected and directly relates to receiving social security benefits. For example, Chris was able to territorialize his home environment due to the financial capability provided by the benefits he receives. Receiving benefits becomes a key *event* in the everyday production of service use. Users receive benefits given their status as 'service users'. This relates to the earlier point about being *visible* to service provision, as the points made here are relevant to those who are visible. Benefits are available to users as they are (largely) out of employment, due to their poor mental health. Depending on the severity of mental health difficulties, users may receive the additional DLA, which provides for people who have difficulty with looking after themselves on a daily basis. This is the case for many service users, Chris being a good example, as he requires additional help in maintaining and looking after himself. Benefits are a functional part of service use, in terms of providing key financial assistance to users whose income is very low.

We can see though that the receipt of benefits also becomes *expressive* of service use, in terms of becoming a *visible* part of community service use. It not only exists as functional, but performs an *aesthetic* event, in being a *visible* part of the landscape of service use. This involves a *reorganisation of function* (Deleuze & Guattari, 1987), in which the function of receiving benefits is reorganised from providing financial help, to actually being *expressive* of service use. The process for users operates in the following way: they experience mental health difficulties leading them to become *visible* to service provision. This can work in a variety of ways, such as individually seeking help, or family seeking help for the user. In most cases the mental health difficulties have resulted in the cessation of employment due to users being unable to work when experiencing such severe mental distress. The mental distress is recognised as requiring treatment, and as such the user formally becomes a service user through receiving treatment (and in most cases a diagnosis). Due to this recognition and incorporation of the user into the service provision 'care', the user is then able to apply for benefits, such as DLA, for which the support of a health professional is required.

The process then results in the user coming to recognise themselves as someone with mental health difficulties through the *visibility* of their benefit entitlement. They receive benefits because they are ill; benefits become expressive of service use. Other examples can be seen below:

Ben: I mean I'm always want to help and stuff (I: mm) (2) and cos I claim DLA (1) I get quite a bit of money (.) I'm always paying for stuff for my family and (1) if someone says "oh I want this but I can't afford it", I'll buy it ya (I: mm) (.) you know what I mean that's (.) the kind of guy I am.....(lines 167-170)

Here Ben is describing how his financial capability allows him to buy things for family and friends. He receives DLA due to being visible to service provision as someone with mental health difficulties. This means that he gets "quite a bit of money", which gives him the freedom to be able to make kind gestures and purchase things for people he recognises as in need of or desiring something. Ben recognises his ability to do this from the reality of receiving DLA, which in turn he is eligible for because of his mental health difficulties. This is a good example of how the receiving of DLA becomes *expressive* of service use. It is not just functional in terms of providing Ben with the means to help him with recruiting the necessary help he requires on a daily basis - for example his mother's ability to work being restricted by her role as his primary carer - but is actually functionally reorganised through the production of being a user allowing him to be able to provide in a financial sense for his loved ones. His *becoming* (in a Deleuzian sense) is produced as someone with financial means.

The expression of service use that social security benefits produce is directly related to people being *service users*, that is, as in contact with, and visibly adhering to the prescriptions and workings of mainstream psychiatric practice. People with mental health difficulties who do not keep contact with service provision in this way would not be afforded the same benefits. With Chris, we saw how benefits allowed him, over time, to fill his flat with the kinds of objects (e.g. satellite television, large amounts of food) that facilitated the self-directed territorialisation of his space. Unsurprisingly, this led to him spending a large amount of time in his home environment. In this way, Chris's bed-sit has become a site for control in a similar way to that of hospital wards.

Although bringing him benefits, being a service user feeds into cultural understandings and practices (e.g. stigmatisation) that can make it difficult to find employment, which in itself could facilitate a much greater integration into society (e.g. through greater financial capacity). Chris's home has become part of the 'control society' (Deleuze, 1990) of mainstream service use.

7.7 Mainstream Space Anxieties

A range of territorializing and expressive events has been documented in this chapter, with the focus on gaining insight into some of the ways that service use operates in two key locations in community mental health; day centres and home environments. It is now appropriate to consider the possibilities that these territorializing acts open up. In users' home environments the effective construction of a space was important, in terms of expressing and marking out that setting as a personal area. In day centres, a range of activities produce a space that is therapeutic and a common safe setting. Users can interact with other users, play games, converse, engage in more formal activities in a place that is safe from the stigmatising stereotypes played out generally in mainstream settings. Additionally, when thinking about the functions of the many territorializing activities seen in this chapter, it is important to consider how users feel about particular settings, and how important it can be to connect with particular spaces, and not others. Territorializing home environments and day centres guards against engaging with more mainstream spaces. The infolding of context is clearly marked out, in terms of affect, in the ways that users' experiences are spatially produced. Let us consider how users feel about engaging with places other than those seen in this chapter. Many users express their concerns and anxieties, which are borne from a variety of experiences. Consider the following extract:

Ian: oh they bring (.) oh ok (2) how (.) how did you come to (.) be (.) coming along to this place?

Ben: er my CPN (1) er (.) sort of sorted it out (I: mm) cos I tried to go to college (I: uh mm) (.) but the big crowds and stuff, I was getting paranoid and (I: mm) (1) i..i..it didn't (.) it didn't (.) gel well with me so (I: mm) she mentioned this place.....(lines 49-54)

In this extract Ben displays anxiety about connecting with mainstream space, in this case a local college. He describes his experiences of enrolling on a course at the local college, a very normal and reasonable thing for someone of Ben's age to do (he was 19 at time of interview). This mainstream space though proved to be too pressured for Ben, as he did not feel able to operate within a setting with such a large amount of people. *Affect*, in terms of the infolding of the context of the college was produced in a challenging way for Ben. It was suggested to him by his CPN that the space of the day centre under focus would be one in which he may feel more comfortable. Ben demonstrates that users are often fearful and anxious about connecting with mainstream space, an anxiety borne from past negative experiences. Ben accounts for the onset of his mental health difficulties as originating from a negative experience of a particular place in his home city:

Ben: and er living in the (NAME REMOVED) (.) when I used to live in the (NAME REMOVED) (I: mm) (1) that was the source of all my problems (I: ok) (.) because it's a bad area, you can't walk down the street without someone picking a fight or (I: mm) (1) pulling out a knife on you (1) it's a terrible place (I: mm) (2) so that was the source, oh well (.) that was what was thought to be the source of (.) all my problems and I think it was (I: mm) (2) and that's what started me off getting ill.....(lines 69-75)

Space has been clearly marked out as a major contributor to the onset of Ben's mental health difficulties in this extract. The part of the city he used to live in was a run-down area in which crime levels were high, and thus residents' sense of security and safety were low. The space then becomes potentialised in terms of negative experiences. Ben feels that at any time someone may 'pull a knife out' or 'pick a fight'. *Affect* is the production of this as a primed space for danger, and the anxiety provoked by experiencing this space has led Ben to become fearful of connecting with mainstream space. Rather, it is the safe space expressed through the events that produce day centre activity that Ben feels able to operate within. He states later that:

Ben: um (2) except coming to this place I just sort of (2) I get up (2) e::r (.) I usually get up about (.) eleven twelve (I: uh mm) (2) and I just generally, I

don't like going out much (I: mm) (1) but I will do if it's necessary (I: mm)...(lines 65-68)

Only going out when necessary demonstrates the anxiety Ben feels regarding connecting with mainstream space. Dave below narrates a similar story:

Dave: yeah (.) I've still got a bit of a confidence pr.. (.) problem at times (1) um I'm not very struck on shopping in (NAME REMOVED) (I: mm) I don't like lots of crowds (I: mm) (.) but I can go (food) shopping in my local town no problem (I: mm) (1) bumping into all sorts of people (.) that's not a problem (I: mm) (.) just don't like going down (NAME REMOVED) (I: mm) (.) I don't know if that's natural for what (.) I don't know if that's the same for everybody, whether they find it stressful or not I: mm) (.) whether it's just me it's (.) I don't enjoy it.....(lines 389-396)

Dave's anxieties are more localised, to a degree. He can successfully connect with 'local' space, in terms of the local food shops. However, when it comes to entering the rich mainstream city space, then Dave feels far less able to connect. This relates to a numerical factor of volume, in terms of people. Mainstream space, such as shopping in the city centre, means connecting with a potentially large number of people. It is these 'crowds' that are the source of anxiety for Dave. Unlike the local space, with its lower volume of people, and of whom Dave is potentially more familiar with through regular visits to local shops, mainstream space becomes a general no-go area. Day centres and home environments provide space where users can spend their time, thus providing the possibility to not connect with mainstream space.

Highlighting the prevalence of concern regarding mainstream space further emphasises the spatial existence of affect (Patton, 2000). Affect here is taken as the infolding of context, of relations. It is how we produce spatialised experience – since it is critical to our linking of our body to action, and sets up, through resonation, intensities of experience of perception. Service users are aware of the huge potential for new connections to be made, making them subject to a variety of forces, that have the potential for negative affect. Whereas the day centres produced connections that increased activity, mainstream spaces are pregnant with such a mass of possible new

avenues, which can produce anxiety in users. Their challenge is to manage their lives in such a way as to minimise exposure to new connections.

7.8 Connecting Safe Spaces

Through the data worked in this chapter we have seen the intricate practices of territorialization that mark out the spaces where users spend their time, namely home and day centre environments. With this, we have seen some of the ways that coding of service user experience are driven into space, and work to code that space as service use space. Community service use is constructed by sets of connections involving the practices under focus here, and thus insight has been gained regarding the operation of service use in community settings. Crucially, these expressive practices and strategies of territorialization serve to mark out personal space, along with constructing and expressing protective boundaries against mainstream space. Connecting the mainstream – non-user focused - space is a major anxiety for a lot of users in the community, and producing visible safe non-mainstream space is vitally important for community users. Thus, the territorializing events seen in this chapter become expressive and productive of safe spaces. These spaces (home environment and day centres) are visible as safe spaces through the connecting of the particular practices productive of that space, be it bulks of food, drink and entertainment facilities with Chris, or the interactionary activities expressed in day centres. Through the provision of safe spaces for interaction, day centres allow for users to engage and connect with other people, in a safe non-mainstream space, as all the members are other users. Thus, the pressures of connecting with non-users are absent. Interaction, users sitting talking and having meals, playing pool, bingo, and the range of other interactionary activities that take place act as *expressions* of this space as safe. They become visual markers, territorializing this space, marking it out as a user-centred space, and one boundaried off from mainstream space. These are the visible expression of service use. Users come to recognise themselves as those who exist in safe spaces through being able to *see* territorializing expressions. Their sense of identity is constructed through these sets of connecting events and actions. All the practices seen in this chapter serve to produce safe spaces and subsequently defend against anxieties of connecting with mainstream space.

Additionally, it is the kind of connections that are facilitated between the objects (both human and non-human) in service use settings that are the central component when defining the operation of spaces. We saw in the day centres that the kinds of connections formed there were productive of a positive space. Users are able to enter into a variety of 'normalised' activities (playing games; listening to music) that serve an important job of normalisation for people who have often been 'abnormalised' due to their mental distress. This is not to say that day centres are the *most* positive spaces for users to occupy. For example, gaining employment would be a means through which a greater number of positive connections could be formed, which would aid closer integration into non-service user spaces. For instance, greater financial capability, contact with non-service users along with service users. However, day centres and their normalised activities facilitate connections between objects that could lead to new connections being formed outside of the day centres. For instance, playing pool could feed into seeking to become part of a local pool team outside of the day centre.

In this chapter we have considered the connections formed between objects in the kinds of places in which users spend their time. This is to understand the production of spatialised experience as formed through the ways that objects inter-relate to produce the existence of space at particular times. To move this on, we need to consider how the connections that form spatial experience can feed into new experiences. In terms of mental health service use, this involves taking a closer look at the political implications of our understanding of service use. This is the aim of the next, and final, chapter.

Chapter 8:

The Politics of Affectivity

‘In short, everything is political, but every politics is simultaneously a *macropolitics* and a *micropolitics*.’

Gilles Deleuze and Felix Guattari, *1000 Plateaus: Capitalism and Schizophrenia*, 1987: 235

8.1 Micropolitics of Service User Research

In this final chapter I would like to cover some of the political implications of the findings of this thesis, along with considering how they fit with directions for future research in the area. Firstly, I would like to work through two short data extracts by way of reiterating the key analytic issues highlighted in this thesis. Following this, I will discuss the political ideas of Deleuze and Guattari, and their demarcation of *micro* and *macropolitics*, before positioning this thesis firmly in the micropolitical realm. Next, I will highlight the macropolitical practices that this thesis may potentially feed into, before looking at ways that this might be accomplished. Consider the following extracts (originally seen in Chapters Four and Six respectively):

- 1) **Ian:** mm (2) what about your diagnosis then? Have you always agreed with it?
Ben: °well I always knew° there was something wrong cos you don’t hear voices for (.) no apparent reason (I: mm) (3) and I kept, when wh..wh..when they didn’t diagnose me at first (.) I kept saying you know (.) I know there’s something wrong (I: mm) (1) and then when it was, the diagnosis was given (.) to me it was like (1) finally some closure (.) you know what I mean I..I have got something wrong (I: mm) (1) but then I (.) on the other hand it was like schizophrenia (.) I’ve got to live with that for the rest of my life (I: mm) (1) so it was kind of mixed emotions (I: mm) (3) so
Ian: so you (1) you think it’s something then (.) that’s it then you’ll (.) you’ll have for the rest of your life.....(lines 342-352)

- 2) **Beatrice:** says take two for now (2) and um (1) see how you go and I did (.) and I (.) I..I..I almost recovered straight away (1) well when I say straight away about (.) half an hour (I: mm) half an hour to an hour (.) I..I felt (.) really better you know (.) whereas before then I was (.) in bed all the time and (.) I only got up if I really needed to and (.) even then I wasn't feeling (.) great (.) I didn't want to cook I didn't want to clean (.) didn't want to do anything (I: mm) but (.) this Procyclidine (.) really helped and I thought oh I must be suffering from the side effects (I: mm) (.) of this drug (1) anyway I took two more the day after (.) then I I I (.) I'd completely recovered (I: mm) (2) and (.) I told my CPN who I saw, I see her on a Friday (.) it was the weekend (1) I think I rang her up on the Monday that was it (.) and told her oh this Procyclidine, you'll have to get me some more (1).....(lines 466-478)

In this first extract with Ben we see the problem of having to address a diagnostic identity of 'schizophrenia', which was something he received after a period of hearing voices. Receiving this diagnosis was not initially a negative event in Ben's life, as it provided an explanation for experiences that had proved distressing (i.e. hearing voices). The problem for service users, is how to negotiate the acceptance and recognition of a category that works to re-code one's experiences in a potentially stigmatising way. This is evidenced, with Ben, in stating "it was kind of mixed emotions", in terms of relief at having an explanation for distressing events, but coupled with this a realisation that he was going to be subject to a range of potential forms of stigmatisation associated with the category 'schizophrenia'. Inherent within this, is the issue of control with regard to decisions over one's life, which becoming a service user can present. For instance, in relation to decisions regarding the mechanism of administering medication, as was seen in Chapter Five.

In the second extract, we see an example of the infolding of biology into service user experience, in terms of the taking of medication. Beatrice reports how prior to receiving medication designed to counteract the side effects of other medication she was taken, her affective state was severely limited. The infolding of the medication into experience worked to render Beatrice barely physically capable of getting out of bed, let alone perform the basic domestic activities necessary to maintain one's home. The

different ways that users' bodies are captured and coded (i.e. by medication) are then driven into space, and the kind of places users spend their time. Users' ability to engage with spaces is indelibly linked to the production of user embodiment, though the infolding of both biological and cultural contexts, which are complex webs of *affect*. With a reminder of some of the key analytic issues from this thesis in mind, let us consider the political concerns involved here.

8.2 The Politics of Deleuze and Guattari

The political thrust of this thesis is indebted to Deleuze and Guattari's conception of politics. Although not always understood as political writers (Patton, 2000), there are strong political concerns at the centre of their philosophy. Crucially these are focused around the notion of *creation*. That is, in creating new ways of thinking about life, which forms a political ontology towards change and process. The central cog of the Deleuze and Guattari machine is one of deterritorialisation, of providing "tools to describe transformative, creative or deterritorialising forces and movements" (Patton, 2000: 9).

Let us begin with some biographical coverage of Deleuze and Guattari. Prior to their meeting around the time of the 1968 student-led protests in Paris, both Deleuze and Guattari had political concerns and activity driving their writing. Deleuze was involved in a variety of political movements throughout his life, such as those concerned with the rights of prisoners, Italian intellectuals, homosexuals and Palestinians (Deleuze, 1990). For example, when the Italian writer Antonio Negri was imprisoned in Italy due to his views being seen to be associated with terrorism, Deleuze wrote an open letter to his judges (see Deleuze, 2006). Indeed, he continued to write in political terms up to his death, with one of his last publications being a short piece criticising America's invasion of Iraq in the Gulf War (Deleuze, 2006).

Guattari's political activity was more pronounced and explicit than that of Deleuze, and started at an earlier time in his life. Having trained as a psychoanalyst, Guattari became very critical of psychoanalytic practice, and also the role of psychoanalysis as part of the capitalist mode of production (Guattari, 1984). These political concerns were manifest in activist movements, and indeed, Guattari stated that it was not so much that he was interested in such socio-political matters, but that they became 'ways of life' for

him (Deleuze, 1990). He was a keen advocate and catalyst of the anti-psychiatric movement, primarily in terms of developing alternative ways of thinking about the production of experiences labelled 'mental disorders', through a sustained re-formulation of the notion of desire in psychoanalysis. At the heart of his writings was the desire to develop concepts that opened up the political climate to the notion of change; placing deterritorialisation as the central concept to achieve this. Thus, both Deleuze and Guattari, as single and co-authors were fuelled by political concerns. However, in relation to mental health, there is an aspect of their analytic writings that needs addressing.

8.3 Schizo-Analysis

In utilising a Deleuze-Guattarian theoretical framework for this thesis, it has been necessary to draw upon a wide range of their writings. In doing this, a concern emerges with regard to the relationship between their thought and mental health. Particularly, their use of the terms 'schizo-analysis' and 'schizophrenia' to define parts of their analytic armoury. The use of schizo-analysis is in the main, part of the critique of psychoanalysis set out in *Anti-Oedipus* (1983). Influenced by Marxist thought, they argued psychoanalysis to be a central mode of production of capitalism. Psychoanalysis becomes part of the capitalist system with the Oedipus complex forming relations that produce ways of thinking about human experience based on the notion of desire as 'lack'. Deleuze and Guattari seek to turn this on its head, arguing instead that desire is a productive force that is produced through relations of force at work that constitute experience.

In a sense, the use of 'schizo-analysis' and 'schizophrenia' is unfortunate. Deleuze and Guattari do not use them to say something specific about the experiences of people to whom such labels are applied. Indeed, it is not their aim to devalue the distress people labelled schizophrenic may experience. Rather, the terms are a means of creating new ways of thinking about the codings of psychoanalysis. They seek to deterritorialise psychoanalytic thought and re-code experience based on a notion of desire as a positive force. In this way, they are not speaking about 'mental health' in either clinical or lay terms, but rather, creating a concept based on an idea that 'schizophrenic' thought is an uncoded (almost pure) form of creativity, outside the capture of other systems of thought. This was a move away from the psychoanalytic positioning of the psyche at

the centre of human experience, through considering life as formed in series of connections. Wholes do not exist as such, in terms of defined essences, i.e. the psyche. Rather, what comes to be known as the psyche is actually formed through a set of interconnecting parts, or fragments. This is where 'schizo' comes from, used to describe their emphasis on the fragmented, partial, connecting production of experience. For Deleuze and Guattari, 'schizo' is not a psychological phenomenon but a way of life, of creative flow that becomes through the relations that connect to form experience (Colebrook, 2002). They do however on occasion use the word 'schizophrenia' in the traditional sense, but on these occasions they refer purely to the way that 'schizo' is captured by biomedical knowledge. However, we have seen there are a number of critiques of this position, which render the reification of certain experiences as 'schizophrenic' highly problematic. Thus, Deleuze and Guattari's use of such vocabulary is misrepresentative, for it suggests the idea that a 'schizophrenic' way of being exists, which is irrational. This frames the term in such a way that does not adhere to a rational and self-contained notion of the subject.

8.4 Molecular Concerns

The issue with addressing what Deleuze and Guattari refer to as 'molar' states (e.g. nations, classes, sexes) and 'molecular' states (e.g. everyday social interactions), is to recognise them not as differences in scale, but rather as different in kind (Patton, 2000). In terms of mental health, 'molecular' is used to describe the fragmented (i.e. multiple and varied) ways that experiences labelled as 'mental disorder' exists in people's everyday lives. A molar state, e.g. the form of expression of the diagnostic term 'schizophrenia', is going to relate to a whole series of fragmented experiences that occur in people's lives on a day-to-day basis (i.e. individual medication regimens seen in Chapter Six). It is the multiple formations of molecular experiences that have been at the heart of this thesis.

Understanding the molecular in this context involves highlighting the analysis in this thesis as grounded in the everyday life experiences of service users. Prime analytic focus has not been on the multiple social forces at work in constituting service use, but rather, how these forces impact upon, and subsequently are re-worked on a day-to-day basis by service users (that is *infolded*). As we have seen, this has involved a specific theoretical tool box, distinct from one that would solely focus on macro

social forces. For instance, critiques that have questioned the reliability and validity of diagnostic categories such as schizophrenia (Bentall, 1990, 2003; Boyle, 2002). These are critiquing pivotal parts of mainstream psychiatric practice in themselves. They are not focusing on how diagnostic categories are taken up and utilised in everyday psychiatrist-patient consultations, but are challenging their claims to psychiatric truth at a macro level. The question this raises, is how to deal with the relationship between micro and macro that is faced here. Are we saying that by focusing on the molecular that analysis can add nothing to debates that largely operate on the molar? One would hope not. This is not a simple problem to overcome, however, in considering the implications of this thesis, it is a question that needs to be taken into account. Although Deleuze and Guattari differentiate macro (molar) and micro (molecular) politics, they do not suggest a strict dichotomy in which one is either operating at a macro level *or* a micro level as such.

‘Every society, and every individual, are thus plied by both segmentarities simultaneously: one molar, the other molecular.’

Deleuze and Guattari, 1987: 235

This is the first point to make, it is not the case that a strict dichotomy exists. What they refer to are distinct *planes*. In relation to mental health, molar states operate in terms of governing institutional formations, e.g. diagnostic manuals. Additionally, there is a molecular level which is produced through connections that are localised through grounding in everyday experiences. For instance, the operation of medication as a psychiatric treatment is the result of a set of forces, including macro phenomenon such as mainstream psychiatric policy decisions regarding treatments, along with micro phenomenon such as service users’ individual medication practices, as seen in Chapter Six. As Patton (2000) pointed out, it is not just a matter of size or quantity. Forces (as we see in the opening extract, Deleuze and Guattari argue that all forces are political) are thus operating both at a molar level *and* at a molecular level, e.g. users’ medication practices. In discussing the 1789 French Revolution Deleuze and Guattari state “what one needs to know is which peasants, in which areas of the South of France, stopped greeting landowners” (1987: 238), to understand the micro operation of the revolution. That is, to gain insight into how the revolution was grounded in the everyday lives of the French, it would be necessary to observe the day-to-day interactions of the peasants

who were fighting against the power of the bourgeois landowners. The presence of the revolution was known to everyone at a macro level, but to really understand how it was being produced and operating in towns and villages across the country it would be necessary to address the micro level interactions between the inhabitants of the country. It was at the molecular level that the revolution was actually produced.

Another point Deleuze and Guattari make is that just because macro and micro operate on different planes, does not mean that they cannot ‘cut in’ on each other. This is an important point. In arguing that this thesis operates primarily at the micro level, is not to suggest that micropolitics cannot speak to macropolitics. In focusing on the molecular operation of users’ lives the aim has been to identify and place emphasis on the *lines of flight* that deterritorialise the forces present in producing psychiatric practice that contribute to the constitution of users’ lives. It is important to start here, so as to be able to understand and analyse service users’ experiences, and through this, to see how the macro social forces of mainstream psychiatry impact upon their day-to-day lives. With Deleuze and Guattari this kind of approach was developed in *Anti-Oedipus*, in part catalysed by the political climate of the day, namely the post-May 1968 disillusion with molar politics.

‘From the viewpoint of micropolitics, a society is defined by its lines of flight, which are molecular.’

Deleuze and Guattari, 1987: 238

For example, in this thesis we saw the ways that users managed to negotiate the tricky terrain of having to orient to, and pass through some of the parts that form the dominant signifying regime of mainstream psychiatry, e.g. diagnostic categories and treatment decisions. In doing this, a variety of strategies were utilised to deterritorialise current thought. For instance, accepting diagnostic labels, but only in a temporal way in referring to a singular or number of instances, rather than at a level of overall constant identity. This involved discursively accounting for experiences. In addition to this, we saw the forms of deterritorialisation at work in terms of users’ bodies and space, which are key sites at which psychiatric forces impact upon users’ lives.

This thesis then, has firmly positioned itself as micro-oriented, in understanding how psychiatric forces deterritorialise users’ everyday lives. It has attempted to unfold some

of the multiple ways that psychiatric practice captures service users' experiences. This has been a great strength of the service user movement. It has managed (although there remains a long way to go) to bring the micro to the macro level. In mental health research, micro forces in service users' lives have for a long time been absent from research. In a sense, this has allowed the macro to go unchecked, which as we have seen in the case of mainstream psychiatry, as experienced by the service users in this study, has not always been beneficial for users.

8.5 Issues with Implications

In the previous section it was argued that micropolitics can cut into macropolitics, and vice versa. In this section, I want to discuss some of the issues associated with the operation of such 'cutting in'. Mental health is an area in which it is very important for such cutting in to work. Many areas in the field remain contested, with such contestation operating in large parts at the macro level, in terms of policy decisions etc. Harper states "mental health service users are routinely portrayed in the media in a negative light and face discrimination in a wide range of spheres of life, including employment, parental rights, housing, immigration, insurance, health care and access to justice.....[A]ction to influence these broader issues requires change at the level of social policy" (2005: 56). The current climate (i.e. at a time when reform of the Mental Health Act is underway), is as important a time as ever for addressing user experience, who lest we need to remind ourselves, are the people such policy decisions will have most effect on, into the wider cultural consciousness. For instance, Rogers et al. (1993) demonstrated a number of ways that service users' views can inform practice, e.g. in placing less emphasis on 'illness', highlighting problems with both in-patient and community care services, and, perhaps most importantly, illustrated the value of incorporating the service user, and their perspective, in research itself.

Of course, it is not as simple as stating that findings from this thesis can be applied directly to current practices, as we recognise the contextualised nature of experience. This means that a set of experiences cannot be mapped onto another without awareness of the contextual practices of each. This thesis has illuminated *some* of the complexity that is mental health service users' lives. With a recognition of such complexity comes the price of realisation that the products of such analysis are not easily translated into items that are effortlessly traded in the market place of implications and applicability

for research. What is happening when trying to move from one forum (analysis) to another (discussing ‘usefulness’ of findings) is that one is moving onto a different *plane*, which inevitably involves different patterns of operation. This though, does not mean that such endeavours are not to be attempted, just that one recognises the inevitable challenges that will be faced. For instance, the use of academic language in the thesis is not one that other relevant groups would normally deal with, e.g. psychiatric clinicians and policy makers (Harper, 1999).

8.6 Application Issues

It is important to map out the terrain from which I speak. The non-clinical base and framework of this thesis differentiates it from a great deal of service user literature that has operated within a clinical professional setting, be it psychiatric, clinical psychology, social work for example. These forms of research have had quite defined paths from which to speak *from* and *to*. Indeed, a lot of funding underlying such research is based upon researchers being active within a discipline, and applying findings back to that discipline, and those closely related to it. As a non-clinician, I have a distinct set of concerns when it comes to implications and applications of my research. For instance, placing service users’ actual experiences at the forefront of research without approaching them as examples of clinical entities, e.g. as a ‘schizophrenic’. Secondly, developing theoretical tools that facilitate an approach to analysis that gets somewhere close to actual grounded experience, without just offering an alternative conceptualisation of what the phenomena *are*, as if they have a distinct essence.

Talking to clinicians is an important aim though, as building knowledge of service user experience has to have clinical implications. Another area to engage is social psychology, in terms of the integration of service user literature and social psychological theory that has developed throughout the thesis. This has evolved through theoretical concerns regarding discursive analyses, e.g. using theoretical tools such as Deleuze and Guattari’s territorialisation to gain insight into the production and understanding of spatialised experience. Additionally, the terrain of social psychological understanding of mental health has been enhanced. The former predominantly theoretically-based concerns have less scope for integrating and informing clinical practice formally, but social psychological literature has important

things to say to clinicians and service users alike. Synoptically, what the thesis has set out to do is to demonstrate that mental health can be approached as a form of living like any other; contribute to a general social psychology of exclusion; and to theoretically develop an approach to analysing forms of content as well as expression (i.e. Deleuzian Discourse Analysis).

8.7 Levels of Service User Research (SUR)

In Chapter Three, I briefly introduced the issue as to what exactly counts as service user research in terms of the general concern of those involved that service users be appropriately and adequately valued. This means, assessing the level at which service users are involved in research, and evaluating the value of different levels.

In the embryonic stages of SUR the main concern was to incorporate service users' views/experiences/perspectives in research, with the recognition that it was a good opportunity to develop understanding of living with mental health difficulties which had been long overlooked, by not analysing the accounts of service users. As we saw in the review of SUR, this kind of service user focused research forms a key strand of SUR, and is indeed, where this thesis sits. In recent years, there has been a drive towards further incorporation of service users in research through their recruitment into the process of designing and undertaking research itself. This has become known as User Involved Research (UIR) (e.g. Clark, Davis, Fisher, Glynn, & Jefferies, 2006; Davis, 2005). One of the catalysing arguments for UIR is that users should not only be the 'subjects' of someone else's research, in which they may still not be adequately empowered due to the researchers holding the main positions of power over the research, but should become actively involved in the research process itself.

This raises an issue as to how best to go about incorporating the service user 'voice' in research. The argument in this thesis is that a varied and multiple approach can provide a strong body of knowledge to be formed. For instance, UIR can enable those service users who wish to take an active role in research to become trained researchers themselves, driving empirical efforts forward from a position of expertise over the underlying experiences under focus. SUR, such as in this thesis, can add to this, by placing analytic efforts directly on service users' experiences. This recognises that not

all users would actually wish to become researchers themselves, and are thus happy to take part in research, such as that of this thesis.

In terms of speaking to service users this thesis has offered a variety of factors that, I would hope, would prove of interest. Firstly, it has developed a method (Deleuzian Discourse Analysis) through which some of the complexity of service users' actually everyday, grounded experiences can be analysed. We have seen throughout the thesis how mediated experience is, and as such, a way of researching service users' experiences that gets empirically close to their everyday lives is, hopefully, a welcome addition. Secondly, through placing service users' experiences at the forefront of the analytic process, an approach has been developed that does not solely offer an alternative reification of service users' experiences. This is not to say that experience can be easily accessed. Rather, many of the ways that experience is captured have had to be dived through in seeking to unearth some of the underlying experiences; the *content* of service users' lives. Thirdly, a series of challenges that face service users' in the current socio-political climate have been presented. For instance, the continued problems posed by the construction of identities in such a way that avoid, or at least lessen, exposure to stigmatisation. Also, the problems of managing daily somatic states when adhering to medication regimens that can produce quite severe side effects. Some more of these issues will be discussed in the final section.

8.8 Clinical Applicability

I now want to say something about what I consider to be the main points this thesis has to say to clinicians. By clinicians, I am referring to the professionals that make up the community mental health teams that have 'front-line' contact with service users. This includes consultant psychiatrists, clinical psychologists, social workers, general practitioners, and community psychiatric nurses. These people are all involved in the everyday clinical management of service users. Of course, frequency of contact is variable, as it is assessed on an individual basis.

Points of interest in terms of clinical impact emerged throughout the analytic work undertaken in this study. Firstly, these related to forms of knowledge users produced. Considerable variability existed within these, but similarities in what was *not* known emerged. Pivotal, these relate to the distinct knowledge practices at work in forms of

clinical knowledge and expertise, and practical knowledge. Users' practical knowledge systems demonstrated considerable utility in a range of issues associated with day-to-day living. This points to a development based upon value, rather than one purely due to the lack of clinical expertise. The utility demonstrated, evidences the need to legitimate forms of practical knowledge (i.e. service user knowledge), rather than see them as lacking in some way due to the absence of expertise in terms of clinical knowledge. This emphasis upon clinical expertise as the only valid form of knowledge has not proved beneficial across the board for service users. In getting to this point, it has been necessary to analyse the kind of relationship service users have to forms of expert knowledge. More specifically, how they try to legitimate their own experiences (as we saw in Chapters Four and Five), and how their knowledge of their own bodies – as produced through affective experience – fits into clinical knowledge. Indeed, the whole drive of the thesis is to emphasise and make clear the value, and necessity, of drawing on and illuminating service users' expertise over their own lives. It has proved to be the case that this does not always cohere neatly with mainstream clinical knowledge, but, to an extent, that is the point. If it did, there would be no need to analyse it.

8.9 Current Political Climate

At present in mental health, the political climate is a fraught one. Government proposals to reform the 1983 Mental Health Act have been circulating for the last few years, with much consultation occurring between the many groups who have a stake in reform (e.g. psychiatrists, clinical psychologists, service users, critical psychiatrists). Some of the key proposals of the reform include providing a broader definition of mental disorder, and greater involvement of users in decisions regarding care and treatment (Department of Health, 2004). Whilst these sound good and positive steps for users, the main point of conflict regarding the proposals relates to those that focus on compulsory treatment, both in-patient and in community settings. Critics of the proposals argue that too much emphasis is being placed on risk and safety, rather than care and treatment (Laurance, 2002). Whilst the safety of users is mentioned, critics feel that the driving force of reform comes from Government concern that the general public want to see affirmative action that people with mental distress who potentially pose a threat to the public are being adequately 'controlled'. Recent, very well broadcast in the media, cases of violent crimes committed by people with mental health

difficulties has led to a cultural consciousness of fear, something the government is concerned to allay (Laurance, 2002).

Of course, people who are a threat to the public, and/or themselves, need to be properly accounted for. The issue in terms of the Mental Health Act (1983) is that these concerns are massively overshadowing a whole raft of other issues, that are very important for users (Laurance, 2002). A government reform of policy is an important opportunity to enact some positive changes.

Greater powers to facilitate compulsory treatment additionally places renewed import on the role of medication in mental health care, and some of the challenges that medication can bring to users have been highlighted in Chapter Six. The catalyst for compulsory treatment is to ensure that people remain on treatment regimens, based on the belief that perpetrators of violent crime have often ceased taking treatment, which is seen as a causal factor in their committing of crime. This emphasises the role of treatment, and as medication is the dominant treatment, a renewed emphasis is placed on it. It is not the case that policies are proposed that recommend more choice and breadth in treatments available for users. Compulsory treatment policies would enact a greater control in societies over users, primarily through medication. Medication works in the same way as Deleuze (1990) suggested technologies work in 'Postscript on Control Societies'; the technology of medication continues and potentially becomes more powerful and controlling if reforms go through. Literature is growing, arguing for a greater choice over treatments, with a real push towards alternative forms of treatment, such as Cognitive Behavioural Therapy (e.g. Gumley, Karatzias, Power, Reilly, McNay, & O'Grady, 2006; Haddock & Lewis, 2005; Tarrier, 2005), and the broad range of psychotherapies (e.g. Isherwood, Burns, & Rigby, 2006; Lysaker, Lancaster, & Lysaker, 2003; Penn, Waldheter, Perkins, Mueser, & Lieberman, 2005; Tarrier, 2005), in which time can be spent in a supportive therapeutic environment to work through issues in users' lives that may have led to them developing mental health difficulties initially. For instance, the high prevalence of abusive histories for users (Read, 2006). We can see that it is as important a time as ever to illuminate service user experience, that is, at a time when key reforms are taking place.

8.10 Other Areas for Input

The concepts that drive this thesis (e.g. deterritorialisation) can speak to other areas of mental health research that are currently working to transform mainstream knowledge practices. A very prominent area is that of the Hearing Voices Network, based on the pioneering work of Romme and Escher (1993; 2000), seen in Chapters Two and Three. Their work on presenting new ways of thinking about the experience of hearing voices has been key in transforming dominant ideas about auditory hallucinations. This is deterritorialisation at work, creating concepts to shift the cultural consciousness into new systems of thought, e.g. not viewing all instances of voice hearing as pathological, which is a clear move away from mainstream psychiatric thought in the area.

Interestingly, as this is written, the 15th anniversary of the Hearing Voices Network is including a seminar looking at the value of Deleuzian theory in analysing experiences of hearing voices. Whilst not aware of the content of the seminar itself, throughout the thesis we have seen reasons why HVN would be interested in Deleuze. For instance, in the move to de-pathologise experiences such as hearing voices, to provide concepts (e.g. deterritorialisation) that facilitate a means by which to demonstrate change and process. Additionally, the political emphasis in his writing, which we saw earlier in the chapter. Deterritorialising the capture of service user experience according to mainstream diagnostic criteria is a pivotal aim of HVN thought and activity.

8.11 Politics of Affectivity

As the thesis draws to a close, I would like to offer a politics of affectivity, based upon the concept of *affect* we have seen worked through in greatest detail in the previous two chapters. This has operated to produce a way of thinking about forms of content in service users' experiences that de-individualises and de-subjectivises their bodies. It has been a concern to look for movement and change in experience that has been of importance. The limited possibilities that exist for service users through the capturing of their lives through the forces of medication and existence as service users, have been demonstrated. What is required is to emphasise the potential for movement, change, process. Only in this way can the micro-analysis of service users' experience cut into macro concerns of institutional decision making and policy design. Understanding affect as a force of movement and change, that despite only being visible on the side of the actual, still marks out the virtual as potential, is a fundamental part of a politics of affectivity that can deterritorialise mental health.

We have seen key areas in which users face challenges in their daily lives. Chapter Four demonstrated the difficulties of managing a diagnostic identity in light of the social effects of receiving labels such as ‘schizophrenia. Chapter Five illuminated some of the problems in being seen to have some kind of control over one’s life, when faced with situations in which control is removed, i.e. with respect to decisions over how medication should be administered. In addition to these, in Chapter Six we saw some of the somatic challenges facing users when adhering to daily medication regimens, particularly when side effects were experienced. It was then a sense of how such experiences are driven into the settings in which users spend their time, and how they code those spaces that formed the analysis in Chapter Seven. In doing this, we got close to the operation of the ‘control society’ of current care in the community, and through this see some of the demands on users in attempting to live their lives in mainstream (i.e. non-pathologised) spaces. The underpinning concept of deterritorialisation running throughout this thesis has served to unfold a lot of the layers of mediation that capture the *flow* of service user experience, and in doing that to offer a conceptualisation and politics of change, of affectivity.

8.12 Final remarks

In this thesis we have learnt some things about the micropolitics of service use: how living with mental health difficulties involves managing a heterogeneous set of forces that impact on one’s life, with some requiring more re-working than others to maintain an adequate level of daily activity (e.g. medication). But where does that leave us? Almost inevitably, with the ubiquitous ‘more research is needed’ suggestion of a concluding section of research. Of course, to make such a suggestion really is to state the obvious. As time moves on, experiences and contexts change, so it is inevitable that more research will be needed if understanding is sought for something at a later date from now.

More specifically, I have sought, and to some extent succeeded I hope, to throw further light on debates surrounding critical social psychological thought about the relationship between discursive and non-discursive practices. Through developing a Deleuzian Discourse Analysis I have offered a version of discourse analysis that facilitated the unfolding of the relationship between forms of content and expression, as grounded in service user experience. This has drawn from across the field of discourse analysis to

date, and attempted to serve as one way through which to be able to analyse both forms of expression and content, as opposed to focusing solely on either one. Also, that such an approach can get ‘closer’ to the actual grounded experiences of service users, rather than solely offer up an alternative reification.

Additionally, by exploring the production of spatialised experience, some knowledge is constructed regarding the operation of community service use, specifically with regard to the kinds of places in which users spend their time, e.g. day centres and home environments. This work adds to the growing micropolitics of service user research, with its expressed aims to continue to cut into the macropolitics of mainstream psychiatry. The area of mental health is one in which much time and effort needs to be spent to ensure that those to whom forms of knowledge are applied have their experiences at the forefront of consideration. This requires a difficult, yet necessary, understanding of the ‘impurity’ of experience. Gaining insight into the ways that experience is presented in dimensions of both content and expression is vital if we are to get close to what it ‘feels’ like to be a service user in today’s society. This thesis has demonstrated that a valuable way to do this is to deterritorialise mental health, but in such a way that does not just offer another reification of service user experience, but analyses, as close as possible, their experiences:

‘We are endlessly relativising, rearranging, dismantling all the accepted theories, and those that resist remain under permanent attack. Far from setting out to mummify them, the aim is to open them out onto further constructions that are just as provisional, but more firmly grounded in the solid earth of experience.’ (Guattari, 1984: 253)

References

- an der Heiden, W. (2001). Methods for evaluating community mental health services. In G. Thornicroft & G. Szukler (Eds.). *Textbook of community psychiatry*. Oxford: Oxford University Press.
- Andrews, J. (2003). Grand master of Bedlam: Roy Porter and the history of psychiatry. *History of Science*, *xli*, 269-286.
- Antaki, C. (2004). Reading minds or dealing with interactional implications? *Theory & Psychology*, *14*(5), 667-683.
- Artaud, A. (1995). *Watchfiends & rack screams: works from the final period*. Boston: Exact Change.
- Astington, J. W., Harris, P. L., & Olson, D. R. (Eds.). (1989). *Developing theories of mind*. Cambridge: Cambridge University Press.
- Austin, J. L. (1962). *How to do things with words*. Cambridge, Mass.: Harvard University Press.
- Baron-Cohen, S. (1989). The autistic child's theory of mind: a case of specific developmental delay. *Journal of Child Psychology and Psychiatry*, *30*, 285-297.
- Barrantes-Vidal, N. (2004). Creativity & madness revisited from current psychological perspectives. *Journal of Consciousness Studies*, *11*(3-4), 58-78.
- Basaglia, F. (1981). Breaking the circuit of control. In D. Ingleby (Ed.). *Critical psychiatry: the politics of mental health*. Harmondsworth: Penguin.
- Basaglia, F., Scheper-Hughes, N., & Lovell, A. (1987). *Psychiatry inside out: selected writings of Franco Basaglia*. New York: Columbia University Press.

- Bayne Smith, M. E. (1996). *Race, gender, and health*. London: Sage.
- Bennett, D. (1991). The drive towards the community. In G. E. Berrios & H. Freeman (Eds.). *150 years of British psychiatry, 1841-1991*. London: Gaskell.
- Bentall, R. P. (1990). *Reconstructing schizophrenia*. London: Routledge.
- Bentall, R. P. (2003). *Madness explained: psychosis and human nature*. London: Allen Lane.
- Berger, P., & Luckmann, T. (1967). *The social construction of reality: a treatise in the sociology of knowledge*. Harmandsworth: Penguin.
- Better services for the mentally handicapped (1975). *White Paper*. London: HMSO.
- Better services for the mentally ill (1975). *White Paper*. London: HMSO.
- Bhugra, D. (2006). Severe mental illness across cultures. *Acta Psychiatrica Scandinavica*, 113, 17-23.
- Blackman, L. (2000). Ethics, embodiment and the voice-hearing experience. *Theory Culture & Society*, 17(5), 55-74.
- Bleuler, E. (1950). *Dementia praecox or the group of schizophrenias* (J. Zinken, Trans.). New York: International University Press.
- Bonta, M. (2005). Becoming-forest, becoming-local: transformations of a protected area in Honduras. *Geoforum*, 36(1), 95-112.
- Bowers, L. (1998). *The social nature of mental illness*. London: Routledge.
- Bowker, G. C., & Star, S. L. (1999). *Sorting things out: classification and its consequences*. Cambridge, Mass.: MIT Press.

- Bowl, R. (1996). Involving service users in mental health services: social services departments and the NHS and Community Care Act 1990. *Journal of Mental Health*, 5(3), 287-303.
- Boyle, M. (1990). *Schizophrenia: a scientific delusion?* London: Routledge.
- Boyle, M. (2002). *Schizophrenia: a scientific delusion?* (2nd. ed.). London: Routledge.
- Bracken, P. J. (2003). Postmodernism and psychiatry. *Current Opinion in Psychiatry*, 16(6), 673-677.
- Brandon, D. (1990). *Innovation without change? - consumer power in psychiatric services*. London: MacMillan.
- Breaking the Silence, (2001, 21st October). *The Observer*, 27.
- Breggin, P. R. (1994). *Toxic psychiatry*. New York: St. Martin's Press.
- British Psychological Society (2000). *Recent advances in understanding mental illness and psychotic experiences*. Leicester: British Psychological Society.
- Brown, S. D. (2001). Psychology and the art of living. *Theory & Psychology*, 11(2), 171-192.
- Brown, S., D., & Stenner, P. (2001). Being affected: Spinoza and the psychology of emotion. *International Journal of Group Tensions*, 30(1), 81-105.
- Brown, S. D., & Lunt, P. (2002). A genealogy of the social identity tradition: Deleuze and Guattari and social psychology. *British Journal of Social Psychology*, 41, 1-23.
- Brown, S. D., Pujol, J., & Curt, B. C. (1999). As one in a web? Discourse, materiality and the place of ethics. In I. Parker (Ed.). *Social constructionism, discourse and realism*. London: Sage.

- Bryant, W., Craik, C., & McKay, E. (2005). Perspectives of day and accommodation services for people with enduring mental illness. *Journal of Mental Health, 14*(2), 109-120.
- Buchanan, A. (1992). A two-year prospective study of treatment compliance in patients with schizophrenia. *Psychological Medicine, 22*(3), 787-797.
- Buchanan, I. (1997). The problem of the body in Deleuze and Guattari, or, what can a body do? *Body and Society, 3*(3), 73-91.
- Burkitt, I. (1991). *Social Selves*. London: Sage.
- Burkitt, I. (1999). *Bodies of thought: embodiment, identity and modernity*. London: Sage.
- Burr, J., & Chapman, T. (2004). Contextualising experiences of depression in women from South Asian communities: a discursive approach. *Sociology of Health & Illness, 26*(4), 433-452.
- Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.
- Butler, J. (1990). *Gender trouble: feminism and the subversion of identity*. London: Routledge.
- Campbell, P. (1996). The history of the user movement in the United Kingdom. In T. Heller, J. Reynolds, R. Gomm, R. Muston & S. Pattison (Eds.). *Mental health matters: a reader*. Basingstoke: MacMillan.
- Campbell, P. (1999). The service user/survivor movement. In C. Newnes, G. Holmes & C. Dunn (Eds.). *This is madness: a critical look at psychiatry and the future of mental health services*.
- Campbell, P., Cobb, A., & Darton, K. (1998). *Psychiatric drugs: users' experiences and current policy and practice*. London: Mind.

Campbell, P. (2001). Surviving social inclusion. In C. Newnes, G. Holmes & C. Dunn (Eds.). *This is madness too: critical perspectives on mental health services*. Ross-on-wye: PCCS Books.

Care in the community (1981). *Green Paper*. London: HMSO.

Christiansen, T., Jorgensen, K. E., & Wiener, A. (1999). The social construction of Europe. *Journal of European Public Policy*, 6(4), 528-544.

Clark, M., Davis, A., Fisher, A., Glynn, T., & Jefferies, J. (2006). *Transforming services, changing lives working with user involvement in the mental health services*. Birmingham: University of Birmingham.

Coffey, M. (2006). Researching service user views in forensic mental health: a literature review. *Journal of Forensic Psychiatry & Psychology*, 17(1), 73-107.

Colebrook, C. (2002). *Gilles Deleuze*. London: Routledge.

Coleman, R. (1999). Hearing voices and the politics of oppression. In C. Newnes, Holmes, G., & Dunn, C. (Ed.). *This is Madness: a critical look at psychiatry and the future of mental health services*. Ross-on-wye: PCCS Books.

Compton, M. T., Rudisch, B. E., Weiss, P. S., West, J. C., & Kaslow, N. J. (2005). Predictors of psychiatrist-reported treatment-compliance problems among patients in routine US psychiatric care. *Psychiatry Research*, 137(1-2), 29-36.

Coppock, V., & Hopton, J. (2000). *Critical perspectives on mental health*. London: Routledge.

Coupland, J., & Gwyn, R. (Eds.). (2003). *Discourse, the body, and identity*. New York: Palgrave Macmillan.

Cramer, J. A., & Rosenheck, R. (1998). Compliance with medication regimens for mental and physical disorders. *Psychiatric Services*, 49(2), 196-201.

Crepaz-Keay, D. (1999). Drugs. In C. Newnes, G. Holmes & C. Dunn (Eds.). *This is Madness: a critical look at psychiatry and the future of mental health services*. Ross-on-wye: PCCS Books.

Crossley, N. (2001). *The social body*. London: Sage.

Davidson, L. (2003). *Living outside mental illness*. New York: New York University Press.

Davies, P., Thomas, P., & Leudar, I. (1999). Dialogical engagement with voices: a single case study. *British Journal of Medical Psychology*, 72, 179-187.

Davis, A. (2005). User involvement in mental health research and development. In D. Sallah & M. Clark (Eds.). *Research and development in mental health; theory, framework and models*. London: Elsevier Science Ltd.

Deleuze, G. (1988). *Foucault*. Minneapolis: University of Minnesota Press.

Deleuze, G. (1990). *Negotiations*. New York: Columbia University Press.

Deleuze, G. (1994). *Difference and repetition*. London: Athlone.

Deleuze, G. (2006). *Two regimes of madness*. New York: Semiotext(e).

Deleuze, G., & Guattari, F. (1983). *Anti-Oedipus: capitalism and schizophrenia*. Minneapolis: University of Minnesota Press.

Deleuze, G., & Guattari, F. (1987). *A Thousand plateaus: capitalism and schizophrenia*. Minneapolis: University of Minnesota Press.

Deleuze, G., & Guattari, F. (1994). *What is philosophy?* New York: Columbia University Press.

Department of Health, (2004). *Draft mental health bill*. London: HMSO.

- Derrida, J. (1983). Letter to a Japanese friend. In D. Wood & R. Bernasconi (Eds.). *Derrida and difference*. Warwick: Parousia Press.
- Derrida, J. (1987). *Positions*. London: Athlone Press.
- Diamond, B., Parkin, G., Morris, K., Bettinis, J., & Bettesworth, C. (2003). User involvement: substance or spin? *Journal of Mental Health*, 12(6), 613-626.
- Dinos, S., Lyons, E., & Finlay, W. M. L. (2005). Does chronic illness place constraints on positive constructions of identity? Temporal comparisons and self-evaluations in people with schizophrenia. *Social Science & Medicine*, 60(10), 2239-2248.
- Douki, S., Taktak, M. J., Ben Zineb, S., & Cheour, M. (1999). Management strategies in first psychotic episode. *Encephale-Revue De Psychiatrie Clinique Biologique Et Therapeutique*, 25, 44-51.
- Dreyfus, H. L., & Rabinow, P. (1983). *Michel Foucault: beyond structuralism and hermeneutics* (2nd ed.). Chicago: University of Chicago Press.
- Edwards, D. (1997). *Discourse and cognition*. London: Sage Publications.
- Edwards, D., & Potter, J. (1992). *Discursive psychology*. London: Sage Publications.
- Ekeland, T. J., & Bergem, R. (2006). The negotiation of identity among people with mental illness in rural communities. *Community Mental Health Journal*, 42(3), 225-232.
- Elkes, J., & Elkes, C. (1954). Effect of Chlorpromazine on the behaviour of chronically overactive psychotic patients. *British Medical Journal*, 2, 560-565.
- Emslie, C., Fuhrer, R., Hunt, K., Macintyre, S., Shipley, M., & Stansfeld, S. (2002). Gender differences in mental health: evidence from three organisations. *Social Science & Medicine*, 54(4), 621-624.

Espelt, N. G., & Benito, J. A. D. (2005). The social construction of the image of Girona: a methodological approach. *Tourism Management*, 26(5), 777-785.

Foster, J. L. H. (2006). Media presentation of the mental health bill and representations of mental health problems. *Journal of Community & Applied Social Psychology*, 16(4), 285-300.

Foucault, M. (1975). *The birth of the clinic: an archaeology of medical perception*. New York: Vintage Books.

Foucault, M. (1986). *The care of the self: the history of sexuality volume 3*. Harmandsworth: Penguin.

Foucault, M. (1995). *Discipline and punish: the birth of the prison*. New York: Vintage Books.

Foucault, M. (1999). *Abnormal: lectures at the College de France 1974-1975*. New York: Picador.

Foucault, M. (2001). *The order of things*. London: Routledge.

Foucault, M. (2002). *Archaeology of knowledge*. London: Routledge.

Foucault, M. (2005). *History of Madness*. London: Routledge.

Fox, J. W. (1990). Social class, mental illness, and social mobility: the social selection-drift hypothesis for serious mental illness. *Journal of Health and Social Behaviour*, 31(4), 344-353.

Frank, A. (1991). For a sociology of the body: an analytic review. In M. Featherstone, M. Hepworth & B. Turner (Eds.). *The body: social process and cultural theory*. London: Sage.

- Frith, C. D., & Corcoran, R. (1996). Exploring 'theory of mind' in people with schizophrenia. *Psychological Medicine*, 26, 521-530.
- Gabe, J. (1991). Personal troubles and public issues: the sociology of long-term tranquilliser use. In J. Gabe (Ed.). *Tranquilliser use: the role of the social sciences*. London: Routledge.
- Garety, P., A., & Freeman, D. (1999). Cognitive approaches to delusions: a critical review of theories and evidence. *British Journal of Clinical Psychology*, 38, 113-154.
- Geekie, J. (2004). Listening to the voices we hear: clients' understandings of psychotic experiences. In J. Read, L. R. Mosher & R. P. Bentall (Eds.). *Models of Madness*. London: Routledge.
- Gelder, M. G., Mayou, R., & Cowen, P. (2001). *Shorter Oxford textbook of psychiatry* (4th ed.). Oxford: Oxford University Press.
- Georgaca, E. (1996). *Exploring 'psychotic discourse': the construction and negotiation of reality and subjectivity in language*. Unpublished Ph.D. Thesis. Manchester Metropolitan University, Manchester.
- Gergen, K. (1985). The social constructionist movement in modern psychology. *American Psychologist*, 40(3), 266-275.
- Gergen, K. J., & Davis, K. (Eds.). (1985). *The social construction of the person*. New York: Springer Verlag.
- Godfrey, M., & Wistow, G. (1997). The user perspective on managing for health outcomes: the case of mental health. *Health & Social Care in the Community*, 5(5), 325-332.
- Goffman, E. (1968a). *Asylums: essays on the social situation of mental patients and other inmates*. New York: Penguin.

- Goffman, E. (1968b). *Stigma: notes on the management of spoiled identity*. Harmondsworth: Penguin.
- Golan, D. (1994). *Inventing shaka: using history in the construction of Zulu nationalism*. Boulder: L. Rienner.
- Guattari, F. (1984). *Molecular revolution: psychiatry and politics*. Harmondsworth: Penguin.
- Gumley, A., Karatzias, A., Power, K., Reilly, J., McNay, L., & O'Grady, M. (2006). Early intervention for relapse in schizophrenia: Impact of cognitive behavioural therapy on negative beliefs about psychosis and self-esteem. *British Journal of Clinical Psychology, 45*, 247-260.
- Gunter, V. J. (2004). The social construction of the ocean. *Society & Natural Resources, 17*(1), 93-95.
- Hacking, I. (1995). *Rewriting the soul: multiple personality and the sciences of memory*. Princeton, N.J.: Princeton University Press.
- Hacking, I. (1999). *The social construction of what?* London: Harvard University Press.
- Haddock, G., & Lewis, S. (2005). Psychological interventions in early psychosis. *Schizophrenia Bulletin, 31*(3), 697-704.
- Harlander, U. (1981). Considerations about psychosis and creativity. *Dynamische Psychiatrie, 14*(4-5), 262-276.
- Harper, D. (1994). The professional construction of 'paranoia' and the discursive use of diagnostic criteria. *British Journal of Medical Psychology, 67*, 131-143.
- Harper, D. (1996). Deconstructing 'paranoia': towards a discursive understanding of apparently unwarranted suspicion. *Theory & Psychology, 6*(3), 432-448.

- Harper, D. (1999). *Deconstructing paranoia: an analysis of the discourses associated with the concept of paranoid delusion*. Unpublished Ph.D. Thesis. Manchester Metropolitan University.
- Harper, D. (2005). The critical professional and social policy: negotiating dilemmas in the UK Mental Health Act campaign. *International Journal of Critical Psychology*, 13, 55-75.
- Harré, R. (1986). *The social construction of emotion*. Oxford: Blackwell.
- Harré, R. (1998). *Positioning theory: moral contexts of interactional action*. Blackwell: Oxford.
- Harré, R., & Gillett, G. (1994). *The discursive mind*. London: Sage.
- Heaton, J. (1999). The gaze and visibility of the carer: a Foucauldian analysis of the discourse of informal care. *Sociology of Health & Illness*, 21(6), 759-777.
- Heidegger, M. (1962). *Being and time*. New York: Harper & Row.
- Henriques, J., Hollway, W., Urwin, C., Venn, C., & Walkerdine, V. (1984). *Changing the subject: psychology, social regulation and subjectivity*. London: Routledge.
- Hepburn, A. (2002). *An introduction to critical social psychology*. London: Sage.
- Hollway, W. (1989). *Subjectivity and method in psychology: gender, meaning and science*. London: Sage.
- Hopton, J. (2006). The future of critical psychiatry. *Critical Social Policy*, 26(1), 57-73.
- Horton-Salway, M. (2001). Narrative identities and the management of personal accountability in talk about ME: A discursive psychology approach to illness narrative. *Journal of Health Psychology*, 6(2), 247-259.

Hospital plan for England and Wales (1962). London: HMSO.

Hostick, T., & Newell, R. (2004). Concordance with community mental health appointments: service users' reasons for discontinuation. *Journal Of Clinical Nursing*, *13*, 895-902.

Howarth, C., & Hook, D. (2005). Towards a critical social psychology of racism: Points of disruption. *Journal of Community & Applied Social Psychology*, *15*(6), 425-431.

Howson, A., & Inglis, D. (2001). The body in sociology: tensions inside and outside sociological thought. *Sociological Review*, *49*(3), 297-317.

Isherwood, T., Burns, M., & Rigby, G. (2006). A qualitative analysis of the 'management of schizophrenia' within a medium-secure service for men with learning disabilities. *Journal of Psychiatric and Mental Health Nursing*, *13*(2), 148-156.

Janssen, I., Krabbendam, L., Bak, M., Hanssen, M., Vollebergh, W., de Graaf, R., & van Os, J. (2004). Childhood abuse as a risk factor for psychotic experiences. *Acta Psychiatrica Scandinavica*, *109*(1), 38-45.

Jefferson, G. (1985). An exercise in the transcription and analysis of laughter. In T. A. van Dijk (Ed.). *Handbook of discourse analysis: vol 3*. London: Academic Press.

Jenkins, P. (1994). *Using murder: the social construction of serial homicide*. New York: A. de Gruyter.

Jones, K. (1993). *Asylums and after: a revised history of the mental health services: from the early 18th century to the 1990s*. Atlantic Highlands, N.J.: Athlone Press.

Jones, K., & Poletti, A. (1985). Understanding the Italian experience. *British Journal of Psychiatry*, *146*, 341-347.

Kafka, F. (1992). *The transformation and other stories*. London: Penguin.

- Kamali, M., Kelly, B. D., Clarke, M., Browne, S., Gervin, M., Kinsella, A., Lane, A., Larkin, C., & O'Callaghan, E. (2006). A prospective evaluation of adherence to medication in first episode schizophrenia. *European Psychiatry, 21*(1), 29-33.
- Katschnig, H. (2002). Kraepelin's, Bleuler's and Schneider's concepts of schizophrenia - their relevance for the stigma process. *Neuropsychiatrie, 16*(1-2), 11-19.
- Knight, M. T. D., Wykes, T., & Hayward, P. (2006). Group treatment of perceived stigma and self-esteem in schizophrenia: a waiting list trial of efficacy. *Behavioural and Cognitive Psychotherapy, 34*(3), 305-318.
- Krumm, S., & Becker, T. (2006). User involvement in mental health services research. *Psychiatrische Praxis, 33*(2), 59-66.
- Kuipers, G. (2006). The social construction of digital danger: debating, defusing and inflating the moral dangers of online humor and pornography in the Netherlands and the United States. *New Media & Society, 8*(3), 379-400.
- Laing, R. D. (1969). *The divided self: an existential study in sanity and madness*. London: Tavistock.
- Laing, R. D., and Esterson, A. (1964). *Sanity, madness, and the family*. London: Tavistock Publications.
- Latour, B. (1987). *Science in action: how to follow scientists and engineers through society*. Milton Keynes: Open University Press.
- Latour, B. (1999). *Pandora's hope: essays on the reality of science studies*. London: Harvard University Press.
- Latour, B., & Woolgar, S. (1979). *Laboratory life: the social construction of scientific facts*. London: Sage.

Laurance, J. (2002). *Pure madness: how fear drives the mental health system*. London: Routledge.

Law, J., & Hassard, J. (1999). *Actor network theory and after*. Oxford: Blackwell.

Le Fanu, J. (1999). *The rise and fall of modern medicine*. London: Little, Brown.

Leder, D. (1990). *The absent body*. Chicago: Chicago University Press.

Lee, S., Chiu, M. Y. L., Tsang, A., Chui, H., & Kleinman, A. (2006). Stigmatizing experience and structural discrimination associated with the treatment of schizophrenia in Hong Kong. *Social Science & Medicine*, 62(7), 1685-1696.

Lehmann, H. E., & Hanrahan, G. E. (1954). Chlorpromazine, new inhibiting agent for psychomotor excitement and manic states. *Archives of Neurology and Psychiatry*, 71, 227-237.

Ley, P. (1997). Compliance among patients. In S. Baum, J. Newman, J. Weinman, R. West & C. McManus (Eds.). *Cambridge handbook of psychology, health and medicine*. Cambridge: Cambridge University Press.

Lorber, J., & Farrell, S., A (Eds.). (1990). *The social construction of gender*. London: Sage.

Loring, M., & Powell, B. (1988). Gender, race, and DSM-III: a study of objectivity of psychiatric diagnostic behaviour. *Journal of Health and Social Behaviour*, 29(1), 1-22.

Lucas, M., & Stevenson, D. (2006). Violence and abuse in psychiatric in-patient institutions: A South African perspective. *International Journal of Law and Psychiatry*, 29(3), 195-203.

Luscher, L. S., Lewis, M., & Ingram, A. (2006). The social construction of organizational change paradoxes. *Journal of Organizational Change Management*, 19(4), 491-502.

- Lysaker, P., Lancaster, R., & Lysaker, J. (2003). Narrative transformation as an outcome in the psychotherapy of schizophrenia. *Psychology and Psychotherapy: Theory, Research and Practice*, 76, 285-299.
- MacGregor Wise, J. (2000). Home: territory and identity. *Cultural Studies*, 14(2), 295-310.
- Maher, B. A. (1974). Delusional thinking and perceptual disorder. *Journal of Individual Psychology*, 30, 98-113.
- Maniacs to be caged. (2004, 9th September). *The Sun*, 2
- Massumi, B. (2000). Too-blue: colour-patch for an expanded empiricism. *Cultural Studies*, 14(2), 177-226.
- Massumi, B. (2002). *Parables for the virtual: movement, affect, sensation*. Durham N.C.: Duke University Press.
- McLaughlin, T. (1996). Coping with hearing voices: an emancipatory discourse analytic approach. *Changes: An International Journal of Psychology and Psychotherapy*, 14, 238-243.
- McLennan, G. (2001). 'Thus': reflections on Loughborough relativism. *History of the Human Sciences*, 14(3), 85-101.
- Mechanic, D. (2001). The scientific foundations of community psychiatry. In G. Thornicroft & G. Szukler (Eds.). *Textbook of community psychiatry*. Oxford: Oxford University Press.
- Mental Health Act (1983). London: DHSS.
- Mental Health Foundation (1999). *The DIY guide to survivor research*. London: Mental Health Foundation.

Merleau-Ponty, M. (1996). *The phenomenology of perception*. London: Routledge.

Middleton, D., & Brown, S. D. (2005). *The social psychology of experience: studies in remembering and forgetting*. London: Sage.

Midgley, G., & Milne, A. (1995). Creating Employment Opportunities for People with Mental-Health Problems - a Feasibility Study for New Initiatives. *Journal of the Operational Research Society*, 46(1), 35-42.

Misdrahi, D., Llorca, P. M., Lancon, C., & Bayle, F. J. (2002). Compliance in schizophrenia: predictive factors, therapeutical considerations and research implications. *Encephale-Revue De Psychiatrie Clinique Biologique Et Therapeutique*, 28(3), 266-272.

Mol, A. (2002). *The body multiple: ontology in medical practice*. London: Duke University Press.

Moncrieff, J. (1999). An investigation into the precedents of modern drug treatment in psychiatry. *History of Psychiatry*, 10, 475-490.

Moncrieff, J. (2006). Psychiatric drug promotion and the politics of neoliberalism. *British Journal of Psychiatry*, 188, 301-302.

Muijen, M. (1996). Scare in the community: Britain in moral panic. In T. Heller, J. Reynolds, R. Gomm, R. Muston & S. Pattison (Eds.). *Mental health matters: a reader*. Basingstoke: Macmillan.

Negri, A. (2004). *Subversive Spinoza*. Manchester: Manchester University Press.

Neugebauer, R., Dohrenwend, B., & Dohrenwend, B. (1980). Formulation of hypotheses about the true prevalence of functional psychiatric disorders among adults in the United States. In B. Dohrenwend, B. Dohrenwend, M. Gould, B. Link, R. Neugebauer & R. Wunsch-Hitzig (Eds.). *Mental illness in the United States epidemiological estimates*. New York: Praeger.

- Newnes, C., & Holmes, G. (1999). The future of mental health services. In C. Newnes, Holmes, G., & Dunn, C. (Eds.). *This is Madness: a critical look at psychiatry and the future of mental health services*. Ross-on-wye: PCCS Books.
- Newnes, C., Holmes, G., & Dunn, C. (Eds.). (1999). *This is madness: a critical look at psychiatry and the future of mental health services*. Ross-on-Wye: PCCS Books.
- Newnes, C., Holmes, G., & Dunn, C. (Eds.). (2001). *This is madness too: critical perspectives on mental health services*. Ross-on-Wye: PCCS Books.
- Nightingale, D., J., & Cromby, J. (Eds.). (1999). *Social constructionist psychology: a critical analysis of theory and practice*. Buckingham: Open University Press.
- Olfson, M., Mechanic, D., Hansell, S., Boyer, C. A., Walkup, J., & Weiden, P. J. (2000). Predicting medication non compliance after hospital discharge among patients with schizophrenia. *Psychiatric Services*, 51(2), 216-222.
- Owen, R. R., Fischer, E. P., Booth, B. M., & Cuffel, B. J. (1996). Medication noncompliance and substance abuse among patients with schizophrenia. *Psychiatric Services*, 47(8), 853-858.
- Paris Spink, M.-J. (1999). Making sense of illness experience. In M. Murray & K. Chamberlain (Eds.). *Qualitative health psychology*. London: Sage.
- Parker, I. (1992). *Discourse dynamics: critical analysis for social and individual psychology*. London: Routledge.
- Parker, I. (1996). Against Wittgenstein - materialist reflections on language in psychology. *Theory & Psychology*, 6(3), 363-384.
- Parker, I. (1998). *Social constructionism, discourse, and realism*. London: Sage.
- Parker, I. (1999a). Against relativism in psychology, on balance. *History of the Human Sciences*, 12(4), 61-78.

- Parker, I. (1999b). The quintessentially academic position. *History of the Human Sciences*, 12(4), 89-91.
- Parker, I. (2002). *Critical discursive psychology*. Basingstoke: Palgrave.
- Parker, I. (2005). *Qualitative psychology: introducing radical research*. Maidenhead: Open University Press.
- Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing psychopathology*. London: Sage.
- Parker, I., & Shotter, J. (1990). *Deconstructing social psychology*. London: Routledge.
- Parr, H. (1997). Mental health, public space, and the city: questions of individual and collective access. *Environment and Planning D: Society & Space*, 15, 435-454.
- Parr, H. (1998). Mental health, ethnography and the body. *Area*, 30(1), 28-37.
- Parr, H. (2000). Interpreting the 'hidden social geographies' of mental health: ethnographies of inclusion and exclusion in semi-institutional places. *Health & Place*, 6, 225-237.
- Patel, N., & Fatimilehin, I., A. (1999). Racism and mental health. In C. Newnes, G. Holmes & C. Dunn (Eds.). *This is madness: a critical look at psychiatry and the future of mental health services*. Ross-on-Wye: PCCS Books.
- Patton, P. (2000). *Deleuze and the political*. London: Routledge.
- Penn, D. L., Waldheter, E. J., Perkins, D. O., Mueser, K. T., & Lieberman, J. A. (2005). Psychosocial treatment for first-episode psychosis: a research update. *American Journal of Psychiatry*, 162(12), 2220-2232.

Petersen, S., Soucar, B., Sherman-Slate, E., & Luna, L. (2004). The social construction of beliefs about cancer: A critical discourse analysis of racial differences in the popular press. *Journal of Applied Biobehavioral Research*, 9(4), 201-229.

Pevalin, D. J., & Goldberg, D. P. (2003). Social precursors to onset and recovery from episodes of common mental illness. *Psychological Medicine*, 33(2), 299-306.

Philo, G. (1996). *Media and mental distress*. New York: Addison Wesley Longman.

Philpot, M., Collins, C., Trivedi, P., Treloar, A., Gallacher, S., & Rose, D. (2004). Eliciting users' views of ECT in two mental health trusts with a user-designed questionnaire. *Journal of Mental Health*, 13(4), 403-413.

Pickering, A. (1984). *Constructing quarks: a sociological history of particle physics*. Edinburgh: Edinburgh University Press.

Pinfold, V. (2000). 'Building up safe havens ... all around the world': users' experiences of living in the community with mental health problems. *Health & Place*, 6(3), 201-212.

Pinfold, V., Huxley, P., Thornicroft, G., Farmer, P., Toulmin, H., & Graham, T. (2003). Reducing psychiatric stigma and discrimination - Evaluating an educational intervention with the police force in England. *Social Psychiatry and Psychiatric Epidemiology*, 38(6), 337-344.

Porter, R. (1990). Foucault's great confinement. *History of the Human Sciences*, iii, 47-54.

Potter, J. (1996). *Representing reality: discourse, rhetoric and social construction*. London: Sage.

Potter, J., Edwards, D., & Wetherell, M. (1993). A model of discourse in action. *American Behavioral Scientist*, 36(3), 383-401.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: beyond attitudes and behaviour*. London: Sage.

Potter, J., Wetherell, M., Gill, R., & Edwards, D. (2002). Discourse: noun, verb or social practice? In I. Parker (Ed.). *Critical discursive psychology*. Basingstoke: Palgrave Macmillan.

Potts, A. (2004). Deleuze on Viagra: (or; what can a 'Viagra-body' do?). *Body & Society*, 10(1), 17-36.

Powell, E. (1961). Report of the annual conference of the National Association for Mental Health. London: MIND.

Powell, R. A., Single, H. M., & Lloyd, K. R. (1996). Focus groups in mental health research: Enhancing the validity of user and provider questionnaires. *International Journal of Social Psychiatry*, 42(3), 193-206.

Prentky, R. A. (2000). Mental illness and roots of genius. *Creativity Research Journal*, 13(1), 95-104.

Radley, A. (1999). Social realms and the qualities of illness experience. In M. Murray & K. Chamberlain (Eds.). *Qualitative health psychology*. London: Sage.

Radley, A. (2003). Flirting. In J. Coupland & R. Gwyn (Eds.). *Discourse, the body, and identity*. Basingstoke: Palgrave MacMillan.

Read, J. (1997). Child abuse and psychosis: A literature review and implications for professional practice. *Professional Psychology-Research and Practice*, 28(5), 448-456.

Read, J. (2005). The bio-bio-bio model of madness. *Psychologist*, 18(10), 596-597.

Read, J. (2006). A research overview of the psychosocial predictors of psychosis, including poverty, ethnicity, intergenerational family dysfunction, loss and isolation. *Acta Psychiatrica Scandinavica*, 114, 12.

- Read, J., van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, *112*(5), 330-350.
- Rettenbacher, M. A., Hofer, A., Eder, U., Hummer, M., Kemmler, G., Weiss, E. M., & Fleischhacker, W. W. (2004). Compliance in schizophrenia: Psychopathology, side effects, and patients' attitudes toward the illness and medication. *Journal of Clinical Psychiatry*, *65*(9), 1211-1218.
- Reynolds, J. & Roffe, J. (2004) An invitation to philosophy. In J. Reynolds & J. Roffe, *Understanding Derrida*. London: Continuum.
- Rhodes, L. A. (1984). "This will clear your mind": the use of metaphors for medication in psychiatric settings. *Culture, Medicine and Psychiatry*, *8*, 49-70.
- Roe, D., & Davidson, L. (2005). Destination and detours of the users' movement. *Journal of Mental Health*, *14*(5), 429-433.
- Rogers, A., Day, J. C., Williams, B., Randall, F., Wood, P., Healy, D., & Bentall, R. (1998). The meaning and management of neuroleptic medication: a study of patients with a diagnosis of schizophrenia. *Social Science & Medicine*, *47*(9), 1313-1323.
- Rogers, A., & Pilgrim, D. (1991). 'Pulling down churches': accounting for the British Mental Health Users' Movement. *Sociology of Health & Illness*, *13*(2), 129-148.
- Rogers, A., & Pilgrim, D. (2000). *Mental health policy in Britain* (2nd ed.). Basingstoke: Palgrave.
- Rogers, A., & Pilgrim, D. (2005). *A sociology of mental health and illness: 3rd edition*. Maidenhead: Open University Press.
- Rogers, A., Pilgrim, D., & Lacey, R. (1993). *Experiencing psychiatry: users' views of services*. London: MacMillan.
- Romme, M., & Escher, S. (1993). *Accepting voices*. London: MIND.

- Romme, M., & Escher, S. (1994). Hearing Voices. *British Medical Journal*, 309, 670.
- Romme, M., & Escher, S. (2000). *Making sense of voices: a guide for mental health professionals working with voice-hearers*. London: MIND.
- Rosch, E., & Lloyd, B. B., (1978). *Cognition and categorization*. New York: L. Erlbaum Associates.
- Rose, N. (2001). Historical changes in mental health practice. In G. Thornicroft & G. Szukler (Eds.). *Textbook of community psychiatry*. Oxford: Oxford University Press.
- Rosler, W. (1992). Griesinger, Wilhelm and the concept of community-based care. *Nervenarzt*, 63(5), 257-261.
- Rubenstein, G. (1995). The decision to remove homosexuality from the DSM: twenty years later. *American Journal of Psychotherapy*, 49(3), 416-427.
- Sacks, H. (1995). *Lectures on conversation*. Oxford: Blackwell.
- Sadler, J. Z. (2005). *Values and psychiatric diagnosis*. Oxford: Oxford University Press.
- Saldanha, A. (2005). Trance and visibility at dawn: racial dynamics in Goa's rave scene. *Social & Cultural Geography*, 6(5), 707-721.
- Salvi, G., Jones, J., & Ruggeri, M. (2005). Systematic review of the role of service users as researchers in mental health studies. *Epidemiologia E Psichiatria Sociale*, 14(4), 217-226.
- Sandwell Public Information Network (2005). *Positive mental health*, from <http://www.webwell.org.uk/server.php?navId=002001003004>. Accessed on September 9th, 2005.

- Scarry, E. (1985). *The body in pain: the making and unmaking of the world*. Oxford: Oxford University Press.
- Schneider, K. (1959). *Clinical psychopathology*. New York: Grune & Stratton.
- Schulze, B., & Angermeyer, M. C. (2002). Changing perspectives: Stigma from the point of view of people with schizophrenia, their families and of mental health professionals. *Neuropsychiatrie*, 16(1-2), 78-86.
- Scull, A. T. (1977). *Museums of madness: the social organization of insanity in 19th century England*. Harmondsworth: Penguin.
- Sharma, P. D. (2000). Social construction of Indian forests. *Man in India*, 79(3-4), 426-427.
- Shilling, C. (2003). *The body and social theory* (2nd ed.). London: Sage.
- Shilling, C. (2005). *The body in culture, technology and society*. London: Sage.
- Shotter, J. (1993). *Conversational realities: constructing life through language*. London: Sage Publications.
- Silvestri, F., & Hallwright, S. (2001). The future approach for community mental health. In C. Newnes, G. Holmes & C. Dunn (Eds.). *This is madness too: critical perspectives on mental health services*. Ross-on-wye: PCCS Books.
- Smith, S. M., O'Keane, V., & Murray, R. (2002). Sexual dysfunction in patients taking conventional antipsychotic medication. *British Journal of Psychiatry*, 181, 49-55.
- Speed, E. (2006). Patients, consumers and survivors: a case study of mental health service user discourses. *Social Science & Medicine*, 62(1), 28-38.

Spiers, S., Harney, K., & Chilvers, C. (2005). Service user involvement in forensic mental health: can it work? *Journal of Forensic Psychiatry & Psychology*, *16*(2), 211-220.

Spinoza, B. (1996). *Ethics*. London: Penguin.

Stainton Rogers, R. (1995). *Social psychology: a critical agenda*. Cambridge: Polity.

Stainton Rogers, W. (2003). *Social psychology: experimental and critical approaches*. Buckingham: Open University Press.

Stenner, P. (1993). Discoursing jealousy. In E. Burman & I. Parker (Eds.), *Discourse analytic research: repertoires and readings of texts in action*. London: Routledge.

Stowell-Smith, M. (1996). *Race, psychopathy and subjectivity*. Unpublished Ph.D. Thesis. Manchester Metropolitan University, Manchester.

Stuart, H. (2006). Media portrayal of mental illness and its treatments - what effect does it have on people with mental illness? *Cns Drugs*, *20*(2), 99-106.

Sullivan, C. (2002). Critical social psychology: an introduction. *Psychologist*, *15*(10), 526-526.

Szasz, T. (1974). *The myth of mental illness: foundations of a theory of personal conduct* (Revised ed.). New York: Harper and Row.

Tarrier, N. (2005). Cognitive behaviour therapy for schizophrenia - a review of development, evidence and implementation. *Psychotherapy and Psychosomatics*, *74*(3), 136-144.

Telford, R., & Faulkner, A. (2004). Learning about service user involvement in mental health research. *Journal of Mental Health*, *13*(6), 549-559.

- Theory & Psychology, (1996). Special issue: The body and psychology. *Theory & Psychology*, 6(4).
- Thomas, P., & Bracken, P. (2004). Hearing voices: a phenomenological-hermeneutic approach. *Cognitive neuropsychiatry*, 9(1/2), 13-23.
- Torrey, E. F., & Zdanowicz, M. (2001). Outpatient commitment: what, why, and for whom. *Psychiatric Services*, 52(3), 337-341.
- Trivedi, P., & Wykes, T. (2002). From passive subjects to equal partners - qualitative review of user involvement in research. *British Journal of Psychiatry*, 181, 468-472.
- Tucker, I. (2004). 'Stories' of chronic fatigue syndrome: an exploratory discursive psychological analysis. *Qualitative Research in Psychology*, 1(2), 153-167.
- Tucker, I. (2006). Towards the multiple body. *Theory & Psychology*, 16(3), 433-440.
- Tuffin, K., & Frewin, K. (2004). Teaching critical social psychology. *Australian Journal of Psychology*, 56, 95.
- Turner, B. S. (1984). *The body and society*. Oxford: Blackwell.
- Tyrer, P. (2001). Methods for evaluating community treatments. In G. Thornicroft & G. Szumkler (Eds.). *Textbook of community psychiatry*. Oxford: Oxford University Press.
- Varela, F. J., Thompson, E., & Rosch, E. (1991). *The embodied mind: cognitive science and human experience*. London: MIT Press.
- Vygotsky, L. (1962). *Thought and language*. Cambridge, MA: Harvard University Press.
- Vygotsky, L. S. (1997). Socialistic modification of human. *Psikhologicheskii Zhurnal*, 18(3). 142-148.

- Walkerdine, V. (1990). *Schoolgirl fictions*. London: Verso.
- Warner, R. (1994). *Recovery from schizophrenia: psychiatry and political economy 2nd Edition*. London: Routledge.
- Wetherell, M. (1998). Positioning and interpretative repertoires: conversation analysis and post-structuralism in dialogue. *Discourse and Society*, 9(3), 387-412.
- Wiggins, S., Potter, J. A., & Wildsmith, A. (2001). Eating your words: discursive psychology and the reconstruction of eating practices. *Journal of Health Psychology*, 6(1), 5-15.
- Williams, J. (1999). Social inequalities and mental health. In C. Newnes, G. Holmes & C. Dunn (Eds.). *This is Madness: a critical look at psychiatry and the future of mental health services*. Ross-on-wye: PCCS Books.
- Williams, S. J. (1996). The vicissitudes of embodiment across the chronic illness trajectory. *Body and Society*, 2(2), 23-47.
- Willig, C. (2001). *Introducing qualitative research in psychology: adventures in theory and method*. Maidenhead: Open University Press.
- Willig, C. (Ed.). (1999). *Applied discourse analysis*. Buckingham: Open University Press.
- Winch, P. (1958). *The idea of a social science and its relation to philosophy*. London: Routledge & Kegan Paul.
- Wittgenstein, L. (1933). *Tractatus logico-philosophicus*. New York: Kegan Paul.
- Wittgenstein, L. (1953). *Philosophical investigations*. Oxford: Basil Blackwell.
- World Health Organization. (1993). *The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research*. Geneva: World Health Organization.

- Yardley, L. (1999). Understanding embodied experience. In M. Murray & K. Chamberlain (Eds.). *Qualitative health psychology*. London: Sage.
- Yardley, L. (Ed.). (1997). *Material discourses of health and illness*. London: Routledge.
- Young, M. (1999). The social construction of tourist places. *Australian Geographer*, 30(3), 373-389.
- Zacher, P. (2001). Psychiatric disorders are not natural kinds. *Philosophy, Psychiatry and Psychology*, 7(3), 167-182.
- Zajac, E. J., & Westphal, J. D. (2004). The social construction of market value: institutionalization and learning perspectives on stock market reactions. *American Sociological Review*, 69(5), 748-749.
- Ziegler, C. E. (2005). Social construction of international politics: identities & foreign policies, Moscow, 1955 and 1999. *Slavic Review*, 64(3), 682-683.

Appendix 1:

Transcript Notation

- (.) - short pause, less than one second. Numbers used in brackets to indicate number of seconds of pause
- :
- colon indicates elongated parts of word. More lengthy elongations indicated by more colons
- [] - square brackets used for brief comments by other person
-
- underlining refers to emphasis
- F
- capitals with underlining to indicate severe emphasis
- “”
- quote marks used when speaker drawing on third party talk
- ()
- used when that section of talk was not entirely clear. Inaudible sections marked by stating inaudible in brackets
- °
- indicate periods of quiet talk
- \
- overlapping speech
- *
- interruption

Appendix 2:

Interview Schedule

INTERVIEW SCHEDULE

Interviews will be semi-structured and based upon three layers of questions. Firstly a level of matters of fact, such as 'what medication do you take?'; followed by an evaluative level, such as 'do you think you see your psychiatrist enough?'; and finally a phenomenological level, such as 'how do you decide whether your medication is working?' The main areas to be covered are medication, service provision, diagnosis, everyday activities and role of support (carers, support groups etc).

Matters of fact:

How long have you been coming along to (day centre name) then?

How did you come to be involved in the support group?

- how long?

Do you go to any other support groups?

Do you work?

Have you ever worked?

Do you have a daily routine?

What do you do when you are at home?

Do you go out much?

- where?

- why?

Do you live on your own?

Do you have any support?

Have you been prescribed medication?

What kind of medication have you taken in the past?

Do you take more than one medication?

What times of the day do you take it?

Is it difficult to remember to take it?

How do you get more medication?

How is it kept?

How does it come?

(Have you received a diagnosis?

- What was it?

- When?)

Evaluative:

Do you see your psychiatrist enough?

(Do you agree with your diagnosis?)

(Why do you think you received that diagnosis?)

Do you think your medication has helped?

Has anything else helped?

Do you see your experiences as problematic?
Have you ever stopped taking your medication?
Do you feel in control of your medication/treatment?
In your experience, do you think medication has become better?
What do you think of the provision of services?
Are you happy with your living arrangements?

Phenomenological:

How do the places you go make you feel?
What are the things you notice about yourself that help you decide whether your medication is working or not?
How does it make you feel physically?
- side effects?
What is it that leads you to believe side effects are result of taking medication?
What are the differences between being on medication and not taking it?
(Do you think other people have experiences like yours?)
(Where do you think these experiences come from?
- internally, externally?)
How do your experiences occur, i.e. at what point do things become problematic, is it a gradual thing?

Appendix 3:

Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Nature of study

The aim of the study is to gain a greater understanding of the lives and experiences of people who have experienced mental health difficulties. The focus is on the ways that service users organise and manage their lives in regard to their experiences, in terms of issues such as medication, support, service provision, and everyday activity. The study is based on the belief that service users' experiences should be placed at the forefront of research in the area of mental health.

What does the study involve?

Participation in the study would involve partaking in an interview of a maximum duration approximately one hour. The interviews would be based on a semi-structured questionnaire, but as the whole basis of the study is to gain knowledge from individuals' experiences themselves, the interviews would be very open.

Right to withdraw

Any participant in the study has the right to withdraw at any stage without having to give a reason. Also, participants could ask for interviews already taken place to not be included if they so wish.

Confidentiality and anonymity

Complete confidentiality and anonymity is guaranteed throughout. Any reference made or excerpts of data included in the final research will have both place and personal names changed. All audio recordings will be stored under lock and key and destroyed on completion of the study.

What will happen to the research?

The research will form part of a doctoral thesis. Parts or all of the research will be submitted for publication in academic and clinical journals and conferences.

Appendix 4:

Informed Consent Form

INFORMED CONSENT FORM

(to be completed after Participant Information Sheet has been read)

The purpose and details of this study have been explained to me. I understand that all procedures have been approved by the Loughborough University Ethical Advisory Committee.

I have read and understood the information sheet and this consent form.

I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in the study.

I understand that I have the right to withdraw from this study at any stage for any reason, and that I will not be required to explain my reasons for withdrawing.

I understand that all the information I provide will be treated in strict confidence.

I agree to participate in this study.

Your name

Your signature

Signature of investigator

Date
